

REPORT 4
PATTON STATE HOSPITAL

June 9-13, 2008

THE HUMAN POTENTIAL CONSULTING GROUP
ALEXANDRIA, VIRGINIA

NOTE

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

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

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Introduction

A. Background Information

The evaluation team, consisting of Court Monitor (Mohamed El-Sabaawi, MD) and four expert consultants (Vicki Lund, PhD, MSN, ARNP; Ramasamy Manikam, PhD; Elizabeth Chura, MSRN; and Monica Jackman, OTR/L) visited Patton State Hospital (PSH) from June 9 to 13, 2008 to evaluate the facility's progress regarding compliance with the Enhancement Plan (EP). The evaluators' objective was to develop a detailed assessment of the status of compliance with all action steps of the EP.

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

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

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

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

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

B. Methodology

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

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

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

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

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

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

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

C. Statistical Reporting

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

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

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

D. Findings

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

1. Key Indicator Data

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

- a. The use of interclass polypharmacy appears to be declining moderately.
- b. Incidents of escape/AWOL spiked earlier in 2008 but appear to have moderated.
- c. Medication variance reporting has increased to levels that are believed to be more representative of variances expected at a facility like PSH.
- d. Incidents of outside hospitalization have approximately doubled in the past 18 months.
- e. Some key indicators still unexpectedly reverse direction fairly consistently from month to month, such as incidents of restraint.

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2. Monitoring, mentoring and self-evaluation

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

- a. PSH has implemented a WRP mentoring program that resulted in improved process of the WRPC.
- b. PSH has presented data showing a positive trend in results of the competency-based WRP training of all members of the WRPTs.
- c. PSH has provided meaningful data analysis of its self-monitoring data in several sections of the EP. This analysis included delineation of areas of low compliance and relative improvement during the current reporting period and compared to the previous period as well as plans to improve compliance.
- d. PSH has strengthened its system of clinical oversight of the WRPTs.
- e. With few exceptions, the DMH has standardized auditing tools for all applicable sections of the EP.
- f. PSH has implemented the DMH standardized tools in all applicable sections in the EP.
- g. The facility's self-monitoring data generally had integrity, were reasonably well organized and the data presented were relevant to requirements of the EP.
- h. PSH has improved the sampling methodology during this review period. However, further work is needed to ensure acceptable samples of appropriately defined target populations across the board.
- i. All facilities must ensure that discipline chiefs and senior executives review the monitoring data on a monthly basis at the facility level and that results of these reviews are used to enhance service delivery within each facility. As mentioned in earlier reports by this monitor, the monitoring data across hospitals should be reviewed quarterly by the State with its Chief CRIPA Consultant so that the aggregate data can be used to enhance the mental health services provided throughout the DMH system.
- j. The DMH has yet to ensure that the tools and data collection are automated.

3. Implementation of the EP

- a. Overall, PSH has developed most of the structures and processes that are required for implementation of the EP. At this juncture, the facility needs to focus its efforts on using the EP processes and monitoring data to refine the quality of clinical services to the individuals.
- b. PSH has maintained substantial compliance with EP requirements in section D.7 (Court Assessments). However, continued vigilance in the preparation of thorough, detailed and thoughtful reports will be necessary to maintain this rating.

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- c. Since the last review period, PSH has made progress in the following areas:
 - i. The process of the WRPC;
 - ii. Scheduling of individuals for the required active treatment hours and correcting discrepancies between WRP and MaPP data in this regard;
 - iii. Timely implementation of WRP reviews;
 - iv. The content of case formulations in many WRPs;
 - v. Lesson plans for PSR Mall nutrition and many Rehabilitation Therapy groups;
 - vi. The quality of Admission Psychiatric Assessments;
 - vii. Timeliness and quality of the Psychology Integrated Assessments;
 - viii. The formats for Admission and Integrated Nursing Assessments;
 - ix. Training regarding Nursing Admission and Integrated Assessments;
 - x. Time limits regarding orders for PRN medications;
 - xi. Drug Utilization Evaluations;
 - xii. Implementation of the Meal Accuracy report;
 - xiii. The Infection Control Department, including staffing and compliance with the EP in a number of departmental areas;
 - xiv. Seclusion and restraints (elimination of the use of side rails as restraints and use of seclusion or restraints as part of behavior interventions);
 - xv. Documentation of dental care services;
 - xvi. Revisions of Medical Care Policies and Procedures to address the deficiencies reported by the court monitor;
 - xvii. Implementation of the medical quarterly reassessments for all individuals with Axis III diagnoses;
 - xviii. Quality (not timeliness) of investigations of abuse/neglect;
 - xix. Functions of the Incident review Committee;
 - xx. Implementation of several risk management initiatives;
 - xxi. Steps to improve the cleanliness of the environment of care; and
 - xxii. Response to individuals' concerns about treatment by dining room staff.
- d. PSH has maintained compliance with the requirement regarding after-hours coverage by Psychiatric and Medical Officers-of-the-Day.
- e. PSH has maintained quality improvements in nutritional assessments and services.
- f. PSH has yet to make progress to meet the required staffing ratios in the admission and long-term units.
- g. PSH has yet to make progress in achieving appropriate linkage between interventions provided at the PSR Mall and objectives outlined in the WRP.
- h. PSH has to finalize a template for the Psychiatric Reassessments and to ensure that these reassessments provide a more concise, individualized and meaningful review of clinical data.

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- i. PSH has yet to make progress in its substance abuse services.
- j. PSH has yet to make progress in reporting of adverse drug reactions.
- k. While PSH has very recently increased the number of medication variances reported, progress has to be seen on a more sustained basis.
- l. PSH has yet to develop and implement mechanisms to improve nursing attention to changes in the physical status of individuals and nurse-physician communications regarding ongoing care and follow up care upon return of individuals from outside hospitalization.
- m. PSH has yet to make significant progress in the current incident and risk management systems. The facility needs to revise current processes, including identification of triggers and thresholds regarding high-risk behavior, establishment of levels of interventions corresponding to the level of risk and appropriate notification and follow up mechanisms. The interventions and follow up should include, but not be limited, to the following:
 - i. First level response by the WRPTs, including timely review of incidents and analysis of contributing factors, timely and appropriate use of Stat and PRN medications, judicious use of restrictive interventions in accord with current DMH procedures and use of positive behavior supports whenever indicated as well as other corrective actions, as needed;
 - ii. Second level review by clinical leadership;
 - iii. Outside consultations, if necessary; and
 - iv. An oversight mechanism to review trends and patterns and initiate systemic performance improvement projects.
- n. The DMH needs to finalize efforts to automate the processes of assessments and WRPs.
- o. Given that the EP provides the basis for the mental health services delivered in the California DMH State Hospitals, it is the monitor's recommendation that the DMH seriously consider standardizing across all hospitals the Administrative Directives that impact these services.
- p. Functional/clinical outcomes of the current structural changes have yet to be identified and implemented to guide further implementation.
- q. A well-functioning PSR Mall that meets the specific needs of the individuals is the centerpiece of the Wellness and Recovery Planning model. Progress remains to be made towards this goal, specifically in the areas of:
 - i. Mall hours: The number of hours of Psychosocial Rehabilitation Mall (PSR) services (i.e., group facilitation or individual therapy) provided by the various disciplines, administrative staff, and others is currently minimal. The following table provides the minimum average number of hours of mall services that DMH facilities should provide:

DMH PSR MALL HOURS REQUIREMENTS

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

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

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

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

- ii. **Progress notes:** PSH has yet to implement a requirement for providers of mall groups and individual therapy to complete and make available to each individual's Wellness and Recovery Planning Team (WRPT) the DMH-approved PSR Mall Facilitator Monthly Progress Note prior to regularly scheduled WRPCs. Without the information in the monthly progress notes, the WRPT has almost no basis for revising an individual's objectives and interventions. This is not aligned with the requirements as stated in the DMH WRP Manual. All hospitals must fully implement the PSR Mall Facilitator Monthly Progress Note in their PSR Malls for all groups and individual therapies.
- iii. **Cognitive screening for PSR Mall groups:** PSR Mall groups should be presented in terms of the cognitive levels of the individuals at the hospital. Individuals can be stratified at three cognitive levels: (a) advanced (above average), (b) average, and (c) challenged (below average). A cognitive screening protocol, utilizing generally accepted testing methods, can be used to determine these levels for those individuals whose primary or preferred language is English.

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The cognitive screening protocol will also provide information for the WRPT psychologist to determine whether a referral to the DCAT and/or neuropsychological service is required. All State hospitals must ensure that cognitive screening has been completed for all individuals and that their Mall groups are aligned with their cognitive levels.

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

4. Staffing

The PSH staffing table below shows the staffing pattern at the hospital as of June 09, 2008. These data were provided by the facility. The table shows that there continues to be shortages of staff in several key areas: senior psychiatrists, senior and staff psychologists, dietary personnel, clinical social workers, rehabilitation therapists and nursing staff (registered nurses and psychiatric technicians). PSH has made progress in recruitment of staff psychiatrists since the last review, but more work is needed to fill all required positions.

Patton State Hospital Vacancy Totals as of 6/9/2008				
Identified Clinical Positions	Budgeted Positions 07/08 FY	Filled Positions	Vacancies	Vacancy Rate
Assistant Coordinator of Nursing Services	5.0	5.0	0.0	0%
Assistant Director of Dietetics	5.0	4.0	1.0	20%
Audiologist I	1.0	1.0	0.0	0%
Chief Dentist	1.0	1.0	0.0	0%
Chief Physician & Surgeon	1.0	1.0	0.0	0%

Patton State Hospital Vacancy Totals as of 6/9/2008				
Identified Clinical Positions	Budgeted Positions 07/08 FY	Filled Positions	Vacancies	Vacancy Rate
Chief, Central Program Services	0.0	0.0	0.0	0%
Chief Psychologist	1.0	1.0	0.0	0%
Clinical Dietician/Pre-Reg. Clin. Dietician	11.0	11.0	0.0	0%
Clinical Laboratory Technologist	1.0	1.0	0.0	0%
Clinical Social Worker	102.5	91.0	11.5	11%
Coordinator of Nursing Services	1.0	1.0	0.0	0%
Coordinator of Volunteer Services	1.0	1.0	0.0	0%
Dental Assistant	4.0	4.0	0.0	0%
Dentist	2.0	2.0	0.0	0%
Dietetic Technician	4.0	3.0	1.0	25%
E.E.G. Technician	0.0	0.0	0.0	0%
Food Services Technician I and II	118.0	101.0	17.0	14%
Hospital Worker	0.0	0.0	0.0	0%
Health Record Technician I	6.0	6.0	0.0	0%
Health Record Techn II sp	3.0	3.0	0.0	0%
Health Record Techn II sup	1.0	1.0	0.0	0%
Health Record Techn III	1.0	1.0	0.0	0%
Health Services Specialist	25.0	22.0	3.0	12%
Institution Artist Facilitator	0.0	0.0	0.0	0%
Licensed Vocational Nurse	81.0	76.0	5.0	6%
Medical Technical Assistant	0.0	0.0	0.0	0%
Medical Transcriber	6.0	6.0	0.0	0%

Patton State Hospital Vacancy Totals as of 6/9/2008				
Identified Clinical Positions	Budgeted Positions 07/08 FY	Filled Positions	Vacancies	Vacancy Rate
Medical Transcriber Sup	0.0	0.0	0.0	0%
Sr Medical Transcriber	0.0	0.0	0.0	0%
Nurse Instructor	5.0	5.0	0.0	0%
Nurse Practitioner	5.0	5.0	0.0	0%
Nurse Coordinator	11.0	11.0	0.0	0%
Office Technician	31.0	27.0	4.0	13%
Pathologist	0.0	0.0	0.0	0%
Pharmacist I	14.0	14.0	0.0	0%
Pharmacist II	1.0	1.0	0.0	0%
Pharmacist Services Manager	1.0	1.0	0.0	0%
Pharmacy Technician	11.0	11.0	0.0	0%
Physician \$ Surgeon	21.0	20.8	0.3	1%
Podiatrist	1.0	1.0	0.0	0%
Pre-Licensed Pharmacist	0.0	0.0	0.0	0%
Pre-Licensed Psychiatric Technician	15.0	15.0	0.0	0%
Program Assistant	8.0	8.0	0.0	0%
Program Consultant (RT,PSW)	2.0	2.0	1.0	0%
Program Director	8.0	8.0	0.0	0%
Psychiatric Nursing Education Director	1.0	1.0	0.0	0%
Psychiatric Technician*	736.0	661.0	75.0	10%
Psychiatric Technician Trainee*	0.0	0.0	0.0	0%
Psychiatric Technician Assistant*	44.1	37.0	7.1	16%

Patton State Hospital Vacancy Totals as of 6/9/2008				
Identified Clinical Positions	Budgeted Positions 07/08 FY	Filled Positions	Vacancies	Vacancy Rate
Psychiatric Technician Instructor	1.0	1.0	0.0	0%
Psychologist-HF, (Safety)	69.6	56.3	13.4	19%
Public Health Nurse II	2.0	2.0	0.0	0%
Radiologic Technologist	1.0	1.0	0.0	0%
Register Nurse*	361.2	343.0	18.2	5%
Reg. Nurse Pre Registered	0.0	0.0	0.0	0%
Rehabilitation Therapist	95.0	68.9	26.2	28%
Special Investigator	3.0	3.0	0.0	0%
Special Investigator, Senior	2.0	1.0	1.0	50%
Speed Pathologist I	1.0	1.0	0.0	0%
Sr. Psychiatrist (Spvr)	23.2	0.0	23.2	100%
Sr. Psychologist (Spvr and Spec)	26.3	10.3	16.1	61%
Sr. Psych Tech (Safety)	77.0	77.0	0.0	0%
Sr. Radiologic Technologist (Specialist)	1.0	1.0	0.0	0%
Sr. Voc. Rehab. Counselor/Voc.Rehab. Counselor2	2.0	2.0	0.0	0%
Staff Psychiatrist	81.2	76.8	4.5	5%
Supervising Psychiatric Social Worker	0.0	0.0	0.0	0%
Supervising Registered Nurse	1.0	1.0	0.0	0%
Supervising Rehabilitation Therapist	0.0	0.0	0.0	0%
Teacher-Adult Educ./Vocational Instructor	16.5	10.0	6.5	39%
Teaching Assistant	0.0	0.0	0.0	0%
Unit Supervisor	34.0	33.0	1.0	3%

Patton State Hospital Vacancy Totals as of 6/9/2008				
Identified Clinical Positions	Budgeted Positions 07/08 FY	Filled Positions	Vacancies	Vacancy Rate
Vocational Services Instructor (Landscp Gardn) (S)	1.0	1.0	0.0	0%

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

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

Psychiatric Mental Health Advanced Practice Nurses and/or Clinical Nurse Specialists should be actively recruited to develop a program and provide education for psychiatric mental health nursing. Within the first 90 days of employment, any nurse who does not have previous experience in psychiatric mental health nursing should be required to complete a basic psychiatric mental health nursing review course.

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

E. Monitor's Evaluation of Compliance

The status of compliance is assessed considering the following factors:

1. An objective review of the facility's data and records;

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

F. Next Steps

1. The Court Monitor's team is scheduled to tour Napa State Hospital July 21-25, 2008. for a follow-up evaluation.
2. The Court Monitor's team is scheduled to reevaluate Patton State Hospital December 8-12, 2008.
3. All compliance reports should be reviewed and utilized, as applicable, by all facilities to guide implementation efforts regardless of the schedule of facility-specific assessments.

Acronyms Used in This Report

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AA	Alcoholics Anonymous
AD	Administrative Directive
ADR	Adverse drug reaction
AIMS	Abnormal Involuntary Movement Scale
A/N	Abuse/Neglect
ASH	Atascadero State Hospital
BCC	Behavioral Consultation Committee
BMI	Body Mass Index
CIS	Clinical Information System
CIPRTA	Comprehensive Integrated Physical Rehabilitation Therapy Assessment
CM	Court Monitor
COPD	Chronic Obstructive Pulmonary Disease
CPR	Cardio-pulmonary resuscitation
CRIPA	Civil Rights of Institutionalized Persons Act
DCAT	Developmental and Cognitive Abilities Team (check)
DMH	Department of Mental Health
DOJ	Department of Justice
DSM-IV-TR	Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition (Text Revision)
DUE	Drug Utilization Evaluation
EKG	Electrocardiogram

Acronyms Used in This Report

EMS	Emergency Medical Service
EP	Enhancement Plan
FRP	Forensic Review Panel
GAF	Global Assessment of Functioning [Score]
H&P	History and Physical [Examination]
HIMD	Health Information Management Department
HIV	Human Immunodeficiency Virus
HSS	Health Services Specialist
IA-RTS	Integrated Assessment—Rehabilitation Therapy Section
IC	Infection Control
IDN	Inter-Disciplinary Note
IPA	Integrated Assessment: Psychology section
IRC	Incident Review Committee
IT	Information Technology
LVN	Licensed Vocational Nurse
MAPP	My Activity and Participation Plan
MIRC	Mortality Interdisciplinary Review Committee
MMSE	Mini Mental Status Examination
MOD	Medical Officer of the Day
MRSA	Methicillin-resistant Staphylococcus aureus
MSH	Metropolitan State Hospital
MTR	Medication Treatment Record

Acronyms Used in This Report

MVR	Medication Variance Report
NA	Narcotics Anonymous
NCMT	Nutrition Care Monitoring Tool
NCS	Neuropsychological Consultation Service
NGA	New generation antipsychotic
NOC	Nocturnal shift
NP	Nursing Policy
NPO	Nulla per Os (nothing by mouth)
NSH	Napa State Hospital
NST	Nutritional Status Type
OSI	Office of Special Investigations
OT	Occupational Therapy/Therapist
PBS	Positive Behavior Support
PC	Penal Code
PFA	Psychology Focused Assessment
PMAB	Prevention and Management of Assaultive Behavior
POST	Physical, Occupational, and Speech/Language Pathology
PPD	Purified Protein Derivative (skin test for tuberculosis)
PPN	Physicians Progress Note
PRA	Patients' Rights Advocate
PRN	Pro re nata (as needed)
PSH	Patton State Hospital

Acronyms Used in This Report

PSR	Psychosocial Rehabilitation
PSST	Psychology Specialized Services Team
PT	<ul style="list-style-type: none"> • Physical Therapy/Therapist (in Sections D.4 and F.4) • Psychiatric Technician (in Sections D.3 and F.3)
P&T	Pharmacy and Therapeutics [Committee]
RD	Registered Dietician
RIAT	Rehabilitation Integrated Assessment Team
RMS	Records Management System
RN	Registered nurse
SA	Substance abuse
SAMHSA	Substance Abuse and Mental Health Services Administration
SLP	Speech Language Pathology/Pathologist
SO	Special Order
TB	Tuberculosis
TD	Tardive dyskinesia
WaRMSS	Wellness and Recovery Model Support System
WRP	Wellness and Recovery Plan
WRPC	Wellness and Recovery Planning Conference
WRPT	Wellness and Recovery Planning Team

Section C: Integrated Therapeutic and Rehabilitation Services Planning

C. Integrated Therapeutic and Rehabilitation Services Planning		
	<p>Each State hospital shall provide coordinated, comprehensive, individualized protections, services, supports, and treatments (collectively "therapeutic and rehabilitation services") for the individuals it serves, consistent with generally accepted professional standards of care. In addition to implementing the therapeutic and rehabilitation planning provisions set forth below, each State hospital shall establish and implement standards, policies, and practices to ensure that therapeutic and rehabilitation service determinations are consistently made by an interdisciplinary team through integrated therapeutic and rehabilitation service planning and embodied in a single, integrated therapeutic and rehabilitation service plan.</p>	<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. PSH has provided meaningful analysis of its self-monitoring data. 2. PSH implemented a WRP mentoring program that has resulted in improved WRPC process. 3. PSH has presented data showing positive results of competency-based WRP training of all WRPT members. 4. PSH has strengthened its system of clinical oversight of the WRPTs. 5. PSH has improved the timeliness of WRP reviews. 6. PSH has made progress in scheduling individuals for required active treatment hours and in correcting the discrepancies between WRP and MAPP data in this regard. 7. PSH increased the number of Mall groups offered. 8. PSH increased the number of Enrichment and Exercise groups offered. 9. The BY CHOICE Program has improved with many new additions to its program, including a café-style incentive store and printing of the individuals' goals and objectives on the back of the BY CHOICE cards. This should be of tremendous help to both the individual and the facilitators.
1. Interdisciplinary Teams		
C.1	<p>The interdisciplinary team's membership shall be dictated by the particular needs and strengths of the individual in the team's care. At a minimum, each State Hospital shall ensure that the team shall:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Gari-Lyn Richardson, Standards Compliance Director 2. George Christison, MD, Acting Chief of Psychiatry 3. Jana Larmer, PsyD, WRP Master Trainer <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. MSH WRP training modules and PSH data regarding the facility's updates of these modules 2. PSH data regarding competency-based WRP training of WRPTs

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		<ol style="list-style-type: none"> 3. DMH WRP Process Observation Monitoring Form 4. DMH WRP Process Observation Monitoring Form Instructions 5. PSH WRP Process Observation Monitoring summary data (November 2007 to April 2008) 6. DMH Clinical Chart Auditing Form 7. DMH Clinical Chart Auditing Form Instructions 8. PSH Clinical Chart Auditing Form summary data (November 2007 to April 2008) 9. DMH WRP Psychiatry Team Leadership Monitoring Form 10. DMH WRP Psychiatry Team Leadership Monitoring Form Instructions 11. PSH WRP Psychiatry Team Leadership summary data (April 2008) 12. PSH data regarding staffing ratios <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPC (Program I, unit 11) for 14-Day review of SZ 2. WRPC (Program I, unit 74) for monthly review of YTP 3. WRPC (Program VI, unit 09) for 14-Day review of TLE 4. WRPC (Program VI, unit 12) for 14-Day review of LBP 5. WRPC (Program VI, unit 35) for monthly review of JJ 6. WRPC (Program VI, unit 70) for monthly review of JJB 7. WRPC (Program VIII, unit 20) for 14-Day review of RLR
C.1.a	<p>Have as its primary objective the provision of individualized, integrated therapeutic and rehabilitation services that optimize the individual's recovery and ability to sustain himself/herself in the most integrated, appropriate setting based on the individual's strengths and functional and legal status and support the individual's ability to exercise his/her liberty interests, including the interests of self determination and independence.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Standardize all WRP training modules (Engagement, Case Formulation, Foci/Objectives/Interventions, Discharge Planning/Community Integration and Team Leadership) for use across facilities and ensure that all these modules are aligned with the DMH WRP Manual.</p> <p>Findings: The modules developed by MSH are aligned with the DMH WRP Manual. PSH has adopted all of the MSH modules except for the Discharge</p>

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		<p>Planning module. The facility has its own Discharge Planning module, which is appropriately aligned with the Manual. PSH began implementation of these modules in May 2008, based on a referral process.</p> <p>Recommendation 2, November 2007: Provide outline of all current and planned WRP training activities, including information on who provides the training, brief description of the scope of the training, any changes in the training (type and personnel) since the last review and an update on current barriers to compliance and the facility's corrective actions.</p> <p>Findings: Since the last review, PSH has reorganized and strengthened its WRP training program as follows:</p> <ol style="list-style-type: none"> 1. In January 2008, a hospital-wide WRP mentoring program was launched. The mentors' group has consisted of seven senior clinicians from the disciplines of psychology, social work and rehabilitation therapy, and eight senior psychiatrists. Training of the mentors was provided initially by the State Consultant, Dr. Ron Boggio, and subsequently by two of the senior psychiatrists. The training included aspects of WRPs and the use of the DMH Observation Monitoring Auditing Tool. 2. The WRP mentors have been organized by program, with each program having a WRP mentoring team comprised of seniors from all four disciplines. This configuration has ensured that each WRPT at the facility has had a dedicated mentor since February 2008. 3. The facility has posted the standardized WRPC task sequence sheet in the WRP meeting rooms for use by the WRPTs; 4. Since February 2008, the main functions of WRP mentors have included the following: <ol style="list-style-type: none"> a. Observation of WRPCs; b. Submission of structured progress notes by email to the Master
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		<p>WRP Trainer;</p> <ul style="list-style-type: none"> c. Weekly mentors' meetings for dissemination of logistical details, discussion of issues encountered by mentors and clarification of WRP issues; d. A system for clarifying WRP technical issues. <p>5. The facility has implemented several updates of the training modules developed by MSH, including hand-outs and guidelines based on MSH lesson outlines, PowerPoint presentations and post-tests. As mentioned above, training on these modules is scheduled to begin in May 2008. The facility plans to provide this training based on referrals of staff by the mentors and/or supervisors and/or self-referral.</p> <p>6. The facility has continued the WRP Overview training of WRPTs. All staff who serve as members of a WRPT are required to attend and pass a statewide test with a score of no less than 95%.</p> <p>Recommendation 3, November 2007: Provide documentation of competency-based training of all members of the WRPTs, including all nursing staff.</p> <p>Findings: PSH has provided documentation showing a positive trend in the results of competency-based training of the WRPTs based on the WRP Overview course. The following is an outline:</p> <ul style="list-style-type: none"> 1. The MD training compliance has increased from 76% in October 2007 to 95% in April 2008. 2. The PhD, Social Work and Rehabilitation Therapist training compliance has increased from 87% in October 2007 to 100% in April 2008. 3. The RN training compliance has increased from 39% in October 2007 to 97% in April 2008. 4. The PT/LVN training compliance has increased from 35% in October 2007 to 97% in April 2008.
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		<p>Recommendation 4, November 2007: Monitor this requirement based on a 20% sample and provide data analysis (derived from Plato worksheets) regarding areas of non-compliance.</p> <p>Findings: PSH used the DMH WRP Clinical Chart Auditing Form to assess compliance with this requirement. The facility reviewed an average sample of 7% of the Monthly, Quarterly and Annual WRPs due each month (November 2007 to April 2008). Beginning in April 2008, the construct validity of this tool was enhanced by having the audit assessments made by senior clinicians. The following are the indicators and corresponding compliance rates. The data showed increased compliance relative to the last review period.</p> <table border="1" data-bbox="976 706 1871 1044"> <tr> <td data-bbox="976 706 1039 857">1.</td> <td data-bbox="1039 706 1755 857"><i>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary and appropriate psychiatric and medical care</i></td> <td data-bbox="1755 706 1871 857">2%</td> </tr> <tr> <td data-bbox="976 857 1039 1044">2.</td> <td data-bbox="1039 857 1755 1044"><i>Treatment, rehabilitation and enrichment services are goal-directed, individualized and informed by a thorough knowledge of the individual's psychiatric, medical and psychosocial history and previous response to such services</i></td> <td data-bbox="1755 857 1871 1044">20%</td> </tr> </table> <p>Recommendation 5, November 2007: Implement all required timeframes for WRP reviews, including the requirement for 30-day reviews in all units.</p> <p>Findings: During this review period, PSH has required that all admission units and all non-admitting units that have a psychiatrist-to-individual ratio of 1:15 fulfill the required timeframes for WRP reviews (including monthly reviews). Those non-admitting teams that have a psychiatrist-to-individual</p>	1.	<i>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary and appropriate psychiatric and medical care</i>	2%	2.	<i>Treatment, rehabilitation and enrichment services are goal-directed, individualized and informed by a thorough knowledge of the individual's psychiatric, medical and psychosocial history and previous response to such services</i>	20%
1.	<i>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary and appropriate psychiatric and medical care</i>	2%						
2.	<i>Treatment, rehabilitation and enrichment services are goal-directed, individualized and informed by a thorough knowledge of the individual's psychiatric, medical and psychosocial history and previous response to such services</i>	20%						

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		<p>ratio that exceeds 1:25 have been required to implement WRP conferences every other month.</p> <p>Other findings: The monitor and his experts attended seven WRPCs that were held in different programs. In general, the meetings showed progress in the process of the team meetings. The following are examples of areas of progress:</p> <ol style="list-style-type: none"> 1. The meetings started on time. 2. The team psychiatrists assumed leadership of all meetings attended. 3. The teams presented a summary of the assessment data and reviewed risk factors prior to the individual's arrival. 4. The teams discussed the key questions to be addressed during the individual's' presence. 5. The team members were respectful of the individuals and made an effort to elicit their input. 6. The teams reviewed the case formulations prior to discussion of foci, objectives and interventions. 7. In general, the teams reviewed the diagnosis, objectives and interventions with the individual. 8. In general, the teams updated the life goals and strengths during the meeting. 9. The teams made an effort to review the individual's attendance (and participation) at the assigned groups. 10. In general, the teams reviewed the By Choice participation and point allocation with the individual. 11. The teams offered a copy of the WRP to the individual. <p>However, the meetings showed some areas of process deficiencies as follows:</p> <ol style="list-style-type: none"> 1. In some meetings, the required core members representing psychology
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		<p>and rehabilitation therapy work were not present.</p> <ol style="list-style-type: none"> 2. The teams spent more time than needed to conduct the monthly reviews. 3. The teams spent much time during the WRPC updating historical information in the case formulation, sometimes at the expense of required updates of the present status section. 4. In some meetings, the teams did not revise the foci, objectives and interventions as indicated. 5. The teams did not consistently review the Task Tracking Form. 6. The teams did not link the individuals' life goals and strengths with the WRP objectives and interventions. 7. There was no mechanism to conduct data-based review of the individuals' progress in Mall groups and to ensure that Mall offerings are properly linked to the WRP objectives. 8. The reviews of the individual's progress towards discharge criteria were either generic or did not occur, and the teams did not consistently discuss with the individual progress needed to meet each criterion. <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue current WRP mentoring program and WRP Overview training. 2. Implement formal training of WRPTs using the modules regarding Engagement, Case Formulation, Foci/Objectives/Interventions, Team Leadership and Discharge Planning/Community Integration. 3. Provide documentation of results of competency-based training of WRPTs in all WRP training courses. 4. Simplify the process of the monthly WRPCs to ensure that these reviews provide updates of the status of the individuals that can be completed within a reasonable timeframe. 5. Monitor this requirement using the DMH Clinical Chart Auditing Form
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		<p>based on a 20% sample and provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p> <p>6. Provide a summary outline of any improvements in practice made as a result of review by the facility of internal monitoring data.</p>									
C.1.b	<p>Be led by a clinical professional who is involved in the care of the individual.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Monitor both presence and proper participation by the team leaders in all WRP meetings, and provide data analysis regarding the specific areas of low compliance.</p> <p>Findings: PSH used the DMH WRP Observation Monitoring Form to assess compliance (November 2007 to April 2008). The average sample was 10% of the WPRCs held each month. The following is an outline of the indicator and sub-indicators, with corresponding mean compliance rates:</p> <table border="1" data-bbox="978 894 1871 1122"> <tr> <td data-bbox="978 894 1052 971">1.</td> <td data-bbox="1052 894 1759 971"><i>Each team is led by a clinical professional who is involved in the care of the individual:</i></td> <td data-bbox="1759 894 1871 971"></td> </tr> <tr> <td data-bbox="978 971 1052 1047">1.a</td> <td data-bbox="1052 971 1759 1047"><i>The clinical professional is a core team member for the individual.</i></td> <td data-bbox="1759 971 1871 1047">81%</td> </tr> <tr> <td data-bbox="978 1047 1052 1122">1.b</td> <td data-bbox="1052 1047 1759 1122"><i>This person is the identified facilitator or the team leader appointed a team facilitator.</i></td> <td data-bbox="1759 1047 1871 1122">21%</td> </tr> </table> <p>The data showed the following:</p> <ol style="list-style-type: none"> Compliance with item 1.a increased from 42% in October 2007 to 98% in April 2008; its mean increased from 36% in the last reporting period to 81% in the current reporting period. Compliance with item 1.b increased from 2% in October 2007 to 98% in April 2008; its mean increased from 2% in the last reporting period to 	1.	<i>Each team is led by a clinical professional who is involved in the care of the individual:</i>		1.a	<i>The clinical professional is a core team member for the individual.</i>	81%	1.b	<i>This person is the identified facilitator or the team leader appointed a team facilitator.</i>	21%
1.	<i>Each team is led by a clinical professional who is involved in the care of the individual:</i>										
1.a	<i>The clinical professional is a core team member for the individual.</i>	81%									
1.b	<i>This person is the identified facilitator or the team leader appointed a team facilitator.</i>	21%									

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		<p>21% in the current reporting period.</p> <p>The facility conducted data analysis showing:</p> <ol style="list-style-type: none"> 1. Seven-day conferences tended to have the lowest levels of compliance for most areas and this was assessed to be due to workload issues. Compliance data tended to fluctuate from month to month based on the number of admissions. 2. 14-day conferences had increased compliance rates with less month-to-month fluctuation, but not as high as the monthly, quarterly and annual conferences. 3. Monthly, quarterly and annual conferences displayed the highest level of compliance, with minimal fluctuations and steady gains over the reporting period. <p>PSH also used the DMH WRP Team Leadership Audit Form based on average sample of 22% (N=two observations per WRPT psychiatrist per month). The following table summarizes the data:</p> <table border="1" data-bbox="976 893 1869 1421"> <tr> <td>1.</td> <td><i>The team psychiatrist was present.</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>The team psychiatrist elicited the participation of all disciplines.</i></td> <td>93%</td> </tr> <tr> <td>3.</td> <td><i>The team psychiatrist ensured the assessments from other disciplines were integrated into the case formulation.</i></td> <td>77%</td> </tr> <tr> <td>4.</td> <td><i>The team psychiatrist ensured the "Present Status" section in the Case Formulation was updated.</i></td> <td>41%</td> </tr> <tr> <td>5.</td> <td><i>The team psychiatrist ensured that the interventions were linked to the measurable objectives.</i></td> <td>59%</td> </tr> <tr> <td>6.</td> <td><i>The team psychiatrist ensured the individuals participated on the treatment, rehabilitation and enrichment activities which are goal-directed, individualized, based on a thorough knowledge of the</i></td> <td>78%</td> </tr> </table>	1.	<i>The team psychiatrist was present.</i>	100%	2.	<i>The team psychiatrist elicited the participation of all disciplines.</i>	93%	3.	<i>The team psychiatrist ensured the assessments from other disciplines were integrated into the case formulation.</i>	77%	4.	<i>The team psychiatrist ensured the "Present Status" section in the Case Formulation was updated.</i>	41%	5.	<i>The team psychiatrist ensured that the interventions were linked to the measurable objectives.</i>	59%	6.	<i>The team psychiatrist ensured the individuals participated on the treatment, rehabilitation and enrichment activities which are goal-directed, individualized, based on a thorough knowledge of the</i>	78%
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		<p style="text-align: center;"><i>individuals' psychosocial history and previous response.</i></p> <p>PSH recognized that the lowest compliance involved updating the Present Status section of the Case Formulation (item 4). The facility also recognized that the compliance rate for item 2 was disconnected from the Observation Auditing data and probably reflected auditor's error. As corrective actions, PSH plans to provide more attention to the updates of the Present Status section and work to achieve acceptable inter-rater agreeability among the senior psychiatrist auditors.</p> <p>Recommendation 2, November 2007: Implement a peer mentoring system to ensure competency in team leadership skills.</p> <p>Findings: Same as in C.1.a.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor this requirement using WRP Process Observation and Team Leadership Monitoring Forms based on samples of 20% and 100%, respectively. 2. Continue data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
C.1.c	Function in an interdisciplinary fashion.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Same as in C.1.a and C.1.b.</p>

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		<p>Findings: Same as in C.1.a and C.1.b.</p> <p>Recommendation 2, November 2007: Provide data analysis regarding the specific areas of low compliance.</p> <p>Findings: PSH used the DMH WRP Observation Monitoring Form (November 2007 to April 2008) to assess compliance with this requirement. The average sample was 10% of the WPRCs held each month. The following are the indicators, sub-indicators and corresponding mean compliance rates:</p> <table border="1" data-bbox="976 634 1864 1011"> <tr> <td>2.</td> <td><i>Each team functions in an interdisciplinary fashion.</i></td> <td></td> </tr> <tr> <td>2.a</td> <td><i>The core team members participate by presenting or updating discipline-specific and or holistic assessment data</i></td> <td>1%</td> </tr> <tr> <td>2.b</td> <td><i>The team reviews and updates the DMH WRPC Task Tracking form.</i></td> <td>32%</td> </tr> <tr> <td>2.c</td> <td><i>Team members present their assessments and consultations as listed in the task tracking form</i></td> <td>7%</td> </tr> <tr> <td>2.d.</td> <td><i>Team members discuss the individual's specific outcomes for the WRP review period.</i></td> <td>1%</td> </tr> </table> <p>The facility conducted data analysis showing the following:</p> <ol style="list-style-type: none"> 1. Compliance with item 2.a has increased from 0% in October 2007 to 5% in April 2008, its mean remained unchanged at 1% in the last and the present reporting periods. This appeared to indicate that is rare for a conference to have the presence and participation of all enduring team members. Data (not shown) revealed that compliance for psychiatric technicians (PTs) lagged significantly behind that of other disciplines. There was an indication that mentoring was having a positive effect as evidenced by increased compliance rates of 	2.	<i>Each team functions in an interdisciplinary fashion.</i>		2.a	<i>The core team members participate by presenting or updating discipline-specific and or holistic assessment data</i>	1%	2.b	<i>The team reviews and updates the DMH WRPC Task Tracking form.</i>	32%	2.c	<i>Team members present their assessments and consultations as listed in the task tracking form</i>	7%	2.d.	<i>Team members discuss the individual's specific outcomes for the WRP review period.</i>	1%
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2.d.	<i>Team members discuss the individual's specific outcomes for the WRP review period.</i>	1%															

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		<p>individual disciplines other than PTs. These ranged from 10-47% in October 2007 and were 43-79% in April 2008.</p> <ol style="list-style-type: none"> 2. Compliance with item 2.b has increased from 2% in October 2007 to 46% in April 2008; its mean increased from 1% in the last reporting period to 32% in the current reporting period. 3. Compliance with item 2.c has increased from 1% in October 2007 to 10% in April 2008, its mean increased from 0% in the last reporting period to 7% in the current reporting period. 4. Compliance with item 2.d. has increased only minimally. 5. Data (not shown) revealed that this cell's low compliance was primarily due to low compliance with the utilization of the PSR Mall notes. <p>PSH plans to prioritize areas of low compliance in its mentoring program.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor this requirement using process observation based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
C.1.d	<p>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary, and appropriate psychiatric and medical care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: 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.</p> <p>Findings: PSH has yet to implement this recommendation.</p>

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		<p>Recommendation 2, November 2007: The Department of Psychiatry manual should include specific requirements regarding psychiatrists' roles as team leaders that are aligned with the functions of the team leaders as outlined in the WRP Manual.</p> <p>Findings: PSH has implemented this recommendation.</p> <p>Recommendation 3, November 2007: Monitor this requirement using the Clinical Chart Auditing Form and provide data analysis regarding specific areas of low compliance.</p> <p>Findings: Using the DMH WRP Clinical Chart Auditing Form, PSH assessed compliance based on average sample of 7% of monthly, quarterly and annual WRPs due for the month (November 2007 to April 2008). The following is a summary of the data:</p> <table border="1" data-bbox="976 893 1864 1380"> <tr> <td data-bbox="976 893 1050 1039">1.</td> <td data-bbox="1050 893 1759 1039"><i>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary, and appropriate psychiatric and medical care.</i></td> <td data-bbox="1759 893 1864 1039"></td> </tr> <tr> <td data-bbox="976 1039 1050 1193">1.a</td> <td data-bbox="1050 1039 1759 1193"><i>The present status and previous response to treatment sections of the case formulation are aligned with the assessments (focused assessment of compliance)</i></td> <td data-bbox="1759 1039 1864 1193">2%</td> </tr> <tr> <td data-bbox="976 1193 1050 1380">1.b</td> <td data-bbox="1050 1193 1759 1380"><i>A review of assessments, WRP and WRP attachments indicate that the information in the WRP is supported by the assessments and DMH PSR Mall Facilitator Monthly Progress Notes (Global assessment of compliance)</i></td> <td data-bbox="1759 1193 1864 1380">2%</td> </tr> </table>	1.	<i>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary, and appropriate psychiatric and medical care.</i>		1.a	<i>The present status and previous response to treatment sections of the case formulation are aligned with the assessments (focused assessment of compliance)</i>	2%	1.b	<i>A review of assessments, WRP and WRP attachments indicate that the information in the WRP is supported by the assessments and DMH PSR Mall Facilitator Monthly Progress Notes (Global assessment of compliance)</i>	2%
1.	<i>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary, and appropriate psychiatric and medical care.</i>										
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		<p>Data provided by PSH showed that compliance with the above three items has increased from 0% in October 2007 to 43%, 48% and 72% respectively in the data collected in April 2008. The facility reported that the increased compliance figures in the April data reflected both a positive mentoring effect and the fact that the data were being collected by senior clinicians.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor this requirement using the Clinical Chart Audit form based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
C.1.e	<p>Ensure that each member of the team participates appropriately in competently and knowledgeably assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary, revising the therapeutic and rehabilitation services.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Improve clinical oversight to ensure competency in the processes of assessments, reassessments, interdisciplinary team functions and proper development and timely and proper updates of case formulations, foci of hospitalization, objectives and interventions.</p> <p>Findings: PSH has significantly improved its clinical oversight system via the implementation of a system of senior clinicians in the four major clinical disciplines. These Seniors provide WRP mentoring, collection of discipline-specific auditing, feedback to teams and analysis of data to develop plans of action. These Seniors oversee persons in their own disciplines regarding discipline-specific tasks, and oversight is ultimately provided by the Chief of that discipline.</p>

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		<p>As mentioned earlier, as of mid-February 2008, all WRPTs were assigned one of the senior clinicians as a mentor. The mentors report on the progress of their teams to the master WRP trainers in the Standards Compliance Department. This team of WRP master trainers is headed by the Acting Chief of Psychiatry. Progress is reported to the master trainers informally via weekly meetings with mentors representing each Program and monthly meetings with the entire group of mentors. Formal progress reports are turned in the form of electronic monthly progress notes on each team. Additionally, audit data on the WRPTs are reviewed by master trainers to assess how teams are trending.</p> <p>Recommendation 2, November 2007: Monitor this requirement and provide data analysis and corrective actions regarding specific areas of low compliance.</p> <p>Findings: PSH used the DMH WRP Observation Monitoring Form (November 2007 to April 2008) and reviewed average sample of 10%of the WRPCs due for the month. The following summarizes the data:</p> <table border="1" data-bbox="976 966 1864 1416"> <tr> <td data-bbox="976 966 1050 1153">3.</td> <td data-bbox="1050 966 1759 1153"><i>Each member of the team participates appropriately in competently and knowledgeably assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary revising the therapeutic and rehabilitative services.</i></td> <td data-bbox="1759 966 1864 1153"></td> </tr> <tr> <td data-bbox="976 1153 1050 1339">3.a</td> <td data-bbox="1050 1153 1759 1339"><i>Each team member presents relevant and appropriate content for the discipline-specific assessments. The Psychiatric Technician presents global observations of the individual for the WRP review period.</i></td> <td data-bbox="1759 1153 1864 1339">1%</td> </tr> <tr> <td data-bbox="976 1339 1050 1416">3.b</td> <td data-bbox="1050 1339 1759 1416"><i>Team members present their assessments and consultations as listed in the Task Tracking Form.</i></td> <td data-bbox="1759 1339 1864 1416">7%</td> </tr> </table>	3.	<i>Each member of the team participates appropriately in competently and knowledgeably assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary revising the therapeutic and rehabilitative services.</i>		3.a	<i>Each team member presents relevant and appropriate content for the discipline-specific assessments. The Psychiatric Technician presents global observations of the individual for the WRP review period.</i>	1%	3.b	<i>Team members present their assessments and consultations as listed in the Task Tracking Form.</i>	7%
3.	<i>Each member of the team participates appropriately in competently and knowledgeably assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary revising the therapeutic and rehabilitative services.</i>										
3.a	<i>Each team member presents relevant and appropriate content for the discipline-specific assessments. The Psychiatric Technician presents global observations of the individual for the WRP review period.</i>	1%									
3.b	<i>Team members present their assessments and consultations as listed in the Task Tracking Form.</i>	7%									

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		3.c	<i>Team members discuss the individual's specific outcomes for the WRP review period.</i>	0%
<p>PSH's data analysis indicated the following:</p> <ol style="list-style-type: none"> 1. Compliance with item 3.a has increased minimally from 0% in October 2007 to 1% in April 2008; its mean remained unchanged at 1% since the last reporting period. While only 1% of audited conferences have appropriate content presentations from every member, evidence of a positive mentoring effect can be discerned in data broken down by discipline (not shown). Compliance of individual disciplines ranged from 1-25% in October 2007 and from 20-63% in April 2008. Only psychiatry had an April 2008 compliance rate exceeding 50% on this item (63%); the lowest compliance rate in April 2008 was reported for RTs, RNs and PTs (low 20s). 2. Compliance with item 3.b. has increased from 0% in October 2007 to 10% in April 2008, its mean increased from 0% compliance in the last reporting period to 7% compliance in the current reporting period. These data are virtually identical to the data in WRP Observation Audit Item 2.a (above) and point to the same conclusions. 3. Compliance with item 3.c has increased minimally from 0% in October 2007 to 1% in April 2008; its mean remained unchanged at 0% compliance since the last reporting period. Analysis of this cell highlighted lack of effective implementation of the PSR Mall notes. A positive mentoring effect was noted in the discussion of clinical and psychosocial outcomes, which increased in compliance from 29% in October 2007 to 69% in April 2008. <p>The facility reported that specific targets for further directed mentoring efforts are: discussion of By Choice, Medical Conditions, MOSES and PBS data, all of which remained below 20% compliance in April 2008.</p>				

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		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor this requirement using the DMH WRP Observation Monitoring Form, based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
C.1.f	<p>Ensure that assessment results and, as clinically relevant, consultation results, are communicated to the team members, along with the implications of those results for diagnosis, therapy and rehabilitation by no later than the next review.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Same as in C.1.a through C.1.e.</p> <p>Findings: Same as in C.1.a through C.1.e.</p> <p>Other findings: Analysis by PSH of compliance by specific disciplines revealed a positive mentoring effect for psychiatrists and psychologists. Both disciplines had a compliance rate of 8% on this item in October 2007, which increased to 25% (psychologists) and 39% (psychiatrists) in April 2008. Compliance remains quite low (<10%) for RTs, RNs and PTs.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as in C.1.a through C.1.e.</p>
C.1.g	<p>Be responsible for the scheduling and coordination of assessments and team meetings,</p>	<p>Current findings on previous recommendations:</p>

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	<p>the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.</p>	<p>Recommendations 1 and 2, November 2007:</p> <ul style="list-style-type: none"> Continue to monitor this requirement using process observation. Address and correct factors related to low compliance. <p>Findings: Using the DMH WRP Observation Monitoring Form, PSH assessed its compliance based on average sample of 10% of the WRPCs that were due each month (November 2007 to April 2008). The following summarizes the data:</p> <table border="1" data-bbox="976 560 1864 1156"> <tr> <td data-bbox="976 560 1050 743">5.</td> <td data-bbox="1050 560 1759 743"><i>The team identified someone to be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.</i></td> <td data-bbox="1759 560 1864 743"></td> </tr> <tr> <td data-bbox="976 743 1050 896">5.a</td> <td data-bbox="1050 743 1759 896"><i>There is an identified WRP recorder who is responsible for the scheduling and coordination of assessments and WRPCs. This person typically records the WRP.</i></td> <td data-bbox="1759 743 1864 896">71%</td> </tr> <tr> <td data-bbox="976 896 1050 1156">5.b</td> <td data-bbox="1050 896 1759 1156"><i>The identified recorder drafts the WRP on the computer and obtains all necessary signatures on the completed WRP, schedules the next conference date and time, Fills out the appointment card for the next WRPC for the individual and fills out the WRPC Task Tracking form at the conference.</i></td> <td data-bbox="1759 896 1864 1156">10%</td> </tr> </table> <p>Data analysis showed the following:</p> <ol style="list-style-type: none"> Compliance with item 5.a has increased from 28% in October 2007 to 91% in April 2008; its mean increased from 29% in the last reporting period to 71% in the current reporting period. Compliance with item 5.b has increased from 2% in October 2007 to 	5.	<i>The team identified someone to be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.</i>		5.a	<i>There is an identified WRP recorder who is responsible for the scheduling and coordination of assessments and WRPCs. This person typically records the WRP.</i>	71%	5.b	<i>The identified recorder drafts the WRP on the computer and obtains all necessary signatures on the completed WRP, schedules the next conference date and time, Fills out the appointment card for the next WRPC for the individual and fills out the WRPC Task Tracking form at the conference.</i>	10%
5.	<i>The team identified someone to be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.</i>										
5.a	<i>There is an identified WRP recorder who is responsible for the scheduling and coordination of assessments and WRPCs. This person typically records the WRP.</i>	71%									
5.b	<i>The identified recorder drafts the WRP on the computer and obtains all necessary signatures on the completed WRP, schedules the next conference date and time, Fills out the appointment card for the next WRPC for the individual and fills out the WRPC Task Tracking form at the conference.</i>	10%									

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		<p>14% in April 2008; its mean increased from 2% in the last reporting period to 10% in the current reporting period. This sub-item has four required elements; compliance with these elements improved from 7-43% in October 2007 to 38-65% in April 2008. The element with lowest compliance rate related to the Task Tracking Form and paralleled findings noted in the analyses of observation items 2.b, 2.c and 3.b, mentioned in previous cells.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor this requirement using the DMH WRP Observation Monitoring Form, based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
C.1.h	<p>Consist of a stable core of members, including at least the individual served; the treating psychiatrist, treating psychologist, treating rehabilitation therapist, the treating social worker; registered nurse and psychiatric technician who know the individual best; and one of the individual's teachers (for school-age individuals), and, as appropriate, the individual's family, guardian, advocates, attorneys, and the pharmacist and other staff.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Develop and implement database that includes information regarding the core membership of all teams in the facility.</p> <p>Findings: PSH has developed and implemented an Excel database that includes the required information and is maintained by the Clinical Administrator's office.</p> <p>Recommendation 2, November 2007: Regularly monitor the attendance by core members, including the individuals, in the WRPCs.</p>

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		<p>Findings: The facility's data regarding WRPC attendance by core members are summarized in the following table, which outlines the mean attendance rates for this reporting period based on an average sample of 10% of WRPCs due each month.</p> <table border="1" data-bbox="978 412 1619 792"> <thead> <tr> <th data-bbox="978 412 1314 526">Core team member</th> <th data-bbox="1314 412 1465 526">Previous reporting period</th> <th data-bbox="1465 412 1619 526">Current reporting period</th> </tr> </thead> <tbody> <tr> <td data-bbox="978 526 1314 565">Individual</td> <td data-bbox="1314 526 1465 565"></td> <td data-bbox="1465 526 1619 565">86%</td> </tr> <tr> <td data-bbox="978 565 1314 604">Psychiatrist</td> <td data-bbox="1314 565 1465 604">89%</td> <td data-bbox="1465 565 1619 604">89%</td> </tr> <tr> <td data-bbox="978 604 1314 643">Psychologist</td> <td data-bbox="1314 604 1465 643">66%</td> <td data-bbox="1465 604 1619 643">62%</td> </tr> <tr> <td data-bbox="978 643 1314 682">Social Worker</td> <td data-bbox="1314 643 1465 682">76%</td> <td data-bbox="1465 643 1619 682">77%</td> </tr> <tr> <td data-bbox="978 682 1314 721">Rehabilitation Therapist</td> <td data-bbox="1314 682 1465 721">68%</td> <td data-bbox="1465 682 1619 721">60%</td> </tr> <tr> <td data-bbox="978 721 1314 760">Registered Nurse</td> <td data-bbox="1314 721 1465 760">42%</td> <td data-bbox="1465 721 1619 760">23%</td> </tr> <tr> <td data-bbox="978 760 1314 792">Psychiatric Technician</td> <td data-bbox="1314 760 1465 792">36%</td> <td data-bbox="1465 760 1619 792">7%</td> </tr> </tbody> </table> <p>Recommendation 3, November 2007: Address and correct the deficiencies regarding core membership and attendance by core members.</p> <p>Findings: PSH reported that WRP training has emphasized the importance of attendance by all core members at all WRPCs and that mentors have discussed this issue with their teams.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> <li data-bbox="978 1317 1829 1385">1. Regularly monitor the attendance by core members, including the individuals, at the WRPCs. <li data-bbox="978 1390 1808 1422">2. Provide data analysis that delineates and evaluates areas of low 	Core team member	Previous reporting period	Current reporting period	Individual		86%	Psychiatrist	89%	89%	Psychologist	66%	62%	Social Worker	76%	77%	Rehabilitation Therapist	68%	60%	Registered Nurse	42%	23%	Psychiatric Technician	36%	7%
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		compliance and relative improvement (during the reporting period and compared to the last period).																																																																
C.1.i	Not include any core treatment team members with a case load exceeding 1:15 in admission teams (new admissions of 90 days or less) and, on average, 1:25 in all other teams at any point in time.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Same as in C.1.h.</p> <p>Findings: Same as in C.1.h.</p> <p>Recommendation 2, November 2007: Ensure consistent compliance with this requirement.</p> <p>Findings: The facility's data for this reporting period, summarized below, showed that PSH has yet to comply with this requirement, particularly regarding the ratios of psychologists on the admission units and psychologists and rehabilitation therapists on the non-admission units.</p> <table border="1" data-bbox="978 935 1839 1240"> <thead> <tr> <th colspan="8">Admissions WRPTs (expected ratios 1:15)</th> </tr> <tr> <th></th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>1. MDs</td> <td>1:16</td> <td>1:16</td> <td>1:17</td> <td>1:16</td> <td>1:15</td> <td>1:15</td> <td>1:16</td> </tr> <tr> <td>2. PhDs</td> <td>1:25</td> <td>1:25</td> <td>1:18</td> <td>1:16</td> <td>1:17</td> <td>1:17</td> <td>1:20</td> </tr> <tr> <td>3. SWs</td> <td>1:18</td> <td>1:15</td> <td>1:17</td> <td>1:15</td> <td>1:14</td> <td>1:15</td> <td>1:16</td> </tr> <tr> <td>4. RTs</td> <td>1:19</td> <td>1:18</td> <td>1:15</td> <td>1:14</td> <td>1:16</td> <td>1:16</td> <td>1:16</td> </tr> <tr> <td>5. RNs</td> <td>1:6</td> <td>1:6</td> <td>1:6</td> <td>1:6</td> <td>1:6</td> <td>1:6</td> <td>1:6</td> </tr> <tr> <td>6. PTs</td> <td>1:3</td> <td>1:3</td> <td>1:3</td> <td>1:3</td> <td>1:3</td> <td>1:3</td> <td>1:3</td> </tr> </tbody> </table>	Admissions WRPTs (expected ratios 1:15)									Nov	Dec	Jan	Feb	Mar	Apr	Mean	1. MDs	1:16	1:16	1:17	1:16	1:15	1:15	1:16	2. PhDs	1:25	1:25	1:18	1:16	1:17	1:17	1:20	3. SWs	1:18	1:15	1:17	1:15	1:14	1:15	1:16	4. RTs	1:19	1:18	1:15	1:14	1:16	1:16	1:16	5. RNs	1:6	1:6	1:6	1:6	1:6	1:6	1:6	6. PTs	1:3	1:3	1:3	1:3	1:3	1:3	1:3
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C.1.j	Not include staff that is not verifiably competent in the development and implementation of interdisciplinary wellness and recovery plans.	<p data-bbox="976 805 1562 833">Current findings on previous recommendation:</p> <p data-bbox="976 878 1419 943">Recommendation, November 2007: Same as in C.1.a through C.1.f.</p> <p data-bbox="976 989 1346 1053">Findings: Same as in C.1.a through C.1.f.</p> <p data-bbox="976 1099 1755 1200">Other findings: Based on data presented by PSH, the current status regarding implementation of this requirement is summarized as follows:</p> <table border="1" data-bbox="976 1240 1696 1393"> <thead> <tr> <th>Discipline</th> <th>Number of clinicians not trained to competency</th> </tr> </thead> <tbody> <tr> <td>Psychiatry</td> <td>4</td> </tr> <tr> <td>Psychology</td> <td>0</td> </tr> </tbody> </table>	Discipline	Number of clinicians not trained to competency	Psychiatry	4	Psychology	0																																																										
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2. Integrated Therapeutic and Rehabilitation Service Planning (WRP)		
	<p>Each State hospital shall develop and implement policies and protocols regarding the development of therapeutic and rehabilitation service plans, referred to as "Wellness and Recovery Plans" [WRP]) consistent with generally accepted professional standards of care, to ensure that:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Individuals AM and JJB 2. Alejandro Fernandez, Supervising Rehabilitation Therapist 3. Andre Bryant, PT, Substance Abuse Coordinator 4. Andrea Banks, PT 5. Anthony Coley, Acting Unit Supervisor 6. Chris Keierleber, RT 7. Christopher Sangdahl, MD, Adviser to Substance Abuse Services 8. Curtis Peters, Supervising Rehabilitation Therapist 9. Davis D'Assis, Unit Supervisor 10. Debra Taylor-Tatum, Supervising Rehabilitation Therapist 11. Dien Mach, MD, Physician and Surgeon 12. Dolores Otto-Moreno, Assistant Director of Nutrition Services 13. Emmanuel Neizer, PT 14. Fred Wolfner, Program Director, Enhancement Services 15. Gari-Lyn Richardson, Director, Standards Compliance 16. George Christison, MD, Acting Chief of Psychiatry 17. Grace Ferris, Assistant Director of Nutrition Services 18. Greg Siples, Chief of Rehabilitation Services 19. Gregory Hargrave, Senior PT 20. Jacqueline Doss-Haynes, Supervising Rehabilitation Therapist 21. Jana Larmer, PhD, Psychologist, WRP Master Trainer 22. Jonas Lunas, RN 23. Julia Fleming, RT, WRP Master Trainer 24. Kira Mellups, PhD, Psychologist 25. Kitchie Miana, Assistant Director of Nutrition Services 26. Kimberly Light-Allende, PsyD, Psychologist 27. Mark Camero, Supervising Rehabilitation Therapist 28. Melanie Byde, PhD, Mall Director 29. Michael Gomes, Supervising Rehabilitation Therapist

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		<p>30. Carlos Luna, Executive Director, Patton State Hospital</p> <p>31. Sean Evans, PhD, Psychologist, PBS Chair</p> <p>32. Stan Hydinger, Supervising Rehabilitation Therapist</p> <p>33. Steven Berman, PhD, Psychologist, BY CHOICE Coordinator</p> <p>34. Tai Kim, Director of Nutrition Services</p> <p>35. Timothea McGinley, PhD, WRPT Psychologist</p> <p>36. Waheed Saeed, MD, Staff Psychiatrist</p> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Charts of the following 188 individuals: AAA, AB, ABT, ADY, AHM, AM, AMC, AO, AP, ATB, AW, BAJ, BJB, BK, BLB, BR, BS, BTH, BW, CB, CCB, CCH, CD, CL, CLC, CMG, CP, CS, CT, CW, DAR, DCD, DCG, DEB, DEG, DFV, DGA, DH, DIT, DJ, DJB, DM, DQ, DR, DRH, EB, ECF, EFM, EJH, EM, EMN, EW, FEA, FR, GAG, GB, GC, GH, GMC, GP, GR, GSG, HJL, HLE, HP, HPV, IC, IM, JAB, JAC, JB, JC, JCB, JD, JDC, JDD, JDM, JF, JGM, JH, JIM, JJ, JJB, JJD, JJK, JJM, JJP, JJS, JMH, JN, JP, JR, JRP, JRW, JSC, JT, JTD, JW, KAM, KEM, KF, KJ, KLA, KLK, LAB, LB, LCB, LD, LEJ, LF, LGH, LJS, LLQ, LMB, LP, LS, MAC, MAT, MB, MD, MEB, MFA, MH, MHK, MI, MJO, MLB, MMH, MMS, MO, MS, MT, ND, NMM, NSC, NWJ, OWV, PAB, PAL, PB, PC, PH, PHL, PL, PLA, PSP, RA, RAR, RBS, RCP, RE, RF, RJ, RLG, RLP, RP, RWT, RYM, RZ, SEL, SH, SJ, SJP, SM, SR, SRB, TC, TCS, TCW, TJE, TK, TLE, TME, VB, VD, VEB, VJW, VM, WAO, WJV, WK, WL, WPC, WPW, WRW, WSD, YTP and ZCJ 2. MSH WRP training modules and PSH data regarding the facility's updates of these modules 3. DMH WRP Process Observation Monitoring Form 4. DMH WRP Process Observation Monitoring Form Instructions 5. PSH WRP Process Observation Monitoring summary data (November 2007 to April 2008) 6. DMH Chart Auditing Form 7. DMH Chart Auditing Form Instructions 8. PSH Chart Auditing summary data (November 2007 to April 2007) 9. DMH Clinical Chart Auditing Form
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		<ol style="list-style-type: none"> 10. DMH Clinical Chart Auditing Form Instructions 11. PSH Clinical Chart Auditing Form summary data (November 2007 to April 2008) 12. DMH WRP Substance Abuse Monitoring Form 13. DMH WRP Substance Abuse Monitoring Form Instructions 14. PSH Substance Abuse Monitoring summary data (February to April 2008) 15. PSH MAPP data regarding active treatment hours scheduled and attended (November 2007 to April 2008) 16. PSH Course Outline: Substance Abuse Trans-theoretical Model (TTM) Skills Training 17. Behavioral Guidelines 18. Completed Request for New Mall Group/Individual Therapy Forms 19. Credentialing/Privileging for Substance Abuse 20. Facilitator Training and Certification (Focus 10) 21. Focus Advisors Committee Meeting Minutes 22. List of individuals with cognitive disorders. 23. List of individuals by Program by unit hours of Mall groups attended 24. List of individuals with high Body Mass Index 25. List of individuals with Substance Abuse disorders. 26. List of new Mall groups 27. List of scheduled exercise groups 28. List verifying staff competency for specific mall groups 29. List of individuals who received Physical, and/or Speech Therapy direct treatment from November 2007-April 2008 30. Mall Groups Hours Cancelled Report 31. Mall provider list 32. Medical, Health, and Wellness (Focus 6) 33. PSH Mall Lesson Plans (Focus 1 through Focus 11) 34. PSH Resource Catalog Procedures and Policy Manual by Foci 35. Psychosocial Enrichment Activity List 36. Transtheoretical Model Pre-/Post-Test Samples
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		<p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPC (Program I, unit 11) for 14-Day review of SZ 2. WRPC (Program I, unit 74) for monthly review of YTP 3. WRPC (Program VI, unit 09) for 14-day review of TLE 4. WRPC (Program VI, unit 12) for 14-day review of LBP 5. WRPC (Program VI, unit 35) for monthly review of JJ 6. WRPC (Program VI, unit 70) for monthly review of JJB 7. WRPC (Program VIII, unit 20) for 14-day review of RLR 8. Collaborative Recovery Mall Group 9. Relaxation Mall Group 10. Anti-Social—Face It and Pace It Mall Group 11. Mood Management Mall Group 12. Psychology Specialized Services Team Meeting
C.2.a	<p>Individuals have substantive input into the therapeutic and rehabilitation service planning process, including but not limited to input as to mall groups and therapies appropriate to their WRP.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Continue and strengthen WRP training that focuses on the process of engaging the individual in providing substantive input.</p> <p>Findings: As mentioned in C.1.a, PSH has adopted the Engagement module developed by MSH to be implemented on a referral basis. No staff has been referred for this training yet.</p> <p>Recommendation 2, November 2007: Continue observation monitoring of this requirement based on a 20% sample and provide data analysis regarding specific areas of low compliance and corrective actions.</p> <p>Findings: PSH used the DMH WRP Observation Monitoring Form and reviewed an average sample of 10% of WRPCs due each month (November 2007 to April</p>

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		<p>2008). The following table outlines the indicator and sub-indicators with corresponding mean compliance rates:</p> <table border="1" data-bbox="955 305 1850 1084"> <tr> <td data-bbox="955 305 1031 451">6.</td> <td data-bbox="1031 305 1734 451"><i>Individuals have substantive input into the therapeutic and rehabilitation service planning process, including but not limited to input as to mall groups and therapies appropriate to their WRP.</i></td> <td data-bbox="1734 305 1850 451"></td> </tr> <tr> <td data-bbox="955 451 1031 565">6.a</td> <td data-bbox="1031 451 1734 565"><i>The WRPT asks the individual for his or her input into the evaluation of progress on each objective, as clinically indicated.</i></td> <td data-bbox="1734 451 1850 565">8%</td> </tr> <tr> <td data-bbox="955 565 1031 748">6.b</td> <td data-bbox="1031 565 1734 748"><i>When the individual has achieved an objective, at the current WRPC, the WRPT discusses with the individual the groups available for the next objective. The individual makes a choice from several equivalent options.</i></td> <td data-bbox="1734 565 1850 748">17%</td> </tr> <tr> <td data-bbox="955 748 1031 899">6.c</td> <td data-bbox="1031 748 1734 899"><i>The WRPT reviews the By Choice points, preferences and allocation with the individual. The individual determines how he or she will allocate the points between WRPCs.</i></td> <td data-bbox="1734 748 1850 899">22%</td> </tr> <tr> <td data-bbox="955 899 1031 1084">6.d</td> <td data-bbox="1031 899 1734 1084"><i>When the individual identifies cultural preferences, the team updates the case formulation and may incorporate them into the individual's WRP objectives and interventions, as relevant.</i></td> <td data-bbox="1734 899 1850 1084">22%</td> </tr> </table> <p data-bbox="955 1133 1833 1198">The facility conducted an analysis of its compliance status showing the following:</p> <ol data-bbox="955 1240 1902 1417" style="list-style-type: none"> <li data-bbox="955 1240 1902 1349">1. Item 6 (overall) has increased from 1% in October 2007 to 5% in April 2008; the mean increased minimally from 1% in the last reporting period to 2% in the current reporting period. <li data-bbox="955 1349 1902 1417">2. Item 6.a has increased from 2% in October 2007 to 7% in April 2008; the mean increased from 4% in the last reporting period to 8% in the 	6.	<i>Individuals have substantive input into the therapeutic and rehabilitation service planning process, including but not limited to input as to mall groups and therapies appropriate to their WRP.</i>		6.a	<i>The WRPT asks the individual for his or her input into the evaluation of progress on each objective, as clinically indicated.</i>	8%	6.b	<i>When the individual has achieved an objective, at the current WRPC, the WRPT discusses with the individual the groups available for the next objective. The individual makes a choice from several equivalent options.</i>	17%	6.c	<i>The WRPT reviews the By Choice points, preferences and allocation with the individual. The individual determines how he or she will allocate the points between WRPCs.</i>	22%	6.d	<i>When the individual identifies cultural preferences, the team updates the case formulation and may incorporate them into the individual's WRP objectives and interventions, as relevant.</i>	22%
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6.d	<i>When the individual identifies cultural preferences, the team updates the case formulation and may incorporate them into the individual's WRP objectives and interventions, as relevant.</i>	22%															

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		<p>current reporting period. The low compliance with this sub-item appeared to relate to WRPTs not discussing each objective with the individual and the WRPs having more objectives as teams are opening more foci.</p> <ol style="list-style-type: none"> 3. Item 6.b has remained at 0% compliance in October and April; its mean increased from 1% in the last reporting period to 2% in the current reporting period. The facility identified a barrier towards compliance within the current software and corrective action is underway. 4. Item 6.c has increased from 1% in October 2007 to 24% in April 2008, its mean increased from 5% in the last reporting period to 17% in the current reporting period. 5. Item 6.d has increased from 0% in October 2007 to 24% in April 2008, its mean increased from 1% in the last reporting period to 22% in the current reporting period. <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue current training and mentoring regarding engagement of individuals. 2. Monitor this requirement using process observation based on at least a 20% sample. 3. Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period). 4. Implement corrective actions to resolve system barriers regarding review and revision of WRPs during the WRPC.
C.2.b	Therapeutic and rehabilitation service planning provides timely attention to the needs of each individual, in particular:	Please see sub-cells for compliance findings.

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<p>C.2.b.i</p>	<p>initial therapeutic and rehabilitation service plans (Admission-Wellness and Recovery Plan ("A-WRP") are completed within 24 hours of admission;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Continue chart audits to assess compliance based on at least a 20% sample.</p> <p>Findings: PSH used the DMH WRP Chart Auditing Form to assess compliance. The average sample was 19% of the A-WRPs due each month (November 2007 to April 2008). The facility reported a mean compliance rate of 98%, which has remained unchanged from the last reporting period.</p> <p>Other findings: This monitor reviewed the charts of 10 individuals (AAA, BJB, FEA, GMC, JAB, JCB, JDD, JMH, KF and THE) who were admitted during this reporting period. The review found compliance in all charts except one (FEA).</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue current practice. 2. Monitor this requirement using the DMH Chart Auditing Form based on at least a 20% sample. 3. Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period), as indicated.
<p>C.2.b.ii</p>	<p>master therapeutic and rehabilitation service plans ("Wellness and Recovery Plan" (WRP)) are completed within 7 days of admission; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, November 2007:</p> <ul style="list-style-type: none"> • Continue chart audits to assess compliance. • Address and correct factors related to low compliance.

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		<p>Findings: Using the above-mentioned auditing process, PSH reported a mean compliance rate of 64%. Data analysis showed that compliance fluctuated from month to month. The facility attributed this to varying workload issues related to the turnover rate in the admission units. The facility plans to open a new admission unit in an effort to ensure that individuals remain on the unit for 60 days or more. This should facilitate the process of WRP and compliance with this requirement.</p> <p>Other Findings: This monitor reviewed the above-mentioned 10 charts and found compliance in all charts except one (JCB).</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor this requirement using the DMH Chart Auditing Form, based on at least a 20% sample. 2. Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period), as indicated. 3. Implement plans to ensure that individuals remain on the admission units for 60 or more days prior to inter-unit transfers.
C.2.b.iii	<p>therapeutic and rehabilitation service plan reviews are performed every 14 days during the first 60 days of hospitalization and every 30 days thereafter. The third monthly review is a quarterly review and the 12th monthly review is the annual review.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Implement the required WRP conference schedule on all teams, including 30-day reviews.</p> <p>Findings: Same as findings for Recommendation 5 in C.1.a.</p>

		<p>Recommendation 2, November 2007: Continue chart auditing, ensure a 20% sample and provide data analysis regarding specific areas of low compliance with corrective actions.</p> <p>Findings: PSH used the DMH WRP Chart Auditing Form to assess compliance (November 2007 to April 2008). Since the last review, the facility has begun implementation of the requirement regarding monthly WRPCs. The samples varied depending on the type of conference. The following table summarizes the data:</p> <table border="1" data-bbox="957 634 1478 826"> <thead> <tr> <th>WRP Review</th> <th>Mean S%</th> <th>Mean %C</th> </tr> </thead> <tbody> <tr> <td>14-day</td> <td>13%</td> <td>62%</td> </tr> <tr> <td>Monthly</td> <td>10%</td> <td>12%</td> </tr> <tr> <td>Quarterly</td> <td>17%</td> <td>6%</td> </tr> <tr> <td>Annual</td> <td>10%</td> <td>23%</td> </tr> </tbody> </table> <p>The data showed improved compliance since the last reporting period in all comparable timeframes.</p> <p>Other findings: Chart reviews by this monitor found compliance in seven charts (AAA, BJB, FEA, GMC, JAB, JDD and JMH) and noncompliance in three (JCB, KF and TJE).</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor this requirement using the DMH Chart Auditing Form based on at least a 20% sample. 2. Provide data analysis that evaluates low compliance and delineates areas 	WRP Review	Mean S%	Mean %C	14-day	13%	62%	Monthly	10%	12%	Quarterly	17%	6%	Annual	10%	23%
WRP Review	Mean S%	Mean %C															
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		<p>of relative improvement (during the reporting period and compared to the last period), as indicated.</p>
<p>C.2.c</p>	<p>Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a thorough knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to such services;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Continue and strengthen training of WRPTs to ensure that:</p> <ul style="list-style-type: none"> a. The case formulation includes appropriate review and analysis of assessments to identify the individual's needs in the psychiatric, medical and psychosocial domains, and b. Foci of hospitalization address all identified needs of the individual in the above domains. <p>Findings: As mentioned in C.1.a, effective May 2008, PSH provides training using the MSH updated modules regarding Case Formulation and Foci/Objectives/Interventions based on a referral process.</p> <p>Recommendation 2, November 2007: Monitor this requirement using the Clinical Chart Auditing Form and the Substance Abuse Checklist, ensure a 20% sample and provide data analysis regarding specific areas of low compliance and corrective actions.</p> <p>Findings: PSH used the DMH Clinical Chart Auditing Form to assess compliance (November 2007 to April 2008). As mentioned earlier, senior clinicians have conducted this auditing since April 2008. The average sample was 7% of the monthly, quarterly and annual WRPs due by month. The mean compliance rate was 20%. Data analysis showed an increase in compliance from 11% in October 2007 to 94% in April 2008.</p> <p>Recommendation 3, November 2007: Ensure that corrective actions address the monitor's findings of deficiency</p>

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		<p>listed above.</p> <p>Findings: PSH reported that the WRP mentors are currently addressing all of the specific deficiencies reported by this monitor regarding the care of individuals suffering from cognitive impairments and seizure disorders.</p> <p>Other findings: This monitor reviewed the charts of several individuals diagnosed with a variety of cognitive and seizure disorders.</p> <p>The review found general evidence of improved attention to the needs of individuals with cognitive impairments, for example by providing interventions that appropriately align with these needs (LAB and WRW) and avoiding high-risk pharmacotherapy for these individuals (HLE, IM, JRW, JW and WRW).</p> <p>In addition, the review found some general improvement in the documentation of interventions designed to teach individuals suffering from seizure disorders about measures to decrease the risks associated with further seizure activity (CLS, JJD, JW and LEJ).</p> <p>Despite these improvements, this monitor found a pattern of deficiencies that must be corrected to achieve substantial compliance in this area. The following is an outline of these deficiencies:</p> <ol style="list-style-type: none"> 1. Individuals diagnosed with cognitive impairments (BJB, HLE, IM, JRW, JW, LAB, WJV and WRW): <ol style="list-style-type: none"> a. The WRPs did not include foci, objectives or interventions to address the needs of individuals diagnosed with Mild Mental Retardation (JRW), Moderate Mental Retardation (WJV) and Borderline Intellectual Functioning (HLE). b. The WRPs included objectives related to diagnoses of Dementia
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		<p>NOS (BJB and IM) that were generic and did not address the cognitive impairment.</p> <ul style="list-style-type: none"> c. The WRP did not include interventions to address the specific needs of an individual diagnosed with Vascular Dementia (JW) and an individual diagnosed with Dementia NOS (IM). d. There is general evidence of limited number of cognitive remediation groups to meet the needs of the relatively large number of individuals diagnosed with cognitive impairments in the facility. e. The present status section of the case formulation did not address the cognitive status of an individual diagnosed with Vascular Dementia (LAB) in specific terms. f. In general, the WRPs did not include adequate measures/ consultations to assess, determine the etiology and/or finalize diagnoses of Cognitive Disorder, NOS (e.g. WRW). <p>2. Individuals diagnosed with seizure disorders (CLS, DFV, JJD, JP, LD, LEJ, PB, CLS and TLE):</p> <ul style="list-style-type: none"> a. The WRPs did not include specific morphological diagnosis regarding the type of seizure disorder in all the charts reviewed. b. The WRPs included objectives that were not meaningful or attainable for some individuals, such as having no seizure activity during admission (LEJ), keeping the individual's airway patent (during seizure activity) and ensuring a medication level within therapeutic range (JP), being free of seizure activity (DFV) and verbalizing safety measures (to be used) during seizure activity (PB). c. The WRP did not include any objectives or interventions that relate to a diagnosis of a seizure disorder in an individual who received a combination of phenytoin and phenobarbital as treatment for this condition (LD). d. There was no documentation in the WRP (or corresponding physician notes) of adequate measures to assess factors related
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		<p>to recurrent seizure activity and measures to minimize the risk of further seizure activity for an individual (LEJ).</p> <ul style="list-style-type: none"> e. The present status sections of the WRPs did not address the status of the individual's seizure activity during the previous interval (JJD and PB). f. The WRPs did not include objectives/interventions to assess the risks of treatment with older anticonvulsant medications, and to minimize its impact on the individual's behavior and cognitive status. Examples include individuals receiving phenytoin (CLS, DFV, JJD, JP, LEJ and PB), phenobarbital (TLE) and a combination of phenytoin and phenobarbital (LD). <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor this requirement using the Clinical Chart Auditing Form based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 3. Address and correct the specific deficiencies outlined by this monitor regarding the care of individuals diagnosed with cognitive impairments and seizure disorders.
C.2.d	<p>Therapeutic and rehabilitation service planning is based on a comprehensive case formulation for each individual that emanates from interdisciplinary assessments of the individual consistent with generally accepted professional standards of care. Specifically, the case formulation shall:</p>	<p>Compliance: Partial.</p>

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<p>C.2.d.i</p>	<p>be derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Continue and strengthen training of the WRPTs to ensure that the case formulations adequately address the requirements in C.2.d. and correct the above deficiencies outlined by this monitor.</p> <p>Findings: Same as Findings for Recommendation 2 in C.1.a and Recommendation 1 in C.2.c.</p> <p>Recommendation 2, November 2007: Continue Clinical Chart auditing, ensure a 20% sample and implement corrective actions regarding areas of low compliance.</p> <p>Findings: PSH used the DMH Clinical Chart Auditing Form to assess compliance (November 2007 to April 2008). The mean average sample was 7% of the monthly, quarterly and annual WRPs. The facility reported a mean compliance rate of 2% with this requirement (item #3 on the form). Data analysis showed improved compliance from 0% in October 2007 to 39% in April 2008.</p> <p>The mean compliance rates for requirements in C.2.d.ii to C.2.d.vi are listed for each corresponding cell below. The sub-indicators are listed as necessary to show the variability in compliance with components of each requirement.</p> <p>Other findings: Chart reviews and WRPCs attended by this monitor and his experts demonstrated that PSH has made some progress as follows:</p> <ol style="list-style-type: none"> 1. A draft of the case formulation was prepared prior to the meeting and
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		<p>the WRPTs reviewed the draft during the meeting.</p> <ol style="list-style-type: none"> 2. The case formulations were completed in the 6-p format. 3. The content of the present status section of the formulation was, in general, more comprehensive compared to the last review. 4. In general, the pertinent history and precipitating factors were included more needed information compared to the last review. 5. In general, substance abuse was addressed as a precipitating and a perpetuating factor. <p>However, the content of most of the formulations showed that the facility has to make further progress regarding the following:</p> <ol style="list-style-type: none"> 1. The present status sections did not include sufficient review and analysis of important clinical events that require modifications in WRP interventions. The most significant deficiencies involved needed information in the reviews of: <ol style="list-style-type: none"> a. Use of restrictive interventions; b. Clinical progress regarding a variety of disorders and high-risk behaviors; and c. Clinical progress towards individualized discharge criteria. 2. There was inadequate linkage within different components of the formulations and between the material in the case formulations and other key components of the WRP (e.g. foci of hospitalization, life goals, strengths, objectives and interventions). <p>These deficiencies must be corrected in order to achieve substantial compliance with this requirement.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement the updated MSH modules regarding Case Formulation. 2. Monitor this requirement using the Clinical Chart Auditing Form based on at least a 20% sample. 3. Provide data analysis that delineates and evaluates areas of low
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		compliance and relative improvement (during the reporting period and compared to the last period).																		
C.2.d.ii	include a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status;	<table border="1"> <tr> <td>4.a</td> <td><i>Pertinent history</i></td> <td>7%</td> </tr> <tr> <td>4.b</td> <td><i>Predisposing factors</i></td> <td>2%</td> </tr> <tr> <td>4.c</td> <td><i>Precipitating factors</i></td> <td>2%</td> </tr> <tr> <td>4.d</td> <td><i>Perpetuating factors</i></td> <td>1%</td> </tr> <tr> <td>4.e</td> <td><i>Previous treatment</i></td> <td>2%</td> </tr> <tr> <td>4.f</td> <td><i>Present status</i></td> <td>1%</td> </tr> </table> <p>Data analysis showed significant increases in compliance with sub-items 4.a, 4.b and 4.e from October 2007 to April 2008 (0% in October 2007 to 34%, 26% and 26%, respectively, in April 2008).</p>	4.a	<i>Pertinent history</i>	7%	4.b	<i>Predisposing factors</i>	2%	4.c	<i>Precipitating factors</i>	2%	4.d	<i>Perpetuating factors</i>	1%	4.e	<i>Previous treatment</i>	2%	4.f	<i>Present status</i>	1%
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4.b	<i>Predisposing factors</i>	2%																		
4.c	<i>Precipitating factors</i>	2%																		
4.d	<i>Perpetuating factors</i>	1%																		
4.e	<i>Previous treatment</i>	2%																		
4.f	<i>Present status</i>	1%																		
C.2.d.iii	consider biomedical, psychosocial, and psychoeducational factors, as clinically appropriate, for each category in § [III.B.4.b] above;	15% (rate increased from 0% in October 2007 to 68% in April 2008).																		
C.2.d.iv	consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment and rehabilitation interventions;	<table border="1"> <tr> <td>6.a</td> <td><i>All five factors: age, gender, culture, treatment adherence, and medication issues (are included)</i></td> <td>15%</td> </tr> <tr> <td>6.b</td> <td><i>(The formulation) addresses how they affect treatment and rehabilitation outcomes</i></td> <td>3%</td> </tr> </table> <p>Data analysis showed that compliance with these sub-items has increased from 5% and 0%, in October 2007 to 78% and 46% in April 2008, respectively.</p>	6.a	<i>All five factors: age, gender, culture, treatment adherence, and medication issues (are included)</i>	15%	6.b	<i>(The formulation) addresses how they affect treatment and rehabilitation outcomes</i>	3%												
6.a	<i>All five factors: age, gender, culture, treatment adherence, and medication issues (are included)</i>	15%																		
6.b	<i>(The formulation) addresses how they affect treatment and rehabilitation outcomes</i>	3%																		
C.2.d.v	support the diagnosis by diagnostic formulation, differential diagnosis and	5% (rate increased from 0% in October 2007 to 68% in April 2008).																		

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	Diagnostics and Statistical Manual DSM-IV-TR (or the most current edition) checklists; and																						
C.2.d.vi	enable the interdisciplinary team to reach sound determinations about each individual's treatment, rehabilitation, enrichment and wellness needs, the type of setting to which the individual should be discharged, and the changes that will be necessary to achieve discharge.	<table border="1"> <tr> <td>8.a</td> <td><i>The present status section addresses the following: Treatment, Rehabilitation and Enrichment</i></td> <td>5%</td> </tr> <tr> <td>8.b</td> <td><i>The case formulation identifies required changes in individual and systems to optimize treatment, rehabilitation and enrichment outcomes</i></td> <td>1%</td> </tr> <tr> <td>8.c</td> <td><i>The case formulation documents a pathway to the discharge setting</i></td> <td>2%</td> </tr> <tr> <td>8.d</td> <td><i>There is evidence of proper analysis of the following information: of identification of foci, objectives treatment, rehabilitation, and enrichment interventions and there is linkage between the case formulation and the foci of hospitalization, life goals and objectives and interventions.</i></td> <td>1%</td> </tr> <tr> <td>8.e</td> <td><i>There is proper linkage within different sections of the case formulation when a factor in one section is related to a factor in another section</i></td> <td>2%</td> </tr> <tr> <td>8.f</td> <td><i>There is evidence of proper analysis of the following information: of identification of foci, objectives treatment, rehabilitation, and enrichment interventions and there is linkage between the case formulation and the foci of hospitalization, life goals and objectives and interventions.</i></td> <td>1%</td> </tr> <tr> <td>8.g</td> <td><i>The case formulation identifies reasonable and attainable goals/objectives (e.g., at the level of</i></td> <td>1%</td> </tr> </table>	8.a	<i>The present status section addresses the following: Treatment, Rehabilitation and Enrichment</i>	5%	8.b	<i>The case formulation identifies required changes in individual and systems to optimize treatment, rehabilitation and enrichment outcomes</i>	1%	8.c	<i>The case formulation documents a pathway to the discharge setting</i>	2%	8.d	<i>There is evidence of proper analysis of the following information: of identification of foci, objectives treatment, rehabilitation, and enrichment interventions and there is linkage between the case formulation and the foci of hospitalization, life goals and objectives and interventions.</i>	1%	8.e	<i>There is proper linkage within different sections of the case formulation when a factor in one section is related to a factor in another section</i>	2%	8.f	<i>There is evidence of proper analysis of the following information: of identification of foci, objectives treatment, rehabilitation, and enrichment interventions and there is linkage between the case formulation and the foci of hospitalization, life goals and objectives and interventions.</i>	1%	8.g	<i>The case formulation identifies reasonable and attainable goals/objectives (e.g., at the level of</i>	1%
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		<p><i>each individual's functioning) that build on the individual's strengths and address the individual's identified needs.</i></p>							
C.2.e	<p>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>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Same as in C.2.c, C.2.f, C.2.g and C.2.o.</p> <p>Findings: Same as in C.2.c, C.2.f, C.2.g and C.2.o.</p> <p>Recommendation 2, November 2007: Continue chart audits, ensure a 20% sample and provide data analysis regarding areas of low compliance and corrective actions.</p> <p>Findings: PSH used the DMH WRP Chart Auditing Form to assess compliance (November 2007 to April 2008). The average sample was 12% of the WRPs due each month. The following outlines the indicator and sub-indicators with corresponding mean compliance rates:</p> <table border="1" data-bbox="955 1157 1738 1417"> <tr> <td data-bbox="955 1157 1031 1344">4.</td> <td data-bbox="1031 1157 1738 1344"> <p><i>The therapeutic and rehabilitation service plan specifies the individual's focus of hospitalization (goals), assessed needs (objectives) and how the staff will assist the individual to achieve his or her goals/objectives (interventions).</i></p> </td> <td data-bbox="1738 1157 1843 1344"></td> </tr> <tr> <td data-bbox="955 1344 1031 1417">4.a</td> <td data-bbox="1031 1344 1738 1417"> <p><i>There is a focus of hospitalization for each axis I, II, and III diagnosis</i></p> </td> <td data-bbox="1738 1344 1843 1417">28%</td> </tr> </table>	4.	<p><i>The therapeutic and rehabilitation service plan specifies the individual's focus of hospitalization (goals), assessed needs (objectives) and how the staff will assist the individual to achieve his or her goals/objectives (interventions).</i></p>		4.a	<p><i>There is a focus of hospitalization for each axis I, II, and III diagnosis</i></p>	28%	
4.	<p><i>The therapeutic and rehabilitation service plan specifies the individual's focus of hospitalization (goals), assessed needs (objectives) and how the staff will assist the individual to achieve his or her goals/objectives (interventions).</i></p>								
4.a	<p><i>There is a focus of hospitalization for each axis I, II, and III diagnosis</i></p>	28%							

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		4.b	<i>There is a focus for each discharge criteria</i>	23%
		4.c	<i>Each focus has an objective and an intervention</i>	29%
		4.d	<i>Each intervention includes the name of the staff responsible for implementation, the group name and the group time/day.</i>	25%
		4.e	<i>Each objective includes a staff intervention in the therapeutic milieu.</i>	6%
<p>Data analysis showed that the compliance rates with these sub-items ranged from 6% to 17% in October 2007. These rates have increased to a range from 9% to 54% in April 2008.</p> <p>The facility identified the failure to include therapeutic milieu interventions to be the greatest contributor to low compliance with this requirement. As corrective actions, the WRP mentors plan to provide further examples of therapeutic milieu interventions and to assist the teams in writing these interventions. In addition, the facility plans to train nursing staff using the Interventions and Mall Integration Module.</p> <p>PSH reported that since the last review, mentors have been working with the WRPTs to ensure all discharge criteria can be traced back to a specific objective with appropriate interventions. In April 2008, the WRPTs were given examples on how to write therapeutic milieu interventions.</p> <p>Other findings: Record review of individuals participating in Rehabilitation Therapist-led PSR Mall groups found that 17% had WRP documentation of focus, none had WRP documentation of objectives, and 48% had WRP documentation of interventions.</p> <p>Review of records for individuals receiving direct Occupational, Physical, and Speech Therapy found that 55% had WRP documentation of focus, 27% had WRP documentation of objectives, and 45% had WRP documentation of</p>				

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		<p>interventions.</p> <p>Upon record review of sample of Nutrition Care assessments completed across assessment sub-types, it was noted that 39% of corresponding WRP documents contained Nutrition Care recommendations, though these recommendations were not written in the form of foci, objectives and interventions.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Same as in C.2.c, C.2.f, C.2.g and C.2.o. 2. Monitor this requirement using the WRP Chart Auditing Form based on at least a 20% sample. 3. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
C.2.f	<p>Therapeutic and rehabilitation service planning is driven by individualized needs, is strengths-based (i.e., builds on an individual's current strengths), addresses the individual's motivation for engaging in wellness activities, and leads to improvement in the individual's mental health, health and well being, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall:</p>	<p>Please see sub-cells for compliance findings.</p>
C.2.f.i	<p>develop and prioritize reasonable and attainable goals/objectives (e.g., at the level of each individual's functioning) that build on the individual's strengths and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Continue and strengthen training of WRPTs to ensure that objectives and</p>

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	<p>address the individual's identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need;</p>	<p>interventions are implemented in accordance with the requirements in the DMH WRP manual.</p> <p>Findings: As mentioned earlier, PSH began implementation of the updated MSH modules regarding objectives and interventions in May 2008. The training will be provided on a referral basis.</p> <p>Recommendation 2, November 2007: Continue monitoring using the Clinical Chart Auditing and Process Observation Forms, ensure a 20% sample and provide data analysis regarding specific areas of low compliance and corrective actions.</p> <p>Findings: PSH used the DMH Chart Auditing Form and reviewed an average sample of 12% of WRPs due each month (November 2007 to April 2008). The following outlines the indicator and sub-indicators with corresponding mean compliance rates:</p> <table border="1" data-bbox="955 893 1848 1416"> <tr> <td data-bbox="955 893 1029 1153">5.</td> <td data-bbox="1029 893 1732 1153"><i>The team has developed and prioritized reasonable and attainable goals/objectives (e.g. at the level of each individuals functioning) that builds on the individuals strengths and addresses the individuals identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need.</i></td> <td data-bbox="1732 893 1848 1153"></td> </tr> <tr> <td data-bbox="955 1153 1029 1226">5.a</td> <td data-bbox="1029 1153 1732 1226"><i>All objectives for Focus 1, 3, and 5 are linked to the individual's stage of change</i></td> <td data-bbox="1732 1153 1848 1226">21%</td> </tr> <tr> <td data-bbox="955 1226 1029 1307">5.b</td> <td data-bbox="1029 1226 1732 1307"><i>The individual's strengths are used in the interventions.</i></td> <td data-bbox="1732 1226 1848 1307">7%</td> </tr> <tr> <td data-bbox="955 1307 1029 1416">5.c</td> <td data-bbox="1029 1307 1732 1416"><i>There is documented rationale in the focus area if any focus of hospitalization does not have an objective or an intervention.</i></td> <td data-bbox="1732 1307 1848 1416">1%</td> </tr> </table>	5.	<i>The team has developed and prioritized reasonable and attainable goals/objectives (e.g. at the level of each individuals functioning) that builds on the individuals strengths and addresses the individuals identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need.</i>		5.a	<i>All objectives for Focus 1, 3, and 5 are linked to the individual's stage of change</i>	21%	5.b	<i>The individual's strengths are used in the interventions.</i>	7%	5.c	<i>There is documented rationale in the focus area if any focus of hospitalization does not have an objective or an intervention.</i>	1%
5.	<i>The team has developed and prioritized reasonable and attainable goals/objectives (e.g. at the level of each individuals functioning) that builds on the individuals strengths and addresses the individuals identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need.</i>													
5.a	<i>All objectives for Focus 1, 3, and 5 are linked to the individual's stage of change</i>	21%												
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5.c	<i>There is documented rationale in the focus area if any focus of hospitalization does not have an objective or an intervention.</i>	1%												

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		<p>Data analysis showed increase in compliance with sub-item 5.a from 21% in October 2007 to 34% in April 2008. Compliance with 5.b remained the same at 6% (October and April). The compliance rate for item 5.c was 1% in October 2007 and 3% in April 2008. The facility recognized that the teams have been increasingly identifying individuals' strengths but have yet to include these strengths in the development of objectives and interventions.</p> <p>PSH also used the DMH WRP Observation Monitoring Form (November 2007 to April 2008). The average sample was 10% of the WRPCs due each month. The mean compliance rate was 2%. The rate was 0% in October 2007 and 3% in April 2008.</p> <p>Other findings: This monitor reviewed the charts of six individuals (BJB, EB, FEA, JCB, JMH and TJE). The review found compliance in one chart (JMH), partial compliance in three (BJB, EB and TJE) and noncompliance in one (JCB).</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement the updated MSH training modules regarding Foci, Objectives and Interventions/Mall Integration. 2. Monitor this requirement based on at least a 20% sample. 3. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
C.2.f.ii	ensure that the objectives/ interventions address treatment (e.g., for a disease or disorder), rehabilitation (e.g., skills/supports, motivation and readiness),	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Continue and strengthen training of WRPTs to ensure that objectives and</p>

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	<p>and enrichment (e.g., quality of life activities);</p>	<p>interventions are implemented in accordance with the requirements in the DMH WRP manual.</p> <p>Findings: Same as findings for Recommendation 1 in C.2.f.i.</p> <p>Recommendation 2, November 2007: Continue chart auditing, ensure a 20% sample and provide data analysis regarding specific areas of low compliance and corrective actions.</p> <p>Findings: PSH used the DMH Chart Auditing Form to assess compliance with the requirements in C.2.f.i to C.2.f.v. The average sample was 12% of the WRPs due each month (November 2007 to April 2008). The following outlines the indicator and sub-indicators with corresponding mean compliance rates regarding this requirement:</p> <table border="1" data-bbox="955 820 1850 1230"> <tr> <td data-bbox="955 820 1031 971">6.</td> <td data-bbox="1031 820 1734 971"><i>The objectives/interventions address treatment (e.g., for a disease or disorder), rehabilitation (e.g., skills/supports, motivation and readiness), and enrichment (e.g., quality of life activities.)</i></td> <td data-bbox="1734 820 1850 971"></td> </tr> <tr> <td data-bbox="955 971 1031 1117">6.a</td> <td data-bbox="1031 971 1734 1117"><i>There are specific skills training and support groups identified in the interventions that are linked to specific objectives and are provided in the PSR mall.</i></td> <td data-bbox="1734 971 1850 1117">52%</td> </tr> <tr> <td data-bbox="955 1117 1031 1230">6.b</td> <td data-bbox="1031 1117 1734 1230"><i>There are specific leisure and recreation groups specified in the interventions that are linked to objective derived to focus 10.</i></td> <td data-bbox="1734 1117 1850 1230">12%</td> </tr> </table> <p>Data analysis showed increases in compliance with the two sub-items from 26% and 4% in October 2007 to 82% and 26% in April 2008, respectively.</p>	6.	<i>The objectives/interventions address treatment (e.g., for a disease or disorder), rehabilitation (e.g., skills/supports, motivation and readiness), and enrichment (e.g., quality of life activities.)</i>		6.a	<i>There are specific skills training and support groups identified in the interventions that are linked to specific objectives and are provided in the PSR mall.</i>	52%	6.b	<i>There are specific leisure and recreation groups specified in the interventions that are linked to objective derived to focus 10.</i>	12%
6.	<i>The objectives/interventions address treatment (e.g., for a disease or disorder), rehabilitation (e.g., skills/supports, motivation and readiness), and enrichment (e.g., quality of life activities.)</i>										
6.a	<i>There are specific skills training and support groups identified in the interventions that are linked to specific objectives and are provided in the PSR mall.</i>	52%									
6.b	<i>There are specific leisure and recreation groups specified in the interventions that are linked to objective derived to focus 10.</i>	12%									

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		<p>Other findings: Reviewing the above-mentioned six charts, this monitor found compliance in three (EB, JCB and JMH) and noncompliance in three (BJB, FEA and TJE).</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as in C.2.f.i.</p>
C.2.f.iii	write the objectives in behavioral, observable, and/or measurable terms;	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Same as above.</p> <p>Findings: The facility reported a mean compliance rate of 7%. Data analysis showed that this item had 0% compliance in October 2007 and 4% compliance in April 2008. The facility anticipates improved compliance when all nursing staff has received training in the Foci and Objectives the Interventions/Mall Integration modules.</p> <p>Other findings: Chart reviews by this monitor found compliance in two charts (BJB and JMH), partial compliance in two (EB and TJE) and noncompliance in two (FEA and JCB).</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as in C.2.f.i.</p>

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C.2.f.iv	include all objectives from the individual's current stage of change or readiness for rehabilitation, to the maintenance stage for each focus of hospitalization, as clinically appropriate;	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Same as above.</p> <p>Findings: The facility reported a mean compliance rate of 29%. Data analysis showed that compliance has increased from 4% in October 2007 to 50% in April 2008</p> <p>Other findings: This monitor found compliance in one chart (JCB), partial compliance in four (BJB, EB, JMH and TJE) and noncompliance in one (FEA).</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as in C.2.f.i.</p>						
C.2.f.v	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>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Same as above.</p> <p>Findings: The following outlines the facility's data for this requirement:</p> <table border="1" data-bbox="955 1226 1848 1412"> <tr> <td data-bbox="955 1226 1029 1377">9.</td> <td data-bbox="1029 1226 1732 1377"><i>The WRP has interventions that relate to each objective, specifying who will do what, within what time frame, to assist the individual meet his/her needs as specified in the objective.</i></td> <td data-bbox="1732 1226 1848 1377"></td> </tr> <tr> <td data-bbox="955 1377 1029 1412">9.a</td> <td data-bbox="1029 1377 1732 1412"><i>The interventions are aligned with their respective</i></td> <td data-bbox="1732 1377 1848 1412">19%</td> </tr> </table>	9.	<i>The WRP has interventions that relate to each objective, specifying who will do what, within what time frame, to assist the individual meet his/her needs as specified in the objective.</i>		9.a	<i>The interventions are aligned with their respective</i>	19%
9.	<i>The WRP has interventions that relate to each objective, specifying who will do what, within what time frame, to assist the individual meet his/her needs as specified in the objective.</i>							
9.a	<i>The interventions are aligned with their respective</i>	19%						

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		<table border="1" data-bbox="955 191 1850 459"> <tr> <td></td> <td><i>objective</i></td> <td></td> </tr> <tr> <td>9.b</td> <td><i>The interventions specify the name of the specific staff responsible for implementing each intervention.</i></td> <td>22%</td> </tr> <tr> <td>9.c</td> <td><i>The type of the intervention is listed.</i></td> <td>26%</td> </tr> <tr> <td>9.d</td> <td><i>The frequency of the intervention is listed.</i></td> <td>30%</td> </tr> <tr> <td>9.e</td> <td><i>The duration of the intervention is listed</i></td> <td>29%</td> </tr> </table> <p>Overall, the mean compliance rate for this requirement has increased from 2% in the last reporting period to 7% in this reporting period.</p> <p>Other findings: This monitor found compliance in two charts (BJB and JMH), partial compliance in three (EB, JCB and TJE) and noncompliance in one (FEA).</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as in C.2.f.i.</p>		<i>objective</i>		9.b	<i>The interventions specify the name of the specific staff responsible for implementing each intervention.</i>	22%	9.c	<i>The type of the intervention is listed.</i>	26%	9.d	<i>The frequency of the intervention is listed.</i>	30%	9.e	<i>The duration of the intervention is listed</i>	29%
	<i>objective</i>																
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9.e	<i>The duration of the intervention is listed</i>	29%															
C.2.f.vi	<p>implement interventions appropriately throughout the individual's day, with a minimum of 20 hours of active treatment per week. Individual or group therapy included in the individual's WRP shall be provided as part of the 20 hours of active treatment per week;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, November 2007:</p> <ul style="list-style-type: none"> • Correct factors related to inadequate documentation of scheduled hours on the WRPs and the discrepancies between WRP and MAPP data. • Continue to monitor hours of active treatment (scheduled and attended) and provide data analysis and corrective actions to ensure that individuals attend the required hours. <p>Findings: PSH's data are summarized in the following table:</p>															

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	Scheduled hours (number of individuals by category)	Attended hours (number of individuals by category)
N	1518	1517
%S	100	100
Hours:		
0-5	20	55
6-10	22	178
11-15	152	625
16-20	1303	655

The facility's data showed an increase in the number of scheduled hours in the category of 11-15 hours (81 in October 2007 to 131 in April 2008) and the number of attended hours in the category of 16-20 (422 to 636). However, the data regarding attended hours may not be reliable due to apparent counting of the same group more than once

Other findings:
This monitor reviewed the above-mentioned six charts to assess documentation of active treatment hours listed on the most recent WRP and corresponding MAPP data regarding hours scheduled and attended:

	WRP scheduled	MAPP scheduled	MAPP attended
BJB	19	20.00	18.00
EB	18	20.25	17.00
FEA	20	20.00	12.5
JCB	19	19.75	13.25
JMH	20	20.00	19.00
TJE	8	17.75	15.50

The monitor's reviews showed that the facility has made progress in the

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		<p>number of hours scheduled and attended since the last reporting period and in correcting the discrepancies between WRP and MAPP data.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor hours of active treatment (scheduled and attended) and provide data analysis and corrective actions to ensure that individuals attend the required hours. 2. Ensure that the same groups are not counted more than once in the calculation of active treatment hours attended by the individuals.
C.2.f.vii	<p>maximize, consistent with the individual's treatment needs and legal status, opportunities for treatment, programming, schooling, and other activities in the most appropriate integrated, non-institutional settings, as clinically appropriate; and</p>	<p>This requirement is currently not applicable to PSH. The facility is unable legally to allow individuals to participate in community treatment opportunities unless accompanied by a CDCR Correctional Officer. This is based on California Welfare and Institutions Code Section 4107(a), which requires that the security of individuals at Patton State Hospital is the responsibility of the Department of Corrections and Rehabilitation.</p> <p>This monitor asked the facility to explore the barriers that exist for CDCR to provide/coordinate security supervision to facilitate community treatment opportunities.</p>
C.2.f.viii	<p>ensure that each therapeutic and rehabilitation service plan integrates and coordinates all services, supports, and treatments provided by or through each State hospital for the individual in a manner specifically responsive to the plan's therapeutic and rehabilitation goals. This requirement includes but is not limited to ensuring that individuals are assigned to</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 3, November 2007:</p> <ul style="list-style-type: none"> • Use the finalized Mall Alignment Checklist to monitor this requirement and provide data analysis regarding areas on low compliance and corrective actions. • Implement mechanisms to ensure proper linkage between type and objectives of mall activities and objectives outlined in the WRP as well as documentation of this linkage.

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	<p>mall groups that link directly to the objectives in the individual's WRP and needs.</p>	<p>Findings: PSH used the DMH Mall Alignment Monitoring Form to assess compliance (November 2007 to April 2008). The facility reviewed an average sample of 20 charts as an interim self-monitoring step. The mean compliance rate was 44%. The facility recognized that the apparent increase in compliance since the last reporting period may be influenced by monitoring limitations rather than reflecting actual progress (the sample size averaged only two to three individuals per program and only one intervention per focus was reviewed for linkage).</p> <p>Recommendation 2, November 2007: Implement electronic progress note documentation by all mall and individual therapy providers.</p> <p>Findings: PSH reported that efforts are underway to improve the utilization of the WaRMSS by the WRPTs in order to facilitate implementation.</p> <p>Other findings: Chart reviews by this monitor found compliance in one chart (JMH), partial compliance in four (BJB, EB, JCB and TJE) and noncompliance in one (FEA).</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor this requirement using the Mall Alignment Monitoring Form. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 3. Implement electronic progress note documentation by all Mall and individual therapy providers and ensure integration of data, as needed, into the WRPs.
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<p>C.2.g</p>	<p>Therapeutic and rehabilitation service plans are revised as appropriate to ensure that planning is based on the individual's progress, or lack thereof, as determined by the scheduled monitoring of identified criteria or target variables, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall:</p>	<p>Please see sub-cells for compliance findings.</p>
<p>C.2.g.i</p>	<p>revise the focus of hospitalization, objectives, as needed, to reflect the individual's changing needs and develop new interventions to facilitate attainment of new objectives when old objectives are achieved or when the individual fails to make progress toward achieving these objectives;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Monitor this requirement using both process observation and chart auditing and analyze and correct factors related to low compliance.</p> <p>Findings: PSH used the DMH WRP Observation Monitoring Form to assess compliance. The average sample was 10% of the WRPCs due each month (November 2007 to April 2008). The mean compliance rate was 3%; the data showed an increase in compliance from 0% in October 2007 to 5% in April 2008. Using the DMH Clinical Chart Auditing Form, the facility reviewed an average sample of 7% of the monthly, quarterly and annual WRPs due by month (November 2007 to April 2008); the mean compliance rate was 2%.</p> <p>The facility assessed a variety of barriers, including software issues and other factors that contributed to low compliance. Corrective actions are underway.</p> <p>Other findings: This monitor reviewed the charts of six individuals (BJB, EB, FEA, JCB, TJE and TLE) and found compliance in two charts (TJE and TLE) and noncompliance in four (BJB, EB, FEA and JCB).</p>

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		<p>Additionally, none of the records reviewed by this monitor of individuals participating in Rehabilitation Therapist-led PSR Mall groups contained WRP documentation of revision of focus, objectives, and/or interventions according to individualized needs. Twenty-nine percent of records for individuals receiving direct Physical, Occupational and/or Speech Therapy contained evidence that treatment modalities and interventions were modified as needed in response to individuals' needs, though none of these records contained WRP documentation of revision of focus, objectives, and/or interventions according to individualized needs.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor this requirement using the Clinical Chart Auditing and the WRP Process Observation Monitoring forms, based on at least a 20% sample 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 3. Resolve systemic barriers contributing to low compliance.
C.2.g.ii	<p>review the focus of hospitalization, needs, objectives, and interventions more frequently if there are changes in the individual's functional status or risk factors (i.e., behavioral, medical, and/or psychiatric risk factors);</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Implement corrective actions to ensure:</p> <ol style="list-style-type: none"> a. Review by the WRPTs of the use of seclusion/restraints and the circumstances related to such use; and b. Timely and appropriate modification of the WRPs in response to the review. <p>Findings: PSH reported that the WRP mentors have received didactic and hands-on training to utilize a software system that facilitates the review of seclusion</p>

		<p>and restraints data. The mentors trained WRPTs on the use of this system.</p> <p>Recommendation 2, November 2007: Continue to monitor this requirement using observation and chart auditing and analyze and correct factors related to low compliance.</p> <p>Findings: Using the DMH WRP Chart Auditing Form (average sample of 12% of the WRPs due each month), PSH reported a mean compliance rate of 8% (November 2007 to April 2008). Data analysis showed that compliance increased from 3% in October 2007 to 33% in April 2008.</p> <p>PSH also used the DMH WRP Observation Monitoring Form and reviewed average sample of 10% of the WRPCs due each month. The mean compliance rate was 11%. The compliance rate increased from 2% in October 2007 to 19% in April 2008.</p> <p>Recommendation 3, November 2007: Revise current monitoring tool to include individuals whose functional status has improved.</p> <p>Findings: The DMH has implemented this recommendation.</p> <p>Other findings: This monitor reviewed the charts of five individuals who experienced the use of seclusion and/or restraints during this reporting period. The following table outlines this review.</p> <table border="1" data-bbox="955 1263 1692 1414"> <thead> <tr> <th>Individual</th> <th>Date of seclusion and/or restraint</th> <th>Date of applicable WRP review</th> </tr> </thead> <tbody> <tr> <td>CLC</td> <td>03/11/08</td> <td>03/13/08</td> </tr> <tr> <td>KLK</td> <td>04/21/08</td> <td>05/06/08</td> </tr> </tbody> </table>	Individual	Date of seclusion and/or restraint	Date of applicable WRP review	CLC	03/11/08	03/13/08	KLK	04/21/08	05/06/08
Individual	Date of seclusion and/or restraint	Date of applicable WRP review									
CLC	03/11/08	03/13/08									
KLK	04/21/08	05/06/08									

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		<table border="1"> <tr> <td>MLB</td> <td>04/26/08</td> <td>05/15/08</td> </tr> <tr> <td>CW</td> <td>05/11/08</td> <td>05/15/08</td> </tr> <tr> <td>RZ</td> <td>02/20/08</td> <td>02/29/08</td> </tr> </table>	MLB	04/26/08	05/15/08	CW	05/11/08	05/15/08	RZ	02/20/08	02/29/08	<p>The review found that only two charts contained documentation of the events that led to the use (KLK and MLB). None of the charts reviewed contained documentation of modification of treatment based on the use of these interventions.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor this requirement using both process observation and chart auditing, based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
MLB	04/26/08	05/15/08										
CW	05/11/08	05/15/08										
RZ	02/20/08	02/29/08										
C.2.g.iii	<p>ensure that the review process includes an assessment of progress related to discharge to the most integrated setting appropriate to meet the individuals assessed needs, consistent with his/her legal status; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Implement the training module regarding Discharge Planning and Community Integration.</p> <p>Findings: As mentioned earlier, this module was implemented in May 2008 on a referral basis.</p> <p>Recommendation 2, November 2007: Monitor this requirement using both process observation and chart auditing, and analyze and correct factors related to low compliance.</p>										

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		<p>Findings: The following is a summary of the facility's data based on the WRP Process Observation Form:</p> <table border="1" data-bbox="955 337 1873 675"> <tr> <td data-bbox="955 337 1050 488">10.</td> <td data-bbox="1050 337 1759 488"><i>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.</i></td> <td data-bbox="1759 337 1873 488"></td> </tr> <tr> <td data-bbox="955 488 1050 561">10.a</td> <td data-bbox="1050 488 1759 561"><i>The team reviews all Foci that are barriers to discharge.</i></td> <td data-bbox="1759 488 1873 561">18%</td> </tr> <tr> <td data-bbox="955 561 1050 675">10.b</td> <td data-bbox="1050 561 1759 675"><i>The team reviews the PSR Mall Facilitator's Monthly Notes for all objectives related to discharge.</i></td> <td data-bbox="1759 561 1873 675">0%</td> </tr> </table> <p>Data analysis showed increases in compliance rates from 7% and 0% in October 2007 to 22% and 1% in April 2008, respectively.</p> <p>Other findings: This monitor reviewed the charts of six individuals (BJB, EB, FEA, JCB, TJE and YTP). The review found the following:</p> <ol style="list-style-type: none"> 1. There was partial (JCB, TJE and YTP) or no (BJB, EB and FEA) delineation of individualized discharge criteria. 2. There was partial (BJB, EB, FEA and YTP) or no (JCB and TJE) adequate documentation, in the present status section, of the team's discussion of progress towards discharge. <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor this requirement using both process observation and chart auditing, based on at least a 20% sample. 	10.	<i>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.</i>		10.a	<i>The team reviews all Foci that are barriers to discharge.</i>	18%	10.b	<i>The team reviews the PSR Mall Facilitator's Monthly Notes for all objectives related to discharge.</i>	0%
10.	<i>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.</i>										
10.a	<i>The team reviews all Foci that are barriers to discharge.</i>	18%									
10.b	<i>The team reviews the PSR Mall Facilitator's Monthly Notes for all objectives related to discharge.</i>	0%									

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		<ol style="list-style-type: none"> 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 3. Develop and implement corrective actions to ensure that discharge criteria are individualized and that the WRPTs document their discussion of progress towards discharge criteria.
C.2.g.iv	base progress reviews and revision recommendations on data collected as specified in the therapeutic and rehabilitation service plan.	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Monitor this requirement using both process observation and clinical chart auditing, and analyze and correct factors related to low compliance.</p> <p>Findings: The facility reported 0% compliance with this requirement based on process observation data.</p> <p>Other findings: This monitor reviewed six charts (BJB, EB, FEA, JCB, JMH and TJE). The review found that Mall progress notes were completed in three charts (BJB, EB and FEA). However, none of the charts included evidence that the information in the progress notes was adequately incorporated in the WRP reviews.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Same as in C.2.g.i. 2. Same as in C.2.f.viii.
C.2.h	Individuals in need of positive behavior supports in school or other settings receive such	Current findings on previous recommendation:

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	supports consistent with generally accepted professional standards of care.	Recommendation, November 2007: Please see F.2.a through F.2.c (including sub-cells) for PBS-related recommendations.																																
C.2.i	Adequate active psychosocial rehabilitation is provided, consistent with generally accepted professional standards of care, that:	Compliance: Partial.																																
C.2.i.i	is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: WRPTs should integrate relevant information from discipline-specific assessments and prioritize the individual's assessed needs.</p> <p>Findings: PSH used item #2 from the DMH Mall Alignment Monitoring Form (<i>Is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions</i>) to address this recommendation, reporting 45% compliance. The table below showing the number of WRPs due each month (N), the number of charts audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.</p> <table border="1"> <thead> <tr> <th></th> <th>11/07</th> <th>12/07</th> <th>1/08</th> <th>2/08</th> <th>3/08</th> <th>4/08</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>1421</td> <td>1412</td> <td>1561</td> <td>1526</td> <td>1548</td> <td>1561</td> <td></td> </tr> <tr> <td>n</td> <td>19</td> <td>24</td> <td>22</td> <td>21</td> <td>19</td> <td>19</td> <td></td> </tr> <tr> <td>%C #2</td> <td>47</td> <td>33</td> <td>46</td> <td>67</td> <td>32</td> <td>42</td> <td>45</td> </tr> </tbody> </table> <p>This monitor reviewed nine charts (CB, DEG, DR, EB, JF, MI, NSC, RP and VD). Six of the WRPs in the charts (CB, DEG, DR, EB, RP and VD) had integrated the relevant information from the discipline-specific assessments into the relevant sections of the individual's WRP. Three of them (JF, MI and NSC) did not fully integrate all available relevant</p>		11/07	12/07	1/08	2/08	3/08	4/08	Mean	N	1421	1412	1561	1526	1548	1561		n	19	24	22	21	19	19		%C #2	47	33	46	67	32	42	45
	11/07	12/07	1/08	2/08	3/08	4/08	Mean																											
N	1421	1412	1561	1526	1548	1561																												
n	19	24	22	21	19	19																												
%C #2	47	33	46	67	32	42	45																											

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		<p>information.</p> <p>Recommendation 2, November 2007: Expand the number of Mall groups and individual therapies to accommodate the assessed needs and interests of individuals.</p> <p>Findings: This monitor's documentation review (progress report, Mall group courses, Mall group schedules) and interview of the Mall Director, Melanie Bye, found that PSH has added 134 new groups since the previous tour. However, lack of facilitators is a barrier to the regular scheduling and functioning of many of these groups. According to the Mall Director, existing groups had to be closed to accommodate new groups due to insufficient numbers of facilitators.</p> <p>Other findings: According to reviews of records of individuals participating in Rehabilitation Therapist-led PSR Mall groups, 82% of PSR Mall group objectives and interventions were aligned with assessment findings regarding individual needs and strengths. A review of records for individuals receiving direct Physical, Occupational and/or Speech Therapy found that 67% of treatment activities were aligned with assessment findings of individual needs.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. WRPTs should integrate relevant information from discipline-specific assessments and prioritize the individual's assessed needs. 2. Continue to offer groups based on the needs of the individuals in the facility.
C.2.i.ii	Has documented objectives, measurable outcomes, and standardized methodology	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Ensure that the learning outcomes are stated in measurable terms.</p>

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		<p>Findings: PSH used item #3 from the DMH Mall Alignment Monitoring Form (<i>Has documented objectives, measurable outcomes and standardized methodology</i>) to address this recommendation, reporting 28% compliance. The table below showing the number of WRPs due each month (N), the number of charts audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.</p> <table border="1" data-bbox="955 522 1875 677"> <thead> <tr> <th></th> <th>11/07</th> <th>12/07</th> <th>1/08</th> <th>2/08</th> <th>3/08</th> <th>4/08</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>1421</td> <td>1412</td> <td>1561</td> <td>1526</td> <td>1548</td> <td>1561</td> <td></td> </tr> <tr> <td>n</td> <td>19</td> <td>24</td> <td>22</td> <td>21</td> <td>19</td> <td>19</td> <td></td> </tr> <tr> <td>%C #3</td> <td>26</td> <td>33</td> <td>46</td> <td>43</td> <td>16</td> <td>3</td> <td>28</td> </tr> </tbody> </table> <p>This monitor reviewed ten charts (CB, DEG, DR, EB, GAG, JF, MI, RA, RP and VD). Five of the WRPs in the charts (EB, GAG, JF, RA and VD) contained learning outcomes stated in measurable terms. The remaining five (CB, DEG, DR, MI and RP) did not state one or more of the learning outcomes in measurable terms.</p> <p>Recommendation 2, November 2007: Ensure that each objective is directly linked to a relevant focus of hospitalization and discharge criteria.</p> <p>Findings: This monitor reviewed six charts (JJB, JP, MHK, NMM, NWJ and PHL). One of the WRPs in the charts (NWJ) addressed the necessary discharge criteria with a relevant focus and an aligned objective for each focus. The remaining five did not.</p> <p>Recommendation 3, November 2007: Ensure that the courses offered have individualized objectives, observable outcomes, and evaluation measures for all individuals attending the course.</p>		11/07	12/07	1/08	2/08	3/08	4/08	Mean	N	1421	1412	1561	1526	1548	1561		n	19	24	22	21	19	19		%C #3	26	33	46	43	16	3	28
	11/07	12/07	1/08	2/08	3/08	4/08	Mean																											
N	1421	1412	1561	1526	1548	1561																												
n	19	24	22	21	19	19																												
%C #3	26	33	46	43	16	3	28																											

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		<p>Findings: PSH used item #11 (<i>Progress reviews and revision recommendations are based on data collected as specified in the therapeutic and rehabilitation service plan</i>) from the DMH WRP Observation Monitoring Form to address this recommendation, reporting 0% compliance. According to the Mall Director, compliance is low due to the lack of full implementation of the Monthly Mall Progress Notes, with an average of only 1.7 progress notes per individual per month being written</p> <p>This monitor's interview of Mall facilitators and review of eight WRPs (CD, DR, EB, JF, NSC, RA, RP and VD) found that individuals in PSR Mall groups do not have individualized objectives, observable outcomes and evaluation measures for all individuals attending the course.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the learning outcomes are stated in measurable terms. 2. Ensure that each objective is directly linked to a relevant focus of hospitalization and discharge criteria. 3. Ensure that the courses offered have individualized objectives, observable outcomes, and evaluation measures for all individuals attending the course.
C.2.i.iii	Is aligned with the individual's objectives that are identified in the individual's Wellness and Recovery Plan	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Ensure that WRPTs write objectives in behavioral, observable, and/or measurable terms.</p> <p>Findings: PSH used item #7 from the DMH WRP Chart Auditing Form (<i>The WRP plan includes behavioral, observable, and/or measurable objectives written in terms of what the individual will do</i>) to address this recommendation,</p>

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reporting 7% compliance. The table below showing the number of WRPs due each month (N), the number of charts audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

	11/07	12/07	1/08	2/08	3/08	4/08	Mean
N	1616	1604	1759	1721	1753	1760	
n	162	169	238	248	212	233	
%S	10	11	14	14	12	13	
%C #7	6	7	6	13	6	4	7

This monitor reviewed nine charts (CB, DEG, DR, EB, GAG, JF, MI, RA and RP). Three of WRPs in the charts (GAG, JF and RA) contained objectives written in behavioral, observable, and/or measurable terms. The remaining six WRPs in the charts (CB, DEG, DR, EB, MI and RP) failed to write all objectives in behavioral, observable, and/or measurable terms.

Recommendation 2, November 2007:

Ensure that all therapies and rehabilitation services provided in the Malls are aligned with the assessed needs of the individuals.

Findings:

PSH used item #4 from the DMH Mall Alignment Monitoring Form (*Is aligned with the individual's objectives that are identified in the individual's wellness and recovery plan*) to address this recommendation, reporting 41% compliance. The table below showing the number of WRPs due each month (N), the number of charts audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

	11/07	12/07	1/08	2/08	3/08	4/08	Mean
N	1421	1412	1561	1526	1548	1561	
n	19	24	22	21	19	19	
%C #4	53	29	67	62	32	0	41

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		<p>This monitor reviewed nine charts (CB, DEG, DR, EB, GAG, JF, MI, RP and VD). The therapies and rehabilitation services provided in the Malls were aligned in seven (CB, DEG, DR, EB, GAG, JF and RP) of the WRPs, but not in the remaining two (MI and VD).</p> <p>Recommendation 3, November 2007: Ensure that the individual's progress is tracked (using the PSH Mall Facilitator Monthly Progress Note) and that participation at different levels and in different groups is adjusted accordingly.</p> <p>Findings: This monitor's documentation review (progress notes and WRPs) and interview of the Mall Director found that Mall Monthly Progress Notes are not being written in a consistent manner. According to the Mall Director, currently only 1.7 progress notes per individual, on average, are being written.</p> <p>This monitor reviewed eight charts (CD, DR, EB, JF, NSC, RA, RP and VD). None of the charts contained the required number of progress notes for each individual. Four of the charts (CD, EB, NSC and VD) contained between one and four progress notes each. However, none of the notes contained sufficient information to determine the individuals' progress in the PSR services.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that WRPTs write objectives in behavioral, observable, and/or measurable terms. 2. Ensure that all therapies and rehabilitation services provided in the Malls are aligned with the assessed needs of the individuals. 3. Ensure that the individual's progress is tracked (using the PSH Mall Facilitator Monthly Progress Note) and that participation at different levels and in different groups is adjusted accordingly.
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C.2.i.iv	utilizes the individual's strengths, preferences, and interests;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Ensure that the individual's strengths, preferences, and interests are clearly specified in the interventions in the individual's WRP in accordance with the DMH WRP manual.</p> <p>Findings: This monitor reviewed 13 charts (CB, DEG, DJ, DR, EB, GAG, IC, JF, JJ, MH, RA, RF and RP). Four of the WRPs in the charts (DEG, DJ, RA and RF) had strengths identified in all or most of the interventions. The remaining nine (CB, DR, EB, GAG, IC, JF, JJ, MH and RP) WRPs did not have strengths identified in most of the interventions.</p> <p>Recommendation 2, November 2007: Ensure that the group facilitators and individual therapists know and use the individual's strengths, preferences and interests when delivering rehabilitation services.</p> <p>Findings: PSH used item #5 from the DMH Mall Alignment Monitoring Form (<i>Utilizes the individual's strengths, preferences and interests</i>) to address this recommendation, reporting 18% compliance. The table below showing the number of WRPs due each month (N), the number of charts audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.</p> <table border="1" data-bbox="955 1188 1875 1344"> <thead> <tr> <th></th> <th>11/07</th> <th>12/07</th> <th>1/08</th> <th>2/08</th> <th>3/08</th> <th>4/08</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>1421</td> <td>1412</td> <td>1561</td> <td>1526</td> <td>1548</td> <td>1561</td> <td></td> </tr> <tr> <td>n</td> <td>19</td> <td>24</td> <td>22</td> <td>21</td> <td>19</td> <td>19</td> <td></td> </tr> <tr> <td>%C #5</td> <td>32</td> <td>17</td> <td>14</td> <td>24</td> <td>21</td> <td>0</td> <td>18</td> </tr> </tbody> </table> <p>This monitor's review of WRPs and Mall progress notes (CD, DR, EB, JF,</p>		11/07	12/07	1/08	2/08	3/08	4/08	Mean	N	1421	1412	1561	1526	1548	1561		n	19	24	22	21	19	19		%C #5	32	17	14	24	21	0	18
	11/07	12/07	1/08	2/08	3/08	4/08	Mean																											
N	1421	1412	1561	1526	1548	1561																												
n	19	24	22	21	19	19																												
%C #5	32	17	14	24	21	0	18																											

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		<p>NSC, RA, RP and VD), observation of Mall groups (Collaborative Recovery Group, Relaxation, Anti-Social-Face It and Pace it, and Mood Management) and interview of Mall facilitators and the Mall Director found that group facilitators and individual therapists do not always know the strengths, preferences and interests of the individuals attending their PSR services. Facilitators usually know the strengths, preferences and interests of the individuals for whom they are on the WRPT, but not otherwise. A few facilitators take the initiative to look up the information in the individual's chart; however, in some cases even this is not possible because WRPs do not always include the strengths in the interventions (for example, CB, EB, IC, JF, MH and RP).</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the individual's strengths, preferences, and interests are clearly specified in the interventions in the individual's WRP, in accordance with the DMH WRP manual. 2. Ensure that the group facilitators and individual therapists know and use the individual's strengths, preferences and interests when delivering rehabilitation services.
C.2.i.v	<p>focuses on the individual's vulnerabilities to mental illness, substance abuse, and readmission due to relapse, where appropriate;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Undertake clinical case formulation as a team rather than by assigning the task to a team member or to non-team members.</p> <p>Findings: This monitor observed two WRPCs (JJB and LBP); in both cases the teams functioned in an interdisciplinary manner. Each member of the team shared relevant information with the rest of the team. In addition, the teams conducted the conference following the expected sequence of steps outlined in the DMH WRP Manual</p>

		<p>Recommendations 2 and 3, November 2007:</p> <ul style="list-style-type: none"> • Include the individual's vulnerabilities in the case formulation under predisposing, precipitating, and perpetuating factors. • Update the present status to reflect the current status of these vulnerabilities. <p>Findings: PSH used item #6 from the DMH Mall Alignment Monitoring Form (<i>Focuses on the individual's vulnerabilities to mental illness, substance abuse and readmission due to relapse, where appropriate</i>) to address this recommendation, reporting 64% compliance. The table below showing the number of WRPs due each month (N), the number of charts audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.</p> <table border="1" data-bbox="957 743 1873 899"> <thead> <tr> <th></th> <th>11/07</th> <th>12/07</th> <th>1/08</th> <th>2/08</th> <th>3/08</th> <th>4/08</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>1421</td> <td>1412</td> <td>1561</td> <td>1526</td> <td>1548</td> <td>1561</td> <td></td> </tr> <tr> <td>n</td> <td>19</td> <td>24</td> <td>22</td> <td>21</td> <td>19</td> <td>19</td> <td></td> </tr> <tr> <td>%C #6</td> <td>63</td> <td>79</td> <td>64</td> <td>62</td> <td>63</td> <td>53</td> <td>64</td> </tr> </tbody> </table> <p>This monitored review six charts (DJ, FR, IC, JJ, JTD and MH). Three of the WRPs in the charts (FR, JJ and JTD) described the individual's vulnerabilities in the case formulation under predisposing, precipitating, and perpetuating factors, and integrated the vulnerabilities in the present status sections of the WRPs. The remaining three (DJ, IC and MH) did not.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Undertake clinical case formulation as a team rather than by assigning the task to a team member or to non-team members. 2. Include the individual's vulnerabilities in the case formulation under predisposing, precipitating, and perpetuating factors. 3. Update the present status to reflect the current status of these vulnerabilities. 		11/07	12/07	1/08	2/08	3/08	4/08	Mean	N	1421	1412	1561	1526	1548	1561		n	19	24	22	21	19	19		%C #6	63	79	64	62	63	53	64
	11/07	12/07	1/08	2/08	3/08	4/08	Mean																											
N	1421	1412	1561	1526	1548	1561																												
n	19	24	22	21	19	19																												
%C #6	63	79	64	62	63	53	64																											

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<p>C.2.i.vi</p>	<p>is provided in a manner consistent with each individual's cognitive strengths and limitations;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: PSR Mall groups should address the assessed cognitive levels of the individuals participating in the group.</p> <p>Findings: This monitor's interview of the Mall Director and the Chief of Psychology, review of the Integrated Assessments (Psychology Section), and observation of Mall groups (Collaborative Recovery Group, Relaxation, Anti-Social-Face It and Pace It, and Mood Management) found that individuals are not always assigned to Mall groups by their cognitive status. Psychologists conduct cognitive screenings as part of the Integrated Assessment: Psychology Section when an individual is admitted to PSH. According to the Mall Director, cognitive strengths and limitations are also assessed in the Substance Abuse groups (challenge 1, 2, and 3).</p> <p>Recommendation 2, November 2007: 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.</p> <p>Findings: PSH does not have a DCAT team at the present time.</p> <p>Current 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. 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.
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<p>C.2.i.vii</p>	<p>Provides progress reports for review by the Wellness and Recovery Team as part of the Wellness and Recovery Plan review process;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1-3, November 2007:</p> <ul style="list-style-type: none"> • Ensure that WRPTs receive timely progress notes on individuals' participation in their psychosocial rehabilitation services. • Automate this system. • Use the data from the PSR Mall Facilitator Monthly Progress Notes in the WRP review process. <p>Findings:</p> <p>This monitor's interview of the Director of Standards Compliance and the Mall Director found that PSH's Mall progress note system is not fully automated. Two staff members distribute and collect around 30,000 Mall progress notes on a monthly basis. The notes contain pre-printed demographic data and the objectives for the individual. The facilitators still have to pen their documentation in the Mall notes. According to the Mall Director, about 1.7 notes per individual per month on average are written and made available to the individual's WRPT.</p> <p>This monitor's review of charts (CD, DR, EB, JF, NSC, RA, RP and VD) found that on average, the charts contained between one and four notes each. The notes did not include sufficient information on the individual's progress towards his/her objectives for the WRPTs to evaluate the progress and make necessary changes.</p> <p>Other findings:</p> <p>According to a review of records of individuals participating in Rehabilitation Therapist-led PSR Mall groups, 22% had evidence of Mall Facilitator Monthly Progress notes, and 4% had progress notes that were completed appropriately. A review of records for individuals receiving direct Physical and Speech Therapy found that 100% of records contained documentation of progress, but none contained documentation of progress in the WRP.</p>
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		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that WRPTs 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 Notes in the WRP review process.
C.2.i.viii	<p>is provided five days a week, for a minimum of four hours a day (i.e., two hours in the morning and two hours in the afternoon each weekday), for each individual or two hours a day when the individual is in school, except days falling on state holidays;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Mandate that all staff at PSH, other than those who attend to emergency medical needs of individuals, will provide services at the PSR Mall during scheduled Mall hours. This includes clinical, administrative and support staff.</p> <p>Findings: This monitor's interview of the Mall Director found that PSH has not formally mandated that all staff, other than those who provide emergency services, provide services during Mall hours. However, the staff interviewed knew that is what is expected of them. According to the Mall Director, units are not closed during Mall hours and individuals are allowed to stay in their units with the television turned on. PSH has changed the start time for the afternoon groups to eliminate the conflict with shift change duties, and to free up staff to facilitate Mall groups. However, the number of available facilitators has not increased much. PSH's progress report showed that the percentage of facilitated hours by certain disciplines had decreased (in comparison with October 2007 and April 2008). For example, Nursing decreased from 71% to 62%, Psychology from 78% to 70%, and Psychiatry from 61% to 52%. Only two disciplines, Rehabilitation Therapists and Social Work, increased from 77% to 82% and from 66% to 77% respectively.</p>

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		<p>Recommendation 2, November 2007: All Mall sessions must be 50 minutes in length. Sessions less than that duration do not contribute to an individual's active treatment hours.</p> <p>Findings: This monitor's documentation review (Mall schedules) and observation of Mall groups (Collaborative Recovery Group, Relaxation, Anti-Social-Face It and Pace It, and Mood Management) found that all Mall groups were scheduled for 50 minutes each. However, for various reasons, not all Mall groups are consistently held for 50 minutes each.</p> <p>PSH used the WaRMSS Database Report to audit the number of groups held for 50 minutes, reporting 68% compliance. The table below showing the number of groups scheduled per month (N), the number of groups conducted for 50 minutes (n), and the percentage of groups conducted for 50 minutes (%C) is a summary of the facility's data.</p> <table border="1" data-bbox="955 820 1873 1015"> <thead> <tr> <th></th> <th>11/07</th> <th>12/07</th> <th>1/08</th> <th>2/08</th> <th>3/08</th> <th>4/08</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>7,170</td> <td>4,894</td> <td>7,200</td> <td>1,861</td> <td>1,697</td> <td>1,636</td> <td></td> </tr> <tr> <td>n</td> <td>5,261</td> <td>2,416</td> <td>4,619</td> <td>1,405</td> <td>1,419</td> <td>1,402</td> <td></td> </tr> <tr> <td>%S</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td></td> </tr> <tr> <td>%C #</td> <td>74</td> <td>50</td> <td>64</td> <td>76</td> <td>84</td> <td>86</td> <td>68</td> </tr> </tbody> </table> <p>Recommendation 3, November 2007: Ensure that individuals participate in their scheduled hours.</p> <p>Findings: This monitor's review of PSH's progress report and interview of the Mall Director found that PSH has attempted to assign all individuals to 20 hours of Mall services per week. While a majority of individuals have been assigned to 20 hours per week, there is still a good number of individuals who were not assigned to the required hours of Mall services. For example 196 out of 1,537 individuals had fewer than 20 hours per week for the</p>		11/07	12/07	1/08	2/08	3/08	4/08	Mean	N	7,170	4,894	7,200	1,861	1,697	1,636		n	5,261	2,416	4,619	1,405	1,419	1,402		%S	100	100	100	100	100	100		%C #	74	50	64	76	84	86	68
	11/07	12/07	1/08	2/08	3/08	4/08	Mean																																			
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%S	100	100	100	100	100	100																																				
%C #	74	50	64	76	84	86	68																																			

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		<p>month of April 2008.</p> <p>PSH used the MAPP report to evaluate the hours of Mall groups attended by individuals. The table below showing the number of individuals in the MAPP report (N) and the hours of Mall groups attended by these individuals is a summary of the facility's data.</p> <table border="1" data-bbox="955 451 1875 678"> <thead> <tr> <th></th> <th>11/07</th> <th>12/07</th> <th>1/08</th> <th>2/08</th> <th>3/08</th> <th>4/08</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>1,466</td> <td>1,521</td> <td>1,525</td> <td>1,538</td> <td>1,519</td> <td>1,537</td> </tr> <tr> <td>0 - 5 hrs/wk</td> <td>30</td> <td>58</td> <td>51</td> <td>47</td> <td>67</td> <td>78</td> </tr> <tr> <td>6 - 10 hrs/wk</td> <td>145</td> <td>189</td> <td>183</td> <td>189</td> <td>182</td> <td>177</td> </tr> <tr> <td>11 - 15 hrs/wk</td> <td>549</td> <td>674</td> <td>643</td> <td>623</td> <td>616</td> <td>646</td> </tr> <tr> <td>16 - 20 hrs/wk</td> <td>742</td> <td>600</td> <td>647</td> <td>648</td> <td>654</td> <td>636</td> </tr> </tbody> </table> <p>As the table above shows, on average between 40% and 50% of the individuals attend between 16 to 20 hours of Mall services per week.</p> <p>Recommendation 4, November 2007: Provide groups as needed by the individuals and written in the individuals' WRPs, adding new groups as needs are identified.</p> <p>Findings: This monitor's documentation review (completed requests for new groups) found that WRPTs are using the request forms to indicate the need for new/change in groups to meet the individuals' needs. PSH has named acting coordinators and focus advisors for each treatment focus, and they are to review the existing Mall groups and identify additional groups as needed. The focus coordinators have increased groups for Focus 5 and Focus 11.</p> <p>The Mall Coordinator also has introduced "drop boxes" for individuals to indicate their group needs/preferences. The Mall Director will coordinate the individuals' identified needs/preferences with the individual's WRPTs.</p>		11/07	12/07	1/08	2/08	3/08	4/08	N	1,466	1,521	1,525	1,538	1,519	1,537	0 - 5 hrs/wk	30	58	51	47	67	78	6 - 10 hrs/wk	145	189	183	189	182	177	11 - 15 hrs/wk	549	674	643	623	616	646	16 - 20 hrs/wk	742	600	647	648	654	636
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16 - 20 hrs/wk	742	600	647	648	654	636																																						

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		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Mandate that all staff at PSH, other than those who attend to emergency medical needs of individuals, will provide services at the PSR Mall during scheduled Mall hours. This includes clinical, administrative and support staff. 2. All Mall sessions must be 50 minutes in length. Sessions less than that duration do not contribute to an individual's active treatment hours. 3. Ensure that individuals participate in their scheduled hours. 4. Provide groups as needed by the individuals and written in the individuals' WRPs, adding new groups as needs are identified.
C.2.i.ix	is provided to individuals in bed-bound status in a manner and for a period that is commensurate with their medical status;	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, November 2007:</p> <ul style="list-style-type: none"> • Ensure that bed-bound individuals are included in the planning and implementation of appropriate activities commensurate with their cognitive status and medical, health, and physical limitations. • 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. <p>Findings:</p> <p>This monitor's visits to units and interview of the Mall Director found that PSH did not have any bed-bound individuals during this review period. However, PSH has plans in place to address the needs of bed-bound individuals, which include the Mall Director meeting with the individual and his/her teams, determining the individual's needs, and adapting the lesson plans to suit his/her needs.</p> <p>Current 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

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		<p>cognitive status and medical, health, and physical limitations.</p> <p>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.</p>
C.2.i.x	routinely takes place as scheduled;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Implement a more focused Mall program that is regularly scheduled, implemented, and provided within the individual's cognitive, medical, physical and functional status.</p> <p>Findings: This monitor's interview of the Mall Director and review of documentation (progress report) found that not all groups are geared to the individual's cognitive, medical, physical and functional status. PSH has taken steps to address this recommendation. The Focus 6 advisor attended training to know more about building programs for cognitively impaired individuals. Acting coordinators and Focus advisors are reviewing the need for additional groups. The Mall Director is distributing cognitive screening information from the Integrated assessments conducted by Psychologists.</p> <p>Recommendation 2, November 2007: Ensure that Mall groups and individual therapies are cancelled rarely, if ever.</p> <p>Findings: This monitor's review of PSH's Mall cancellation data found that on average, about 24% of scheduled Mall groups were cancelled in the last six months. In April 2008, only 5% of Mall groups were cancelled.</p> <p>A variety of reasons were given for the cancellations. The reasons include</p>

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		<p>holidays, education/training, alternate activities, forensic, locked units, resource issues, and coverage/staffing. The number of groups cancelled due to coverage/staffing ranged between 93 and 764 groups per month over the last six month. The number of cancelled groups under "other" is also high (ranging between 181-525 groups per month). PSH should analyze this category further and find ways to reduce, if not eliminate, these reasons for cancellation of scheduled Mall groups.</p> <p>Recommendation 3, November 2007: Ensure that all disciplines facilitate a specified minimum number of hours of Mall groups.</p> <p>Findings: This monitor's review of PSH's data on staff Mall facilitation hours found that none of the disciplines consistently met their scheduled hours of Mall service. The participation from a few critical disciplines is low including Psychiatry (52%), Psychology (70%), and Nursing (62%). On the other hand, Rehabilitation Therapists increased from 77% to 82%, and Social Work increased from 66% to 77%. According to the Mall Director, staffing shortage in some disciplines required the existing staff to shoulder the extra work, causing additional shortages of facilitator availability for Mall groups.</p> <p>Current 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.
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<p>C.2.i.xi</p>	<p>includes, in the evenings and weekends, additional activities that enhance the individual's quality of life; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Develop a list of all enrichment activities available along with names of staff competent in facilitating the activities in accordance with generally accepted professional standards of care.</p> <p>Findings: This monitor's review of PSH's enrichment activities list found that PSH carries out a wide variety of enrichment activities (activities that are not part of the PSR services). The structure and organization of the enrichment activities are not centralized. The activities are organized and implemented at the unit level. This monitor observed that enrichment activity schedules were posted on unit walls.</p> <p>Recommendation 2, November 2007: Plan and organize these activities such that there is minimal interruption, individuals are reinforced to participate regularly in these activities, and as much as possible eliminate competing activities that act as a barrier for individuals to participate in such activities.</p> <p>Findings: This monitor noted that the activities are organized around the unit schedules. There is very little interruption within the units, except for lockdowns, holidays, and emergencies. The staff conducting these activities come from the units and therefore know the individuals well enough to encourage and reinforce them to participate in the various activities. However, except for the AA and NA groups, the groups are not tracked and/or monitored through the MaPP scheduler.</p> <p>Recommendation 3, November 2007: Increase the number of hours of enrichment activities per individual provided in the evenings and weekends.</p>
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		<p>Findings: This monitor's review of PSH's offerings of enrichment activities found that there has been a steady increase each month in the number of hours and number of groups of activities offered. For example, the number of exercise groups in May 2008 was 135 compared to 77 groups in 2007 (according to the Mall Director, the 135 groups can accommodate as many as 2,025 individuals).</p> <p>Recommendation 4, November 2007: Ensure that there is uniformity in the methodology and process of how the groups are organized and managed.</p> <p>Findings: This monitor's interview of the Mall Director and unit staff found that the enrichment activities are not conducted in a uniform manner regarding methodology, process and procedures. According to the Mall Director, Rehabilitation Therapists at PSH were provided training on leading Leisure and Recreational group activities. The Mall Director is arranging for similar training to be provided to all nursing staff, as nursing staff primarily lead the activities on weekends and evenings.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop a list of all enrichment activities available along with names of staff competent in facilitating the activities in accordance with generally accepted professional standards of care. 2. Plan and organize these activities such that there is minimal interruption, individuals are reinforced to participate regularly in these activities, and as much as possible eliminate competing activities that act as a barrier for individuals to participate in such activities. 3. Increase the number of hours of enrichment activities per individual provided in the evenings and weekends. 4. Ensure that there is uniformity in the methodology and process of how
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		the groups are organized and managed.																																
C.2.i.xii	is consistently reinforced by staff on the therapeutic milieu, including living units.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: All WRPs should have therapeutic milieu interventions clearly specified in the intervention sections.</p> <p>Findings: This monitor reviewed ten charts (BW, CCB, DCD, DJ, DJB, IC, JJ, JT, MH and RJ). Two of the WRPs in the charts (DJ and RJ) specified therapeutic milieu interventions, in addition to active treatment interventions, in the intervention sections of the individuals' WRPs. The remaining eight (BW, CCB, DCD, DJB, IC, JJ, JT and MH) did not fulfill this criteria.</p> <p>Recommendation 2, November 2007: Ensure that unit staff reinforces individuals appropriately during Mall group activities as well as in the units.</p> <p>Findings: PSH used item #12 from the Therapeutic Milieu Observation Monitor (<i>Staff is observed discussing mall activities with individuals</i>) to address this recommendation, reporting 12% compliance. The table below showing the number of audits (2 per month, one each for AM and PM shifts) scheduled (N), the number of audits completed (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.</p> <table border="1" data-bbox="955 1190 1873 1344"> <thead> <tr> <th></th> <th>11/07</th> <th>12/07</th> <th>1/08</th> <th>2/08</th> <th>3/08</th> <th>4/08</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>132</td> <td>132</td> <td>132</td> <td>132</td> <td>132</td> <td>132</td> <td></td> </tr> <tr> <td>n</td> <td>99</td> <td>176</td> <td>130</td> <td>117</td> <td>113</td> <td>139</td> <td></td> </tr> <tr> <td>%C #12</td> <td>25</td> <td>9</td> <td>9</td> <td>18</td> <td>4</td> <td>14</td> <td>12</td> </tr> </tbody> </table> <p>This monitor observed two WRPCs (JJB and LPB) and four Mall groups</p>		11/07	12/07	1/08	2/08	3/08	4/08	Mean	N	132	132	132	132	132	132		n	99	176	130	117	113	139		%C #12	25	9	9	18	4	14	12
	11/07	12/07	1/08	2/08	3/08	4/08	Mean																											
N	132	132	132	132	132	132																												
n	99	176	130	117	113	139																												
%C #12	25	9	9	18	4	14	12																											

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		<p>(Collaborative Recovery Group, Relaxation, Anti-Social-Face It and Pace it, and Mood Management). The staff in these activities frequently and appropriately reinforced individuals in their groups.</p> <p>Current 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 as in the units.
C.2.j	<p>Adequate, individualized group exercise and recreational options are provided, consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1-4, November 2007:</p> <ul style="list-style-type: none"> • Establish group exercises and recreational activities for all individuals. • Provide training to Mall facilitators to conduct the activities appropriately. • Track and review participation of individuals in scheduled group exercise and recreational activities. • Implement corrective action if participation is low. <p>Findings:</p> <p>This monitor's documentation review (exercise groups activity lists) and interview of the Mall Director found that PSH is offering group exercises and recreational activities. As of April 2008, 723 individuals were scheduled in exercise groups. Attendance by these individuals in the exercise/recreational groups for the month of April 2008 stood at 76%. PSH has also conducted staff training on exercise, leisure, and recreational groups. To date, 108 staff have received the training on Focus 6 and Focus 10.</p> <p>The table below showing the number of exercise groups offered by Mall Terms is a summary of the facility's data:</p>

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		<table border="1" data-bbox="955 228 1759 347"> <tr> <td>Winter 2007</td> <td>Spring 2007</td> <td>Summer 2007</td> <td>Fall 2007</td> <td>Winter 2008</td> <td>Spring 2008</td> </tr> <tr> <td>77</td> <td>102</td> <td>82</td> <td>109</td> <td>106</td> <td>96</td> </tr> </table> <p>According to the Mall Director, accuracy of attendance monitoring will improve when tracking is done through the MaPP system, and plans for corrective action for low participation will be made once accurate attendance data is available.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Establish group exercises 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. 	Winter 2007	Spring 2007	Summer 2007	Fall 2007	Winter 2008	Spring 2008	77	102	82	109	106	96
Winter 2007	Spring 2007	Summer 2007	Fall 2007	Winter 2008	Spring 2008									
77	102	82	109	106	96									
C.2.k	<p>Individuals who have an assessed need for family therapy services receive such services in their primary language, as feasible, consistent with generally accepted professional standards of care and that these services, and their effectiveness for addressing the indicated problem, are comprehensively documented in each individual's chart.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: The facility should develop a system for the provision of family education materials at admission and again during the process of discharge as indicated.</p> <p>Findings: This monitor's documentation review (AD #11.05) found that PSH has established a policy requiring notification of families upon admission and transfer of individuals. A handout "Recovery Is a Journey We Take Together" is to be included in the notification mailings. The handout</p>												

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		<p>discusses mental illness and how the family members can get involved in their loved one's recovery. Family participation in their loved one's recovery is also a topic in the facility's Tri-Annual Patton/CONREP Meeting.</p> <p>Recommendation 2, November 2007: Ensure that family therapy services are provided as indicated.</p> <p>Findings: This monitor's interview of the Chief of Social Work found that she has worked with WRPTs to refer families for family psycho-education groups. Once the families are identified by the WRPTs, the individual's permission is sought to contact the families. Upon consent of the individual, the families are contacted to determine their interest in the Family Education Group. The WRPT then sends the referral to the Social Work Service. The Social Work Service then contacts the families to offer the services. According to the Chief of Social Work, referrals were received for four families. PSH has also developed a Needs Assessment Questionnaire (six families have completed and returned the questionnaire). According to the Chief of Social Work, family education groups are held monthly following the NAMI-Patton meetings. The family education schedule has been advertised in the NAMI-Patton Newsletter. Documentation also showed that PSH held a Recovery Symposium titled "Choices in Recovery" in March 2008. There were two presentations at the Symposium: "Relapse Awareness and Prevention Strategies" and "In Our Voice." PSH also held a "Family Day" for Unit 24 in April 2008, during which families were given the opportunity to learn about the living environments of their loved ones.</p> <p>According to the Chief of Social Work, PSH has obtained family psycho-education teaching/training materials to conduct the groups. The materials include a curriculum for Family Psycho-education Groups, Trainers Manual and consumer guidebooks.</p> <p>A review of the documentation found the following program to be offered</p>
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		<p>monthly, beginning in April 2008:</p> <ul style="list-style-type: none"> • April: Rights and responsibilities of patients, family members, and professionals. • May: Involuntary medication. • June: Communication tips with family members. • July: Limit-setting and boundaries with family members. • August: The Conditional Release Program. <p>According to PSH's progress report, 16 family members attended the April and May 2008 Family Education sessions.</p> <p>The table below showing the Programs, the numbers of family meetings held, and the nNumber of families attending the meetings is a summary of the facility's data.</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <thead> <tr> <th>Program</th> <th>Number of family meetings</th> <th>Number of families that participated</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>23</td> <td>21</td> </tr> <tr> <td>3</td> <td>8</td> <td>4</td> </tr> <tr> <td>4</td> <td>6</td> <td>6</td> </tr> <tr> <td>5</td> <td>3</td> <td>3</td> </tr> <tr> <td>6</td> <td>20</td> <td>16</td> </tr> <tr> <td>7</td> <td>3</td> <td>3</td> </tr> <tr> <td>8</td> <td>1</td> <td>1</td> </tr> </tbody> </table> <p>The facilities may want to coordinate their program schedules and advertise to all families who have shown interest to enable them to attend topics of interest in a facility closest to their living area.</p> <p>Compliance: Substantial.</p>	Program	Number of family meetings	Number of families that participated	1	23	21	3	8	4	4	6	6	5	3	3	6	20	16	7	3	3	8	1	1
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		<p>Current recommendations: Continue to provide family services as needed.</p>																
C.2.1	<p>Each individual's therapeutic and rehabilitation service plan identifies general medical diagnoses, the treatments to be employed, the related symptoms to be monitored by nursing staff (i.e., registered nurses ["RNs"], licensed vocational nurses ["LVNs"] and psychiatric technicians) and the means and frequency by which such staff shall monitor such symptoms, consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1-3, November 2007:</p> <ul style="list-style-type: none"> • Provide training regarding the WRP process and required documentation. • Implement revised Medical Conditions Auditing tool when approved. • Continue to monitor this requirement. <p>Findings: PSH's data from the DMH Integration of Medical Conditions into WRP Audit from February-April 2008, based on a 21% mean sample of all individuals with at least one diagnosis listed on the Axis III diagnosis who had a WRP due each month, indicated the following mean compliance rate for each item listed below:</p> <table border="1" data-bbox="955 820 1852 1422"> <tr> <td><i>All medical conditions listed in Axis III are included on the Medical Conditions form.</i></td> <td>48%</td> </tr> <tr> <td><i>The WRP includes each medical condition listed on the Medical Conditions form.</i></td> <td>43%</td> </tr> <tr> <td><i>Each medical condition or diagnosis listed on the Medical Conditions form has a focus statement.</i></td> <td>46%</td> </tr> <tr> <td><i>Each medical condition or diagnosis listed on the Medical Conditions form has at least one objective.</i></td> <td>55%</td> </tr> <tr> <td><i>Each medical condition or diagnosis listed on the Medical Conditions form has at least one intervention.</i></td> <td>54%</td> </tr> <tr> <td><i>There is an appropriate focus statement for each medical condition or diagnosis.</i></td> <td>7%</td> </tr> <tr> <td><i>There is an appropriate objective for each medical condition or diagnosis.</i></td> <td>4%</td> </tr> <tr> <td><i>Each current medical condition or problem has at least one objective.</i></td> <td>42%</td> </tr> </table>	<i>All medical conditions listed in Axis III are included on the Medical Conditions form.</i>	48%	<i>The WRP includes each medical condition listed on the Medical Conditions form.</i>	43%	<i>Each medical condition or diagnosis listed on the Medical Conditions form has a focus statement.</i>	46%	<i>Each medical condition or diagnosis listed on the Medical Conditions form has at least one objective.</i>	55%	<i>Each medical condition or diagnosis listed on the Medical Conditions form has at least one intervention.</i>	54%	<i>There is an appropriate focus statement for each medical condition or diagnosis.</i>	7%	<i>There is an appropriate objective for each medical condition or diagnosis.</i>	4%	<i>Each current medical condition or problem has at least one objective.</i>	42%
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		<table border="1"> <tr> <td><i>The objective is written in observable, measurable and/or behavioral terms as to what the individual will do.</i></td> <td>5%</td> </tr> <tr> <td><i>The objective leads to improvement in the individual's quality of life.</i></td> <td>37%</td> </tr> <tr> <td><i>There are appropriate intervention(s) for each objective.</i></td> <td>1%</td> </tr> <tr> <td><i>Each objective related to current medical problem has at least one intervention.</i></td> <td>49%</td> </tr> <tr> <td><i>The intervention includes the related symptoms to be monitored by nursing staff for each condition.</i></td> <td>8%</td> </tr> <tr> <td><i>The intervention specifies the means by which the staff will monitor these symptoms for each condition.</i></td> <td>5%</td> </tr> <tr> <td><i>The intervention specifies the frequency by which staff will monitor these symptoms for each condition.</i></td> <td>5%</td> </tr> <tr> <td><i>The intervention identifies staff to perform these interventions by title.</i></td> <td>25%</td> </tr> </table> <p>According to interview with Nursing staff and PSH's progress report, Nursing staff are now being required to take Foci and Objective and Interventions and Mall Integration training beginning in May 2008 to address compliance issues relating to this requirement.</p> <p>Other findings: See F.3.c.</p> <p>Compliance: Partial.</p> <p>Current recommendations: See F.3.c.</p>	<i>The objective is written in observable, measurable and/or behavioral terms as to what the individual will do.</i>	5%	<i>The objective leads to improvement in the individual's quality of life.</i>	37%	<i>There are appropriate intervention(s) for each objective.</i>	1%	<i>Each objective related to current medical problem has at least one intervention.</i>	49%	<i>The intervention includes the related symptoms to be monitored by nursing staff for each condition.</i>	8%	<i>The intervention specifies the means by which the staff will monitor these symptoms for each condition.</i>	5%	<i>The intervention specifies the frequency by which staff will monitor these symptoms for each condition.</i>	5%	<i>The intervention identifies staff to perform these interventions by title.</i>	25%
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C.2.m	The children and adolescents it serves receive, consistent with generally accepted professional standards of care:	The requirements of Section C.2.m are not applicable because PSH does not serve children and adolescents.																

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C.2.m.i	Therapy relating to traumatic family and other traumatic experiences, as clinically indicated; and	
C.2.m.ii	reasonable, clinically appropriate opportunities to involve their families in treatment and treatment decisions.	
C.2.n	Policies and procedures are developed and implemented consistent with generally accepted professional standards of care to ensure appropriate screening for substance abuse, as clinically indicated.	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Implement the policy and procedure regarding Substance Abuse Screening.</p> <p>Findings: PSH has a draft policy and procedure, but has yet to implement this recommendation.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Implement the policy and procedure regarding Substance Abuse Screening.</p>
C.2.o	Individuals who require treatment for substance abuse are provided appropriate therapeutic and rehabilitation services consistent with generally accepted professional standards of care.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Increase and strengthen training of WRPTs and SAS providers to improve assessment by the teams of the stages of change and the development of specific and individualized corresponding objectives and interventions.</p> <p>Findings: Since the last review, nine substance abuse provider staff members have</p>

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		<p>received the substance abuse training. At this time, a total of 109 substance abuse providers have received this training. The Trans-Theoretical Model (TTM) curriculum was used in this training. WRPT members have yet to receive any training in this area. PSH plans to begin this training in July 2008.</p> <p>Recommendations 2 and 3, November 2007:</p> <ul style="list-style-type: none"> • Continue monitoring using the Substance Abuse Checklist based on a 20% sample of a defined target population. • Standardize the substance abuse auditing mechanisms across all state facilities based on the Substance Abuse Checklist. <p>Findings:</p> <p>The DMH has standardized the monitoring tool regarding this requirement. Using this tool, PSH reviewed an average sample of 13% of all individuals with a current diagnosis of substance abuse as listed in WRP, Integrated Assessment: Psychiatric Section or, if admitted before January 2008, the last monthly Psychiatric Progress Note. The following outlines the indicators and sub-indicators with corresponding mean compliance rates (February to April 2008):</p> <table border="1" data-bbox="955 966 1854 1417"> <tr> <td>1.</td> <td><i>Substance abuse is integrated into the case formulation and discussed in the present status.</i></td> <td></td> </tr> <tr> <td>1.a.</td> <td><i>Substance abuse is integrated into the case formulation in one of the first 5 P's.</i></td> <td>69%</td> </tr> <tr> <td>1.b</td> <td><i>The individual's current substance abuse status is discussed in the present status of the case formulation.</i></td> <td>17%</td> </tr> <tr> <td>1.c</td> <td><i>Substance abuse diagnosis is in the Axis I diagnosis.</i></td> <td>69%</td> </tr> <tr> <td>1.d.</td> <td><i>There is a focus of treatment for substance abuse.</i></td> <td>67%</td> </tr> <tr> <td>2.</td> <td><i>There is an appropriate Focus statement listed under Focus #5.</i></td> <td>28%</td> </tr> </table>	1.	<i>Substance abuse is integrated into the case formulation and discussed in the present status.</i>		1.a.	<i>Substance abuse is integrated into the case formulation in one of the first 5 P's.</i>	69%	1.b	<i>The individual's current substance abuse status is discussed in the present status of the case formulation.</i>	17%	1.c	<i>Substance abuse diagnosis is in the Axis I diagnosis.</i>	69%	1.d.	<i>There is a focus of treatment for substance abuse.</i>	67%	2.	<i>There is an appropriate Focus statement listed under Focus #5.</i>	28%
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		3.	<i>There is at least one objective related to the individual's stage of change.</i>	
		3.a	<i>Each objective is defined or stated in behavioral, observable and/or measurable terms.</i>	9%
		3.b	<i>The objectives are accurately staged and start with the individual's current stage of change and progresses to the maintenance stage of change.</i>	29%
		3.c	<i>The objectives are aligned with the discharge criteria.</i>	22%
		4.	<i>There are interventions that are appropriately linked to the active objective(s).</i>	
		4.a	<i>The interventions align with the objectives to assist the individual meet his/her objectives.</i>	35%
		4.b	<i>The interventions are stated in terms of what the staff will do to assist the individual to meet his or her recovery objectives.</i>	31%
		4.c	<i>The frequency, duration and specific providers are listed for each active intervention.</i>	44%
		4.d	<i>The interventions are appropriate for the stage of change.</i>	27%
		5.	<i>The active treatment for substance abuse that is specified in the WRP is aligned with the individual's mall schedule.</i>	48%
		6.	<i>The discharge criteria related to substance abuse are individualized and written in behavioral, observable and/or measurable terms.</i>	
		6.a	<i>The discharge criteria describe the improvements in the individual's behavior and symptoms that should occur as a result of the interventions provided in order to transition to the next level of care.</i>	11%
		6.b	<i>The criteria is individualized and written in behavioral, observable and/or measurable terms.</i>	5%

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		<p>PSH did not provide an analysis of the above data.</p> <p>The facility also used the WRP Clinical Chart Auditing Form to assess compliance (November 2007 to April 2008). The average sample was 12% of WRPs due each month. The facility reported a mean compliance rate of 34% with the requirement that the WRPs include at least one objective and intervention when substance abuse is diagnosed on Axis I. Compliance with this requirement has increased from 13% in October 2007 to 56% in April 2008.</p> <p>Recommendation 4, November 2007: The substance recovery program should develop and utilize clinical outcomes for individuals and process outcomes for the program.</p> <p>Findings: PSH's data did not adequately address this recommendation. The facility plans to utilize pre- and post-tests to assess substance abuse groups' learning outcomes</p> <p>Recommendation 5, November 2007: Ensure that all individuals receive substance abuse services based on their assessed needs.</p> <p>Findings: PSH did not address this recommendation.</p> <p>Other findings: This monitor reviewed the charts of six individuals diagnosed with substance use disorders (FEA, JAB, JCB, JJM, JMH and TJE). The reviewed found the following pattern:</p> <ol style="list-style-type: none">1. Substance abuse was listed as a diagnosis on the WRP in all cases except
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		<p>one (FEA).</p> <ol style="list-style-type: none"> 2. All charts included a focus statement regarding substance abuse. 3. All charts except one (JJM) included foci??, objective(s) and intervention(s) related to substance abuse. 4. The objectives and interventions were properly linked to the stages of change in only three charts (JAB, JCB and TJE). <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Provide an outline of the training provided to WRPTs and SAS providers related to this requirement during this reporting period. 2. Monitor this requirement using the DMH Substance Abuse Auditing Form based on at least a 20% sample. 3. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 4. Specify current status regarding development and implementation of clinical and process outcomes related to substance abuse services. 5. Ensure that all individuals receive substance abuse services based on their assessed needs.
C.2.p	<p>Group facilitators and therapists providing therapeutic and rehabilitation services (in groups or individual therapy) are verifiably competent regarding selection and implementation of appropriate approaches and interventions to address therapeutic and rehabilitation services objectives, are verifiably competent in monitoring individuals' responses to therapy and rehabilitation, and receive regular, competent supervision.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, November 2007:</p> <ul style="list-style-type: none"> • Monitor the competency of group facilitators and therapists in providing rehabilitation services. • Ensure that providers have education, training and experience appropriate to the scope and complexity of services provided. <p>Findings: This monitor's documentation review (PSHs progress report and training</p>

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		<p>documentation) and interview of the Mall Director found that PSH has established a dedicated Mall group trainer for nursing as well as Focus coordinators. PSH has conducted numerous facilitator/therapist training sessions over the last six months. Training has been conducted for Focus 10 (105 facilitators) and Focus 11 (63) in March 2008, for facilitators providing the focus on "Hope and Spirituality" (April 2008), and for those who facilitate Focus 6 (469 facilitators) between January and April 8, 2008. In addition, nursing staff (220 nurses) were trained in effective facilitation of Mall groups, and 193 nurses were trained on developing and implementing curricula and lesson plans for specific Mall groups (Winter and Spring terms). Medication Education training is offered on a weekly basis, and to date 87 facilitators have attended the training sessions. In addition, PSH has trained 109 Focus 5 facilitators, 32 Focus 4 facilitators, and 49 Focus 7 facilitators.</p> <p>PSH should continue to provide training to those in need. But more importantly, PSH should evaluate the competency of the group facilitators and group therapists and provide them with needed feedback and support.</p> <p>Compliance: Partial.</p> <p>Current 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 education, training and experience appropriate to the scope and complexity of services provided.
C.2.q	Group facilitators and therapists providing therapeutic and rehabilitation services in the field of substance abuse should be certified substance abuse counselors.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Ensure that all group facilitators complete the substance abuse training curriculum.</p>

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		<p>Findings: This monitor's documentation review (training documentation and PSH's progress report) found that 109 staff have completed the substance abuse training curriculum. According to the Mall Director, 51 of the 57 staff facilitating substance abuse groups this term have completed the substance abuse training. The Mall Director also reported that PSH has sufficient numbers of staff trained in substance abuse to offer additional groups for individuals with substance abuse issues.</p> <p>Recommendation 2, November 2007: Clarify and streamline staff competency criteria to ensure their alignment with the current training curriculum.</p> <p>Findings: This monitor's documentation review (substance abuse post-test and substance abuse curriculum) found that PSH has developed and implemented a post-test to evaluate individuals undergoing substance abuse curriculum training. The post-test questions are derived from the curriculum material.</p> <p>Recommendation 3, November 2007: Ensure that training includes all of the five stages of change.</p> <p>Findings: This monitor's review of the training curriculum and training data found that PSH substance abuse training includes all five stages of change.</p> <p>Recommendation 4, November 2007: Establish a review system to evaluate the quality of services provided by these trained facilitators.</p> <p>Findings: This monitor's documentation review found that PSH has developed and</p>
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		<p>implemented two sets of assessment tools to evaluate the quality of services provided in substance abuse. One assessment tool is for the pre-contemplative group facilitators and the other for facilitators of the remaining four stages of change. According to the Mall Director, PSH has completed 12 audits. The data was not available for this monitor's review.</p> <p>Recommendation 5, November 2007: Ensure that providers serving individuals at the pre-contemplation stage are trained to competency and meet substance abuse counseling competency.</p> <p>Findings: This monitor's interview of the Mall Director found that all providers serving individuals at the pre-contemplation stage have received training. This monitor reviewed fourteen of the "Pre-Contemplative Group Facilitation Review" forms, and the findings are in agreement with the facility's data.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that all group facilitators complete the substance abuse training curriculum. 2. Ensure that providers serving individuals at the pre-contemplation stage are trained to competency and meet substance abuse counseling competency.
C.2.r	Transportation and staffing issues do not preclude individuals from attending appointments.	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, November 2007:</p> <ul style="list-style-type: none"> • Establish an automated system to track cancellation of scheduled appointments. • Ensure that all appointments are completed.

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		<p>Findings: This monitor's interview of the Mall Director found that PSH has not completed the automated system to track cancellation of scheduled appointments. According to the Mall Director, the WaRMSS team is working on automating the system. At present, only the Dental Department is said to be tracking missed appointments, and cancellations for Dental appointments were found to be as high as 50%; however, only 1% of these were due to transportation issues.</p> <p>Compliance: Partial.</p> <p>Current 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.
C.2.s	<p>Adequate oversight to treatment, rehabilitation and enrichment groups is provided to ensure that individuals are assigned to groups that are appropriate to their assessed needs, that groups are provided consistently and with appropriate frequency, and that issues particularly relevant for this population, including the use of psychotropic medications and substance abuse, are appropriately addressed, consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Ensure that individuals' cognitive levels, needs, and strengths are utilized when considering group assignments.</p> <p>Findings: This monitor's documentation review (Integrated Assessments: Psychology sections, WRPs, and PSH's progress report), observation of WRPCs (JJB and LPB), observation of Mall groups (Collaborative Recovery Group, Relaxation, Anti-Social-Face It and Pace it, and Mood Management), and interview of the Mall Director found that not all groups are offered at the individuals' levels of functioning. However, PSH has started to address this recommendation. WRPs are using cognitive screening information from Integrated Assessments to assign individuals' to groups.</p>

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		<p>Recommendation 2, November 2007: Ensure that providers and facilitators are knowledgeable, competent, and motivated to translate course content to meet individuals' needs.</p> <p>Findings: PSH used item #10 from the DMH Clinical Chart Audit Form (see below) to address this recommendation, reporting 3% compliance. The table below with its monitoring indicator showing the number of WRPs due each month (N), the number of charts audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.</p> <p><i>Adequate oversight to treatment, rehabilitation and enrichment groups is provided to ensure that individuals are assigned to groups that are appropriate to their assessed needs, that groups are provided consistently and with appropriate frequency, and that issues particularly relevant for this population, including the use of psychotropic medications and substance abuse, are appropriately addressed, consistent with generally accepted professional standards of care.</i></p> <table border="1"> <thead> <tr> <th></th> <th>11/07</th> <th>12/07</th> <th>1/08</th> <th>2/08</th> <th>3/08</th> <th>4/08</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>1088</td> <td>1121</td> <td>1300</td> <td>1246</td> <td>1268</td> <td>1263</td> <td></td> </tr> <tr> <td>n</td> <td>86</td> <td>87</td> <td>134</td> <td>115</td> <td>86</td> <td>23</td> <td></td> </tr> <tr> <td>%S</td> <td>8</td> <td>8</td> <td>10</td> <td>9</td> <td>7</td> <td>2</td> <td></td> </tr> <tr> <td>%C #10</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>78</td> <td>3</td> </tr> </tbody> </table> <p>This monitor's documentation review (PSH's training documentation and Progress report), interview of the Mall Director, and observation of Mall groups (Collaborative Recovery Group, Relaxation, Anti-Social-Face It and Pace it, and Mood Management) found that PSH has conducted training sessions to its staff on Mall facilitation. The facilitators observed by this monitor showed a good command of the topics and had lesson plans with hand-outs. They actively engaged the individuals in their groups and offered frequent verbal reinforcement of the individual's efforts.</p>		11/07	12/07	1/08	2/08	3/08	4/08	Mean	N	1088	1121	1300	1246	1268	1263		n	86	87	134	115	86	23		%S	8	8	10	9	7	2		%C #10	0	0	0	0	0	78	3
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%C #10	0	0	0	0	0	78	3																																			

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		<p>However, the facilitators' ability to meet individual needs was limited by their lack of information about the individuals' needs, goals, and strengths. According to the Mall Director, the facilitators' ability to meet individual needs will improve when the Mall Monthly Progress Note system is fully automated and implemented.</p> <p>Recommendation 3, November 2007: Ensure that progress notes are written in a timely fashion and made available to the individual's WRPT.</p> <p>Findings: This monitor's documentation review (Mall Progress Notes) found that PSH's Mall progress note system is not fully automated and that the facilitators were not writing Mall progress notes regularly for review by the WRPTs. The two WRPCs observed by this monitor (JBB and LPB) did not have the monthly notes for review. PSH's data showed that on average, only 1.7 progress notes per individual per month were made available to the WRPTs.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that individuals' cognitive levels, needs, and strengths are utilized when considering group 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 WRPT.
C.2.t	Treatment, rehabilitation and enrichment services are monitored appropriately against rational, operationally-defined target variables and revised as appropriate in light of significant	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Implement and monitor PSH Mall Facilitator Monthly Progress Notes.</p>

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	<p>developments, and the individual's progress, or lack thereof;</p>	<p>Findings: This monitor's documentation review (PSH progress report, WRPs and Mall Progress Notes) and interview with the Mall Director found that PSH has implemented the requirement to write Mall progress notes. However, the system is yet to be fully automated.</p> <p>The table below is a summary of the facility's data showing the number of Mall progress notes received by the WRPTs by each month.</p> <table border="1" data-bbox="955 560 1717 714"> <thead> <tr> <th></th> <th>1/08</th> <th>2/08</th> <th>3/08</th> <th>4/08</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>30,000</td> <td>30,000</td> <td>30,000</td> <td>30,000</td> </tr> <tr> <td># Notes</td> <td>198</td> <td>9</td> <td>2,469</td> <td>2,896</td> </tr> <tr> <td>%C</td> <td>1</td> <td>0</td> <td>8</td> <td>10</td> </tr> </tbody> </table> <p>According to the Mall Director, on average 1.7 notes per individual per month are written and submitted to the WRPTs.</p> <p>Recommendation 2, November 2007: Ensure that WRPTs review PSH Mall Facilitator Monthly Progress Notes, document individual progress or lack thereof, and discuss the findings with the individual.</p> <p>Findings: PSH used item #11 from the DMH Clinical Chart Audit Form (see below) to address this recommendation, reporting 0% compliance (range of 0%-9% for the six month period). The table below with its monitoring indicator showing the number of WRPs due each month (N), the number of charts audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.</p> <p><i>Treatment, rehabilitation and enrichment services are monitored appropriately against rational, operationally-defined target variables and</i></p>		1/08	2/08	3/08	4/08	N	30,000	30,000	30,000	30,000	# Notes	198	9	2,469	2,896	%C	1	0	8	10
	1/08	2/08	3/08	4/08																		
N	30,000	30,000	30,000	30,000																		
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		<p><i>revised as appropriate in light of significant developments, and the individual's progress, or lack thereof.</i></p> <table border="1" data-bbox="955 302 1875 495"> <thead> <tr> <th></th> <th>11/07</th> <th>12/07</th> <th>1/08</th> <th>2/08</th> <th>3/08</th> <th>4/08</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>1088</td> <td>1121</td> <td>1300</td> <td>1246</td> <td>1268</td> <td>1263</td> <td></td> </tr> <tr> <td>n</td> <td>86</td> <td>87</td> <td>134</td> <td>115</td> <td>86</td> <td>23</td> <td></td> </tr> <tr> <td>%S</td> <td>8</td> <td>8</td> <td>10</td> <td>9</td> <td>7</td> <td>2</td> <td></td> </tr> <tr> <td>%C 11</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>9</td> <td>0</td> </tr> </tbody> </table> <p>This monitor reviewed the charts of six individuals (JJB, JP, MHK, NMM, NWJ and PHL). None of the WRPs in the charts contained documentation indicating that monthly progress notes were reviewed and that progress or lack thereof was discussed with the individual at his/her WRPC.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement and monitor PSH Mall Facilitator Monthly Progress Notes. 2. Ensure that WRPTs review PSH Mall Facilitator Monthly Progress Notes, document individual progress or lack thereof, and discuss the findings with the individual. 		11/07	12/07	1/08	2/08	3/08	4/08	Mean	N	1088	1121	1300	1246	1268	1263		n	86	87	134	115	86	23		%S	8	8	10	9	7	2		%C 11	0	0	0	0	0	9	0
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%C 11	0	0	0	0	0	9	0																																			
C.2.u	<p>Individuals are educated regarding the purposes of their treatment, rehabilitation and enrichment services. They will be provided a copy of their WRP when appropriate based on clinical judgment.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Increase the number of groups that offer WRP education, and provide data analysis and corrective actions to improve compliance.</p> <p>Findings: PSH presented the following data regarding the number of WRP groups offered by Mall term. In comparison to the last reporting period, the data showed some increase in the number of these groups:</p>																																								

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		# of WRP Groups Offered by Mall Term					
		Winter 2007	Spring 2007	Summer 2007	Fall 2007	Winter 2008	Spring 2008
		42	60	20	26	44	67
<p>Recommendation 2, November 2007: Provide data regarding number of individuals attending WRP education and data analysis and corrective actions to improve compliance.</p> <p>Findings: During the first two weeks after admission, individuals at PSH receive WRP education in a session of the orientation group provided in the Mall units. Subsequently, individuals receive WRP education weekly in a unit-based Mall group. The following table illustrates the facility's data regarding the number of individuals who have attended WRP education training during their first month of admission.</p>							
WRP Education							
	Nov 07	Dec 07	Jan 08	Feb 08	Mar 08	Apr 08	
# Admissions	76	102	96	104	97	98	
# Attended	49	21	66	98	91	94	
% Compliance	64	20	69	94	94	96	
<p>Recommendation 3, November 2007: Monitor implementation of the requirement to provide individuals a copy of their WRPs, when clinically appropriate.</p> <p>Findings: PSH presented data based on the DMH WRP Observation Monitoring Form. The average sample was 11% of the WRPCs due each month (March and April 2008). The mean compliance rate was 61%.</p>							

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		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Increase the number of groups that offer WRP education. 2. Provide data regarding number of individuals attending WRP education during the course of hospitalization. 3. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 																		
C.2.v	<p>Staff educates individuals about their medications, the expected results, and the potential common and/or serious side effects of medications, and staff regularly asks individuals about common and/or serious side effects they may experience.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Increase the number of groups that offer education regarding medication management.</p> <p>Findings: PSH presented the following data regarding the number of Medication Education groups offered by Mall term. The providers are psychiatrists and registered nurses. The facility has increased the number of these groups from 48 at the beginning of the fall 2007 Mall term (October 2007) to 67 in the beginning of the Spring term (April 2008).</p> <table border="1" data-bbox="957 1117 1740 1308"> <thead> <tr> <th colspan="6"># of Medication Education Groups Offered by Mall Term</th> </tr> <tr> <th>Winter 2007</th> <th>Spring 2007</th> <th>Summer 2007</th> <th>Fall 2007</th> <th>Winter 2008</th> <th>Spring 2008</th> </tr> </thead> <tbody> <tr> <td>31</td> <td>46</td> <td>34</td> <td>48</td> <td>38</td> <td>67</td> </tr> </tbody> </table> <p>Compliance: Partial.</p>	# of Medication Education Groups Offered by Mall Term						Winter 2007	Spring 2007	Summer 2007	Fall 2007	Winter 2008	Spring 2008	31	46	34	48	38	67
# of Medication Education Groups Offered by Mall Term																				
Winter 2007	Spring 2007	Summer 2007	Fall 2007	Winter 2008	Spring 2008															
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		<p>Current recommendation: Increase the number of groups that offer education regarding medication management.</p>
<p>C.2.w</p>	<p>Interdisciplinary teams review, assess, and develop positive clinical strategies to overcome individual's barriers to participation in therapeutic and rehabilitation services.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Assess barriers to individuals' participation in their WRPs and provide strategies to facilitate participation.</p> <p>Findings: PSH did not address this recommendation.</p> <p>Recommendations 2 and 3 November 2007:</p> <ul style="list-style-type: none"> • Use systematic methods of behavior change including Motivational Interviewing, Narrative Restructuring Therapy and other cognitive behavioral interventions to change the individuals' attitudes to participate in their assigned groups and individual therapies. • Provide training to the WRPTs to ensure implementation of: <ul style="list-style-type: none"> ○ Appropriate individual therapy to individuals' non-adherence to WRP; and ○ Clinical strategies to help individuals achieve readiness to engage in group activities. <p>Findings: The facility reported that the previously described mentoring program and current plan to provide training based on the MSH Engagement module are sufficient to address these recommendations. However, no specific information was provided regarding Recommendation 2.</p> <p>Recommendation 4, November 2007: Develop and implement monitoring tools to assess compliance with this item.</p>

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		<p>Findings: PSH presented data regarding the number of individuals who did not adhere to WRP or to school programs (for children and adolescents). The threshold for adherence was 20% of the interventions in seven consecutive days. During this reporting period, the number of these individuals remained relatively stable (mean was 616). However, the facility recognized that the data were limited by the fact that individuals were counted as having refused Mall groups in situations in which the groups were cancelled related to a staff issue or individuals were unable to attend due to medical or legal appointments.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Assess barriers to individuals' participation in their WRPs and provide strategies to facilitate participation.2. Use systematic methods of behavior change including Motivational Interviewing, Narrative Restructuring Therapy and other cognitive behavioral interventions to change individuals' attitudes toward participation in assigned groups and individual therapies.3. Present data regarding the number of individuals who were non-adherent to WRP and improve data reliability.
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Section D: Integrated Assessments

D. Integrated Assessments		
D	<p>Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual shall receive, promptly after admission to each State hospital, an accurate and comprehensive assessment of the conditions responsible for the individual's admission, to the degree possible given the obtainable information at the time of admission. Thereafter, each individual shall receive an accurate and comprehensive reassessment of the reasons for the individual's continued hospitalization whenever there has been a significant change in the individual's status, or a lack of expected improvement resulting from clinically indicated treatment. The individual's interdisciplinary team shall be responsible for investigating the past and present medical, nursing, psychiatric, and psychosocial factors bearing on the individual's condition, and, when necessary, for revising assessments and therapeutic and rehabilitation plans in accordance with new information that comes to light. Each State hospital shall monitor, and promptly address deficiencies in the quality and timeliness of such assessments.</p>	<p>Summary of Progress on Psychiatric Assessments and Diagnoses:</p> <ol style="list-style-type: none"> 1. PSH has made progress in correcting some of the deficiencies in the admission psychiatric assessments. 2. The DMH has finalized a new template for the admission psychiatric assessment that meets generally accepted professional standards of care. The template includes updated suicide and violence risk assessment instruments. Proper implementation of this template should significantly improve compliance with EP requirements and the quality of risk assessments upon admission to the state's forensic facilities. <p>Summary of Progress on Psychological Assessments:</p> <ol style="list-style-type: none"> 1. PSH established a system of tracking and monitoring school-aged individuals' and other individuals' in need of cognitive and academic assessments within 30-days of admission. The result showed that all required assessments were conducted within the timeline. 2. PSH took strong steps including shifting of Psychologists efforts and providing extra hours of work for staff to conduct "catch up" Integrated psychological Assessment: Psychological Section on individuals' admitted prior to the effective date (June 1, 2006). 3. PSH has refined the trigger threshold and integrated it with assessments to be conducted and services provided for individuals with maladaptive behaviors. This process has seen a strong increase in the number of behavior guidelines developed and implemented this reporting period. 4. PSH has hired a Spanish speaking Psychologist. A significant improvement is noted in the assessment of individuals' whose primary/preferred language is other than English. <p>Summary of Progress on Nursing Assessments: PSH has implemented ongoing training regarding Nursing Admission and</p>

		<p>Integrated Assessments.</p> <p>Summary of Progress on Rehabilitation Therapy Assessments:</p> <ol style="list-style-type: none"> 1. The revised IA-RTS was implemented in January 2008 and all Rehabilitation Therapy focused assessments were implemented in April 2008. 2. Audit tools for the IA-RTS and focused assessments have been implemented. An integrated D4 Monitoring tool has been developed and implemented. <p>Summary of Progress on Nutrition Assessments:</p> <ol style="list-style-type: none"> 1. Feedback and training continues to be provided to RD's individually and as a group during RD Meetings, with monthly audit reports and data sheets given for each RD to track their progress. 2. RD's performance improvement in the areas that do not meet Substantial. is monitored monthly. Corrective action is taken when indicated and reflected in RD's performance evaluation. 3. Low staffing continues to affect the timeliness of Nutrition Care assessments, particularly type D.5.i and j.ii. assessments. Currently each RD is responsible for an average caseload of 150 individuals. <p>Summary of Progress on Social History Assessments:</p> <ol style="list-style-type: none"> 1. The Social Work Assessment Monitoring Tools were finalized. 2. Improvement is observed in the quality of Social Work Integrated Assessments and Psychosocial Assessments. <p>Summary of Progress on Court Assessments:</p> <p>PSH has maintained substantial compliance with EP requirements both for 1026 and 1370 reports. Continued compliance will require ongoing vigilance in preparing thoughtful, complete and detailed reports.</p>
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Section D: Integrated Assessments

1. Psychiatric Assessments and Diagnoses		
	<p>Each State hospital shall provide all of the individuals it serves with routine and emergency psychiatric assessments and reassessments consistent with generally accepted professional standards of care; and,</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Wadsworth Murad, MD, Acting Medical Director 2. Steven Maurer, MD, Chief of Medical Staff 3. Gari-Lyn Richardson, Standards Compliance Director <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. The charts of the following 50 individuals: AAA, AR, AV, AW, BJB, CH, CLC, CW, DLW, DM, DRL, EA, FEA, GA, GC, GJ, GMC, JAB, JCB, JDD, JJP, JMH, JMP, KDM, KF, KLK, LB, LLL, MB, MLB, MMS, MO, MW, PAS, PSR, RB, RG, RS, RTH, RZ, SF, SOG, SRB, TH, THE, TJE, TLB, TNT, TR and YB 2. DMH new template for the Admission Psychiatric Assessment 3. DMH Admission Psychiatric Assessment Auditing Form 4. PSH Admission Psychiatric Assessment summary data (February to April 2008) 5. DMH Integrated Psychiatric Assessment Auditing Form 6. PSH Integrated Psychiatric Assessment Auditing summary data (February to April 2008) 7. PSH Admission Medical Assessment Auditing Form 8. Admission Medical Assessment Auditing summary data (November 2007 to April 2008) 9. DMH Monthly Physician Progress Note (PPN) Auditing Form 10. DMH Weekly PPN Auditing Form 11. PSH Physician Progress Note Auditing summary data (February to April 2008) 12. PSH template for the Psychiatrist Performance Profile 13. DMH Physician Transfer Note Auditing Form 14. PSH Physician Transfer Note Auditing summary data (February to April 2008)

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<p>D.1.a</p>	<p>Each State hospital shall use the diagnostic criteria in the most current Diagnostics and Statistical Manual of Mental Disorders ("DSM") for reaching the most accurate psychiatric diagnoses.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Finalize statewide efforts to consolidate and standardize monitoring instruments regarding psychiatric initial and integrated assessments (initial, integrated and transfer) and reassessments.</p> <p>Findings: The DMH has developed and finalized the indicators and operational instructions for the following instruments:</p> <ol style="list-style-type: none"> 1. DMH Admission Psychiatric Assessment Auditing Form 2. DMH Integrated Assessment: Psychiatry Section Auditing Form 3. DMH Physician Inter Unit Transfer Note Auditing Form 4. DMH Monthly Physician Progress Note (PPN) Auditing Form 5. DMH Weekly PPN Auditing Form <p>The indicators and instructions are appropriate to requirements of the EP. The DMH has yet to finalize a standardized tool regarding the Admission Medical Assessment.</p> <p>Recommendations 2 and 3, November 2007:</p> <ul style="list-style-type: none"> • Continue to monitor this requirement using the Initial Admission Assessment, Integrated Psychiatric Assessment and Monthly Progress Note auditing forms and ensure sample size of at least 20%. • Provide data analysis regarding areas of low compliance, with corrective actions. <p>Findings: PSH used the DMH Admission and Integrated Psychiatric Assessment and Monthly Physician Progress Note Audit Forms to assess compliance (February to April 2008). The average samples were 48%, 70% and 11%, respectively, of the assessments/reassessments due each month. The</p>
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following is an outline of the indicators and corresponding mean compliance rates:

Admission Assessment	
<i>Admission diagnosis Axis I-V are addressed</i>	87%
<i>DSM-IV diagnosis consistent with history and presentation</i>	71%

Integrated Assessment	
<i>Includes psychiatric history, including a review of present and past history; statements from the individual are included, if available.</i>	99%
<i>Includes diagnosis and medications given at previous facility</i>	58%
<i>Includes diagnostic formulation</i>	88%
<i>Includes differential diagnosis</i>	69%
<i>Includes current psychiatric diagnoses that</i>	
<i>Addresses all five axes</i>	98%
<i>Is consistent with current history and presentation</i>	97%

Monthly progress notes	
<i>The note includes the five-axis diagnosis and this is consistent with the current presentation and recent developments</i>	68%
<i>If there is a NOS diagnosis or no diagnosis on Axis I, there is documentation that justifies the diagnosis</i>	20%
<i>Deferred and rule-out diagnosis are resolved within 60 days of initiation of the diagnosis and there is a clear description of the rationale for the specific resolution</i>	14%

PSH's data showed compliance rates that were variable in comparison to the last review period regarding the Admission Assessment and the Monthly Progress Notes. The facility identified a number of barriers to compliance and presented the following plan:

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		<ol style="list-style-type: none"> 1. The first Psychiatrist Performance Profile will be available for distribution to seniors, giving seniors individual-level results and giving the Chief of Psychiatry program-level results; 2. The lowest-performing individuals will be mentored by their supervising seniors; 3. The senior in charge of the lowest-performing program will receive mentorship from the Chief of Psychiatry; 4. Departmental trends will be presented quarterly to the entire Department of Psychiatry; 5. The DMH New Admission Template will be implemented; 6. Areas in which poor compliance is due to across-the-board low scores will require training at the program and department levels; 7. Auditor training and reliability testing will be completed; and 8. The new position of Consult Liaison Psychiatrist Specialist (0.5 FTE) will facilitate the communication of information between PSH and referring institutions. <p>Recommendation 4, November 2007: Provide ongoing feedback and mentoring by senior psychiatrists to correct the deficiencies outlined by this monitor (D.1.c.i through D.1.c.iii).</p> <p>Findings: Since the last review, PSH has appointed eight Acting Senior Psychiatrists (January 2008) and each program currently has a senior psychiatrist (two Senior Psychiatrists supervise the Admission Program). The facility reported that during this reporting period, the senior psychiatrists have focused on mentoring of the WRPTs and auditing psychiatrist notes. To address the deficiencies outlined by this monitor, the senior psychiatrists provided two mandatory training sessions (March 26 and April 16, 2008); individual meetings with staff psychiatrists, including targeted feedback on audit data; and program-wide meetings with staff psychiatrists. Effective April 2008, the Acting Chief of</p>
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		<p>Professional Education has been analyzing data from different audits and providing feedback to psychiatrists and senior psychiatrists. Additionally, this person has served as the liaison between the Standards Compliance Department and Psychiatry staff.</p> <p>The facility is currently in the process of finalizing a template for the monthly PPN that incorporates feedback from users.</p> <p>Other findings: Chart reviews by this monitor showed that the facility has made progress in correcting the deficiencies in the quality of the admission psychiatric assessments that were noted in the last review. In addition, the DMH has finalized a new template for the admission psychiatric assessment that includes suicide and violence risk. This template meets current generally accepted professional standards of care and proper implementation can significantly enhance compliance with EP requirements. The facility has yet to implement this template. As mentioned earlier, the facility is currently in the process of finalizing a new template for the monthly psychiatric reassessments. At this time, there continues to be a pattern of deficiencies in the implementation of the admission and integrated assessments and reassessments (see D.1.c.ii, D.1.c.iii and D.1.f) that must be corrected to achieve substantial compliance with this requirement.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Standardize the monitoring tool regarding the Initial Medical Assessment. 2. Implement the above-mentioned corrective action plan to improve compliance. 3. Monitor this requirement using the DMH Admission Assessment,
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		<p>Integrated Psychiatric Assessment and Monthly Progress Note auditing forms based on at least 20%.</p> <p>4. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p>
D.1.b	Each State hospital shall ensure that all psychiatrists responsible for performing or reviewing psychiatric assessments:	Please see sub-cells for compliance findings.
D.1.b.i	are certified by the American Board of Psychiatry and Neurology ("ABPN") or have successfully completed at least three years of psychiatry residency training in an Accreditation Counsel for Graduate Medical Education accreditation program, and	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Ensure that all psychiatrists who function as attending physicians and are responsible for performing or reviewing psychiatric assessments are in compliance with this requirement.</p> <p>Findings: Same as findings for Recommendations 3 and 4 in D.1.a.</p> <p>Other findings: At present, the facility employs a total of 81 psychiatrists. This represents a gain of four psychiatrists since the last reporting period. The facility continues to have three psychiatrists who are out of compliance with this requirement of the EP. The status of these psychiatrists is as follows:</p> <ol style="list-style-type: none"> 1. One psychiatrist is board-certified in Family Practice; 2. One psychiatrist is board-certified in Family Practice and board-certified in Substance Abuse Treatment. He is working in the substance abuse program. 3. One psychiatrist is currently on an extended family leave and be monitored by the Chief of Psychiatry upon return.

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		<p>Compliance: Partial.</p> <p>Current recommendations: Ensure consistent compliance with this requirement.</p>
D.1.b.ii	<p>Are verifiably competent (as defined by privileging at initial appointment and thereafter by reprivileging for continued appointment) in performing psychiatric assessments consistent with each State Hospital's standard diagnostic protocols.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Implement the Physician Performance Profile and utilize data in the process of reappointment/reprivileging.</p> <p>Findings: PSH began implementation of the quality profile, but has yet to use the information gathered in the processes of reappointment and reprivileging.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Implement the Physician Performance Profile and utilize data in the process of reappointment/reprivileging.</p>
D.1.c	<p>Each State hospital shall ensure that:</p>	<p>Please see sub-cells for compliance findings.</p>
D.1.c.i	<p>Within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Medical Assessment that includes:</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Continue to monitor this requirement, and include refusals and deferrals of the examination and follow-up as well as completeness and quality of the examination.</p>

Section D: Integrated Assessments

		<p>Findings: PSH used the facility's Initial Admission Medical Assessment Monitoring Form to assess compliance. The average sample was 93% of the admissions each month (November 2007 to April 2008). The mean compliance rate was 89%. The mean compliance rates for the requirements in D.1.c.i.1 to D.1.c.i.5 are reported in each corresponding cell below. The sub-indicators are listed as necessary.</p> <p>Recommendation 2, November 2007: Identify barriers to compliance with the requirement regarding completeness, quality and follow-up of refusals of the physical examination and develop and implement corrective actions.</p> <p>Findings: The facility has yet to implement this recommendation pending finalization and use of the new DMH standardized tool.</p> <p>Other findings: This monitor reviewed the charts of 10 individuals (AAA, BJB, FEA, GMC, JAB, JCB, JDD, JMH, KF and TJE) who were admitted during this reporting period. The review found timely implementation in all cases. However, two charts included inadequate (JCB) or no (JAB) plan of care for identified medical conditions. In addition, there was no documentation of follow-up regarding refusal of the examination (TJE) or parts of the examination (AAA).</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor this requirement using the standardized DMH tool based on at least a 20% sample and ensure that monitoring addresses the quality of the assessments, including the plan of care and follow-up
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Section D: Integrated Assessments

		<p>regarding incomplete examinations.</p> <p>2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p>
D.1.c.i.1	a review of systems;	89%
D.1.c.i.2	medical history;	90%
D.1.c.i.3	physical examination;	89%
D.1.c.i.4	diagnostic impressions; and	90%
D.1.c.i.5	management of acute medical conditions	90%
D.1.c.ii	<p>within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Psychiatric Assessment that includes:</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, November 2007:</p> <ul style="list-style-type: none"> • Monitor the admission psychiatric assessment for timeliness, completeness and quality and ensure that the compliance rates account for the completeness and quality of each item. • Identify barriers to compliance and develop and implement corrective actions. <p>Findings: PSH used the DMH Admission Psychiatric Assessment Auditing Form and reviewed an average sample of 48% of the admissions each month (February to April 2008). The mean compliance rate was 76%. The rates for the requirements in D.1.c.ii.2 through D.1.c.ii.6 are listed for each corresponding cell below. The sub-indicators are listed, as necessary.</p> <p>Other findings: This monitor reviewed the charts of the above-mentioned 10 individuals.</p>

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		<p>The review found that in general, the quality of the assessments has improved compared to the last reporting period. However, the following deficiencies were noted:</p> <ol style="list-style-type: none"> 1. The admission psychiatric assessment was not completed in three charts (JMH, KF and TJE). 2. The assessment indicated that the individual's cognition was "intact." This was in conflict with the provisional diagnosis of Dementia of the Alzheimer's Type. 3. The assessment included a reference to the individual's cognition as being "intact" but the individual was reportedly mute and the subsequent integrated assessment indicated that the individual's muteness precluded an adequate cognitive examination. 4. The history of present illness did not contain basic information that was needed to inform the assessment (JCB). 5. The assessment of thought content did not include specifics regarding the nature of auditory hallucinations (AAA and JAB), grandiose and bizarre delusions (JDD) and paranoid thinking (AAA). <p>These deficiencies must be corrected to achieve substantial compliance. As mentioned earlier, the DMH has finalized a new template for the admission assessment that includes updated suicide and violence risk assessment instruments. Proper implementation of this template should enhance compliance with requirements of the EP and improve the quality of admission risk assessment across the facilities.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement the new DMH template for the admission psychiatric assessment. 2. Monitor this requirement using the standardized DMH tool based on
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		<p>at least a 20% sample.</p> <p>3. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p>																		
D.1.c.ii.1	psychiatric history, including a review of presenting symptoms;	<table border="1"> <tr> <td><i>Psychiatric history, including a review of presenting symptoms.</i></td> <td>75%</td> </tr> <tr> <td><i>Identifying data including legal status.</i></td> <td>96%</td> </tr> <tr> <td><i>Discharge diagnosis and condition</i></td> <td>83%</td> </tr> <tr> <td><i>Reason for admission and chief complaint</i></td> <td>91%</td> </tr> <tr> <td><i>History of present illness</i></td> <td>88%</td> </tr> <tr> <td><i>Psychiatric history</i></td> <td>89%</td> </tr> <tr> <td><i>Substance abuse history</i></td> <td>91%</td> </tr> <tr> <td><i>Allergies</i></td> <td>99%</td> </tr> <tr> <td><i>Current medications.</i></td> <td>97%</td> </tr> </table>	<i>Psychiatric history, including a review of presenting symptoms.</i>	75%	<i>Identifying data including legal status.</i>	96%	<i>Discharge diagnosis and condition</i>	83%	<i>Reason for admission and chief complaint</i>	91%	<i>History of present illness</i>	88%	<i>Psychiatric history</i>	89%	<i>Substance abuse history</i>	91%	<i>Allergies</i>	99%	<i>Current medications.</i>	97%
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D.1.c.ii.2	complete mental status examination;	90%																		
D.1.c.ii.3	admission diagnoses;	Same as in D.1.a (admission psychiatric assessment).																		
D.1.c.ii.4	completed AIMS;	99%																		
D.1.c.ii.5	laboratory tests ordered; and	99%																		
D.1.c.ii.6	consultations ordered.	57%																		
	Plan of care	<table border="1"> <tr> <td><i>Plan of care</i></td> <td></td> </tr> <tr> <td><i>Regular psychotropic medications with rationale</i></td> <td>85%</td> </tr> <tr> <td><i>PRN and/or Stat medications as applicable, with specific</i></td> <td>86%</td> </tr> </table>	<i>Plan of care</i>		<i>Regular psychotropic medications with rationale</i>	85%	<i>PRN and/or Stat medications as applicable, with specific</i>	86%												
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		<i>behavioral indicators</i>	
		<i>Special precautions to address risk factors as indicated</i>	94%
D.1.c.iii	<p>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>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, November 2007:</p> <ul style="list-style-type: none"> • Monitor the integrated psychiatric assessment for timeliness, completeness and quality and ensure that the compliance rates account for the completeness and quality of each item. • Identify barriers to compliance and develop and implement corrective actions. <p>Findings: PSH used the DMH Integrated Assessment: Psychiatry Section Auditing Form. The average sample was 79% of the assessments due each month (February to April 2008). The mean compliance rate for this requirement was 92%. The rates for other requirements in D.1.c.iii are listed corresponding cells below. The sub-indicators are listed, as necessary.</p> <p>Other findings: The above-mentioned chart reviews by this monitor found the following deficiencies:</p> <ol style="list-style-type: none"> 1. The assessments were missing in two charts (JMH and TJE). 2. The assessment did not include several historical sections (AAA, FEA, JAB and JCB) with no evidence that the information was subsequently documented. 3. The plan of care was inadequately aligned with the differential diagnosis (BJB). 4. The assessment of strengths was generic and focused on the individual's desire to leave the facility (in most charts). 5. The assessment of strengths included an inappropriate statement 	

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		<p>that had no relevance to strengths (JCB).</p> <ol style="list-style-type: none"> 6. The diagnostic formulation was written as a rehash of the inter-disciplinary case formulation (GMC). 7. The assessment of insight and judgment was generic (in most charts). 8. The cognitive examination was inadequate for an individual diagnosed with Cognitive Disorder, NOS (JAB). 9. There was no differential diagnosis as indicated by the history and presentation (JAB). 10. The assessment included many statements that were incomprehensible (KF). <p>These deficiencies must be corrected to achieve substantial compliance.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor this requirement using the standardized DMH tool based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 												
D.1.c.iii. 1	psychiatric history, including a review of present and past history;	<table border="1"> <tr> <td><i>Psychiatric history, including a review of present and past history</i></td> <td>50%</td> </tr> <tr> <td><i>Identifying data including legal status</i></td> <td>100%</td> </tr> <tr> <td><i>Statements from the individual are included, if available</i></td> <td>99%</td> </tr> <tr> <td><i>Chief complaint</i></td> <td>99%</td> </tr> <tr> <td><i>Diagnosis and medications given at previous facility are included</i></td> <td>58%</td> </tr> <tr> <td><i>Effectiveness of medications from previous facility is included</i></td> <td>53%</td> </tr> </table>	<i>Psychiatric history, including a review of present and past history</i>	50%	<i>Identifying data including legal status</i>	100%	<i>Statements from the individual are included, if available</i>	99%	<i>Chief complaint</i>	99%	<i>Diagnosis and medications given at previous facility are included</i>	58%	<i>Effectiveness of medications from previous facility is included</i>	53%
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D.1.c.iii. 10	management of identified risks.	85%																

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D.1.d	Each State hospital shall ensure that:	Please see sub-cells for compliance findings.																									
D.1.d.i	Clinically justifiable diagnoses are provided for each individual, and all diagnoses that cannot be clinically justified for an individual are discontinued no later than the next review;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Continue medical education programs to psychiatry staff to improve competency in the area of assessment of cognitive and other neuropsychiatric disorders and provide data regarding number and disciplines of attendees.</p> <p>Findings: During this reporting period, PSH facilitated the following live lectures:</p> <table border="1" data-bbox="989 672 1881 1414"> <thead> <tr> <th>Date</th> <th>Title</th> <th>Speaker/ affiliations</th> <th>Number of Attendees</th> <th>Disciplines</th> </tr> </thead> <tbody> <tr> <td>12/19/07</td> <td><u>Ooey Gooley</u> <u>Brain: The Neuroplastic Brain</u></td> <td>*William A. Lawrence, MD Loma Linda University</td> <td>41</td> <td>MD/ SW (2)</td> </tr> <tr> <td>1/16/08</td> <td><u>MDs' Contribution to the Mall</u></td> <td>*Melanie Byde, PhD/ PSH *April Wursten, PhD/ Loma Linda University</td> <td>41</td> <td>MD</td> </tr> <tr> <td>2/20/08</td> <td><u>2008 Psychopharmacology Review & Written Exam</u></td> <td>*Michael A. Cummings, MD/ PSH</td> <td>32</td> <td>MD</td> </tr> <tr> <td>4/2/08</td> <td><u>Schizophrenia Conference:</u> *Treatment-Resistant Bipolar Disorder *Best Practices</td> <td>*Michael J. Gitlin, MD UCLA *Mark Steven</td> <td>272</td> <td>MD (84) PhD (53) SW (38) RT(29) PharmD (6) RD (6) RN (26)</td> </tr> </tbody> </table>	Date	Title	Speaker/ affiliations	Number of Attendees	Disciplines	12/19/07	<u>Ooey Gooley</u> <u>Brain: The Neuroplastic Brain</u>	*William A. Lawrence, MD Loma Linda University	41	MD/ SW (2)	1/16/08	<u>MDs' Contribution to the Mall</u>	*Melanie Byde, PhD/ PSH *April Wursten, PhD/ Loma Linda University	41	MD	2/20/08	<u>2008 Psychopharmacology Review & Written Exam</u>	*Michael A. Cummings, MD/ PSH	32	MD	4/2/08	<u>Schizophrenia Conference:</u> *Treatment-Resistant Bipolar Disorder *Best Practices	*Michael J. Gitlin, MD UCLA *Mark Steven	272	MD (84) PhD (53) SW (38) RT(29) PharmD (6) RD (6) RN (26)
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			<p>in Promoting Community Integration</p> <p>*Brain Myelination and Treatment Implications for Severe Neuropsychiatric Disorders</p> <p>*Refractory Symptoms in Schizophrenia: Current and Investigational Approaches</p> <p>*Bringing Consumers from the Community into State Hospitals to Help Develop and Deliver Recovery-Based Programs</p> <p>*Treatment Malls in a State Hospital: Optimizing Their Therapeutic Value</p>	<p>Salzer, PhD University of Pennsylvania</p> <p>*George Bartzokis, MD UCLA</p> <p>*Donald Goff, MD Harvard Medical School</p> <p>*Margaret Swarbrick, PhD New Jersey School of Health-Related Professions</p> <p>*April Wursten, PhD PSH</p>		<p>PT (24) Other (6)</p>
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		5/21/08	The Psychiatry of Women Throughout the Lifecycle: Fertility, Pregnancy, and Peri-Menopause	*Ildiko J. Hodde, MD Psychiatrist, Private Practice	Not available	Not available																
PSH also facilitated the following videoconferences:																						
<table border="1"> <thead> <tr> <th data-bbox="989 574 1131 639">Date</th> <th data-bbox="1131 574 1572 639">Title</th> <th data-bbox="1572 574 1728 639">Number of Attendees</th> <th data-bbox="1728 574 1883 639">Disciplines</th> </tr> </thead> <tbody> <tr> <td data-bbox="989 639 1131 704">12/12/07</td> <td data-bbox="1131 639 1572 704">Cognitive Deficits in Schizophrenia: Assessment and Treatment</td> <td data-bbox="1572 639 1728 704">34</td> <td data-bbox="1728 639 1883 704">MD</td> </tr> <tr> <td data-bbox="989 704 1131 808">3/12/08</td> <td data-bbox="1131 704 1572 808">Clinical Debate: Are Some Antipsychotics More Effective Than Others?</td> <td data-bbox="1572 704 1728 808">44</td> <td data-bbox="1728 704 1883 808">MD</td> </tr> <tr> <td data-bbox="989 808 1131 911">5/14/08</td> <td data-bbox="1131 808 1572 911">Calming the Bipolar Storm: Treating Acute Mania and Mixed Episodes in Patients with Bipolar Disorder</td> <td data-bbox="1572 808 1728 911">32</td> <td data-bbox="1728 808 1883 911">MD</td> </tr> </tbody> </table>							Date	Title	Number of Attendees	Disciplines	12/12/07	Cognitive Deficits in Schizophrenia: Assessment and Treatment	34	MD	3/12/08	Clinical Debate: Are Some Antipsychotics More Effective Than Others?	44	MD	5/14/08	Calming the Bipolar Storm: Treating Acute Mania and Mixed Episodes in Patients with Bipolar Disorder	32	MD
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<p>Recommendation 2, November 2007: Same as in D.1.a.</p>																						
<p>Findings: Same as in D.1.a.</p>																						
<p>Other findings: This monitor reviewed the charts of 13 individuals who have received diagnoses listed as NOS continuously for more than two months during this reporting period. The review found general evidence of deficiencies in the documentation of efforts to finalize the diagnosis, as indicated, the individuals' status regarding cognitive impairments, as indicated and/or alignment of the diagnostic information in the current WRP with</p>																						

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		<p>the corresponding psychiatric progress notes The following table outlines the reviews:</p> <table border="1" data-bbox="991 302 1879 987"> <thead> <tr> <th>Initials</th> <th>Diagnosis</th> </tr> </thead> <tbody> <tr> <td>BJB</td> <td>Dementia NOS</td> </tr> <tr> <td>CH</td> <td>Psychotic Disorder NOS</td> </tr> <tr> <td>DRL</td> <td>Depressive Disorder NOS</td> </tr> <tr> <td>JJP</td> <td>Cognitive Disorder, NOS</td> </tr> <tr> <td>JMP</td> <td>Impulse Control Disorder NOS</td> </tr> <tr> <td>LLL</td> <td>Depressive Disorder NOS</td> </tr> <tr> <td>PAS</td> <td>Dementia NOS</td> </tr> <tr> <td>RG</td> <td>Psychotic Disorder NOS (WRP)</td> </tr> <tr> <td>RS</td> <td>Mood Disorder, NOS</td> </tr> <tr> <td>RSR</td> <td>Dementia NOS (WRP) vs. Dementia Due to General Medical Condition (corresponding psychiatric note)</td> </tr> <tr> <td>SOG</td> <td>Cognitive Disorder, NOS and Borderline Intellectual Functioning</td> </tr> <tr> <td>TLB</td> <td>Psychotic Disorder NOS (WRP) vs. Paranoid Schizophrenia (corresponding psychiatric note).</td> </tr> <tr> <td>TNT</td> <td>Impulse Control Disorder NOS and Attention Deficit Hyperactivity Disorder NOS</td> </tr> </tbody> </table> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue medical education programs to psychiatry staff to improve competency in the area of assessment of cognitive and other neuropsychiatric disorders and provide data regarding number and disciplines of attendees. 2. Same as in D.1.a. 	Initials	Diagnosis	BJB	Dementia NOS	CH	Psychotic Disorder NOS	DRL	Depressive Disorder NOS	JJP	Cognitive Disorder, NOS	JMP	Impulse Control Disorder NOS	LLL	Depressive Disorder NOS	PAS	Dementia NOS	RG	Psychotic Disorder NOS (WRP)	RS	Mood Disorder, NOS	RSR	Dementia NOS (WRP) vs. Dementia Due to General Medical Condition (corresponding psychiatric note)	SOG	Cognitive Disorder, NOS and Borderline Intellectual Functioning	TLB	Psychotic Disorder NOS (WRP) vs. Paranoid Schizophrenia (corresponding psychiatric note).	TNT	Impulse Control Disorder NOS and Attention Deficit Hyperactivity Disorder NOS
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D.1.d.ii	The documented justification of the diagnoses is in accord with the criteria contained in the most current DSM (as per DSM-IV-TR Checklist);	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Same as in D.1.d.i.</p> <p>Findings: Same as in D.1.d.i.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as in D.1.d.i.</p>
D.1.d.iii	Differential diagnoses, "deferred," or "rule-out" diagnoses, and diagnoses listed as "NOS" ("Not Otherwise Specified") are timely addressed (i.e., within 60 days), through clinically appropriate assessments, and resolved in a clinically justifiable manner; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Same as D.1.d.i.</p> <p>Findings: Same as in D.1.d.i.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as in D.1.d.i.</p>
D.1.d.iv	"no diagnosis" is clinically justified and documented.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Same as in D.1.d.i.</p>

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		<p>Findings: Same as in D.1.d.i.</p> <p>Recommendation 2, November 2007: Audit all individuals who have received "No Diagnosis" on Axis I to determine clinical justification.</p> <p>Findings: PSH reported that no individual currently has this diagnosis. During this reporting period, three individuals received this diagnosis and the diagnosis was resolved within three months of the date it was established.</p> <p>Compliance: Substantial.</p> <p>Current recommendations: Same as in D.1.d.i.</p>		
D.1.e	<p>Each State hospital shall ensure that psychiatric reassessments are conducted at a frequency that reflects the individual's clinical needs. At a minimum the reassessments are completed weekly for the first 60 days on the admissions units and monthly on other units.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Monitor this requirement based on at least a 20% sample and analyze and correct factors related to low compliance.</p> <p>Findings: PSH used the DMH Weekly Physician Progress Note (PPN) Auditing Form to assess compliance. The average sample was 13% of individuals between seven and 60 days of admission. The following outlines the indicator with sub-indicators and corresponding mean compliance rates:</p> <table border="1" data-bbox="989 1339 1881 1406"> <tr> <td data-bbox="989 1339 1780 1406"><i>Each State Hospital shall ensure that psychiatric reassessments are conducted at a frequency that reflects</i></td> <td data-bbox="1780 1339 1881 1406"></td> </tr> </table>	<i>Each State Hospital shall ensure that psychiatric reassessments are conducted at a frequency that reflects</i>	
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		<p><i>the individual's clinical needs. At a minimum the reassessments are completed weekly for the first 60 days on the admission units:</i></p>	
		<p><i>There is a note present every seven days from the date of admission, with the understanding that the Integrated Assessment: Psychiatry Section can serve as the first weekly note</i></p>	57%
		<p><i>The note must contain the subjective complaint</i></p>	58%
		<p><i>The note must contain the objective findings</i></p>	65%
		<p><i>The note must contain the assessment</i></p>	64%
		<p><i>The note must contain the plan of care</i></p>	66%
		<p>The facility also used the DMH Monthly PPN Auditing Form to assess compliance with the timeliness of these notes. The average sample was 11% of the individuals who have been hospitalized for 90 or more days. The mean compliance rate with this requirement was 84%.</p> <p>Other findings: This monitor reviewed the charts of 10 individuals (AAA, BJB, FEA, GMC, JAB, JCB, JDD, JMH, KF and TJE) to assess compliance with the requirement regarding weekly progress notes. The review found compliance in six charts (AAA, BJB, FEA, GMC, JAB and JDD) and noncompliance in four (JCB, JMH, KF and TJE).</p> <p>This monitor reviewed other charts to assess compliance with the requirements in D.1.f regarding the monthly progress notes (see other findings in D.1.f).</p> <p>Compliance: Partial.</p> <p>Current recommendations: 1. Monitor this requirement based on a review of at least a 20% sample.</p>	

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		<p>2. Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period).</p>
<p>D.1.f</p>	<p>Each State hospital shall ensure that psychiatric reassessments are documented in progress notes that address the following:</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Develop and implement a format for psychiatric reassessments that ensures correction of the deficiencies outlined in this monitor's report and in the previous report.</p> <p>Findings: As mentioned earlier, the facility is in the process of finalizing a new template for the monthly psychiatric progress notes.</p> <p>Recommendation 2, November 2007: When the individuals receive both pharmacological and behavioral interventions, the reassessments need to address the following specific items:</p> <ol style="list-style-type: none"> a. Review of behavioral plans prior to implementation as documented in progress notes and/or behavioral plan; b. Review of individual's progress in behavioral treatment; c. Differentiation, as clinically appropriate, of learned behaviors from behaviors that are targeted for pharmacological treatment; and d. Modification, as clinically appropriate, of diagnosis and/or pharmacological treatment based on above reviews/assessments. <p>Findings: The above-mentioned template addresses this recommendation.</p> <p>Recommendation 3, November 2007: Monitor this requirement based on at least a 20% sample and provide data analysis regarding low compliance with corrective actions.</p>

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		<p>Findings: The facility used the DMH Monthly PPN Auditing Form to assess compliance with the timeliness of these notes. The average sample was 11% of the individuals who have been hospitalized for 90 or more days. The mean compliance rates for the requirements in D.1.f.i to D.1.f.vii are entered in each corresponding cell below. The sub-indicators are listed as necessary.</p> <p>The facility conducted data analysis to assess its progress since the last review. Given that the data reported during the last review were based on the PSH Monthly PPN Auditing Form, the analysis focused on the audit fields that were unchanged in the DMH tool. The following table demonstrates improved compliance when the mean rates for the months of November 2007 to January 2008 were compared with the rates for the month of February to April 2008.</p> <table border="1" data-bbox="989 820 1890 1421"> <thead> <tr> <th>Audit field</th> <th>11/07 to 1/08</th> <th>2/08 to 4/08</th> </tr> </thead> <tbody> <tr> <td><i>Subjective complaints</i></td> <td>75%</td> <td>89%</td> </tr> <tr> <td><i>Identified target symptoms are documented</i></td> <td>55%</td> <td>69%</td> </tr> <tr> <td><i>Mental status examination is documented</i></td> <td>71%</td> <td>97%</td> </tr> <tr> <td><i>MMSE is completed and documented in the Progress Note</i></td> <td>14%</td> <td>56%</td> </tr> <tr> <td><i>AIMS completed in the Progress Note</i></td> <td>29%</td> <td>78%</td> </tr> <tr> <td><i>There is documentation to support regular exchange of data or information with psychologists regarding differentiation of learned behavior and behavior targeted for pharmacologic</i></td> <td>13%</td> <td>33%</td> </tr> </tbody> </table>	Audit field	11/07 to 1/08	2/08 to 4/08	<i>Subjective complaints</i>	75%	89%	<i>Identified target symptoms are documented</i>	55%	69%	<i>Mental status examination is documented</i>	71%	97%	<i>MMSE is completed and documented in the Progress Note</i>	14%	56%	<i>AIMS completed in the Progress Note</i>	29%	78%	<i>There is documentation to support regular exchange of data or information with psychologists regarding differentiation of learned behavior and behavior targeted for pharmacologic</i>	13%	33%
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		<p><i>treatment and documented evidence of integration of treatment</i></p>		
		<p><i>Current status of medical problems and treatment are documented. There is documentation of medical condition, treatment and impact on psychiatric status (management).</i></p>	<p>36%</p>	<p>36%</p>
		<p>Other findings: Chart reviews by this monitor found the following:</p> <ol style="list-style-type: none"> 1. Inconsistent formats are still being used to complete the monthly notes. 2. There was general evidence that the progress notes that were completed in a structured and consistent format (e.g. AV, AW, GC, GJ, KDM, MB, MLB, MW, RB, RG, TB, TH and THE) contained more adequate and comprehensive documentation than those notes that were not (AR, DLW, DM, JMP, KF, MO, RTH, SRB and TR). 3. In general, the monitor's findings indicated that PSH still falls short of substantial compliance with EP requirements in this section. <p>This monitor also reviewed the charts of five individuals who have experienced the use of seclusion and/or restraint during this review period (CLC, CW, KLK, MLB and RZ). The purpose of this review was to assess the documentation in the progress notes regarding the use of PRN/Stat medications prior to seclusion and/or restraint. This review is also relevant to the requirements of D.1.f.vi and F.1.b. The review found that deficiencies still exist as follows:</p> <ol style="list-style-type: none"> 1. PRN medications were prescribed for generic indications. 2. There was inadequate documentation in the progress notes of the appropriateness and efficacy of the PRN regimen and of timely 		

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		<p>adjustment of regular treatment following the repeated use of PRN medications.</p> <p>3. There was no documentation of a face-to-face assessment by the psychiatrist with 24 hours of the administration of Stat medications.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Finalize and implement a format for psychiatric reassessments that ensures correction of the deficiencies outlined in this monitor's report and in the previous report. 2. Monitor this requirement based on a review of at least a 20% sample. 3. Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period). 																
D.1.f.i	significant developments in the individual's clinical status and of appropriate psychiatric follow up;	<table border="1"> <tr> <td><i>Subjective complaints are documented</i></td> <td>90%</td> </tr> <tr> <td><i>Identified target symptoms are documented</i></td> <td>70%</td> </tr> <tr> <td><i>Participation in treatment is documented</i></td> <td>67%</td> </tr> <tr> <td><i>Progress towards objectives in the WRP</i></td> <td>56%</td> </tr> <tr> <td><i>The mental status exam is documented</i></td> <td>97%</td> </tr> <tr> <td><i>The individual's legal status and any change in legal status, if applicable</i></td> <td>70%</td> </tr> <tr> <td><i>Current status of medical problems and treatment are documented</i></td> <td>32%</td> </tr> <tr> <td><i>Relevant lab data and consults are documented</i></td> <td>48%</td> </tr> </table>	<i>Subjective complaints are documented</i>	90%	<i>Identified target symptoms are documented</i>	70%	<i>Participation in treatment is documented</i>	67%	<i>Progress towards objectives in the WRP</i>	56%	<i>The mental status exam is documented</i>	97%	<i>The individual's legal status and any change in legal status, if applicable</i>	70%	<i>Current status of medical problems and treatment are documented</i>	32%	<i>Relevant lab data and consults are documented</i>	48%
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D.1.f.ii	Timely and justifiable updates of diagnosis and treatment, as clinically appropriate;	<table border="1"> <tr> <td><i>The MMSE is completed and documented in the progress note</i></td> <td>55%</td> </tr> </table>	<i>The MMSE is completed and documented in the progress note</i>	55%														
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		<i>The current diagnosis includes resolution of NOS, deferred, and rule-out diagnoses, if applicable</i>	59%
D.1.f.iii	Analyses of risks and benefits of chosen treatment interventions;	<i>The risks for the current psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented</i>	38%
		<i>The benefits for the current psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented</i>	49%
		<i>Rationale for the current psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented</i>	45%
D.1.f.iv	Assessment of, and attention to, high-risk behaviors (e.g., assaults, self-harm, falls) including appropriate and timely monitoring of individuals and interventions to reduce risks;	<i>There is a description of the current risks specific to this individual and the precautions instituted to minimize those risk</i>	59%
		<i>The monthly note identifies specific risk behaviors including triggers during the interval period</i>	60%
		<i>If applicable, treatment is modified to minimize risk</i>	44%
D.1.f.v	Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications;	<i>Rationale for current psychopharmacology plan including analysis of risks and benefits</i>	34%
		<i>There is a description of any side effects caused by medications, including sedation and cognitive impairment</i>	54%
		<i>The AIMS was done annually for all individuals and quarterly if there is a positive AIMS or a current diagnosis or history</i>	77%

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		<i>of Tardive Dyskinesia</i>									
D.1.f.vi	Timely review of the use of "pro re nata" or "as-needed" ("PRN") and "Stat" (i.e., emergency psychoactive) medications and adjustment of regular treatment, as indicated, based on such use; and	<table border="1"> <tr> <td><i>Describes the rationale/specific indications for all PRN orders</i></td> <td>44%</td> </tr> <tr> <td><i>Reviews the PRNs and Stats during the interval period.</i></td> <td>47%</td> </tr> <tr> <td><i>Discusses use of PRN/Stat as indicated to reduce the risk of restrictive interventions.</i></td> <td>29%</td> </tr> <tr> <td><i>Describes modification of regularly scheduled medication regimen based on the use of PRN/Stat medications.</i></td> <td>21%</td> </tr> </table>	<i>Describes the rationale/specific indications for all PRN orders</i>	44%	<i>Reviews the PRNs and Stats during the interval period.</i>	47%	<i>Discusses use of PRN/Stat as indicated to reduce the risk of restrictive interventions.</i>	29%	<i>Describes modification of regularly scheduled medication regimen based on the use of PRN/Stat medications.</i>	21%	
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D.1.f.vii	Verification in a clinically justifiable manner, that psychiatric and behavioral treatments are properly integrated. The psychiatrist shall review the positive behavior support plan prior to implementation to ensure consistency 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.	<table border="1"> <tr> <td><i>There is a description in the note of the response to non-pharmacologic treatment</i></td> <td>59%</td> </tr> <tr> <td><i>There is documentation to support evidence of regular exchange of data or information with psychologists regarding differentiation of learned behaviors and behaviors targeted for psychopharmacologic treatments and document evidence of integration of treatments</i></td> <td>32%</td> </tr> <tr> <td><i>If applicable, there is documentation to support that the psychiatrist reviewed the PBS plan prior to implementation to ensure consistency with psychiatric formulation</i></td> <td>38%</td> </tr> <tr> <td><i>There is modification, as clinically appropriate, of diagnosis and/or pharmacological treatment based on above reviews/assessments</i></td> <td>40%</td> </tr> </table>	<i>There is a description in the note of the response to non-pharmacologic treatment</i>	59%	<i>There is documentation to support evidence of regular exchange of data or information with psychologists regarding differentiation of learned behaviors and behaviors targeted for psychopharmacologic treatments and document evidence of integration of treatments</i>	32%	<i>If applicable, there is documentation to support that the psychiatrist reviewed the PBS plan prior to implementation to ensure consistency with psychiatric formulation</i>	38%	<i>There is modification, as clinically appropriate, of diagnosis and/or pharmacological treatment based on above reviews/assessments</i>	40%	
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<i>There is modification, as clinically appropriate, of diagnosis and/or pharmacological treatment based on above reviews/assessments</i>	40%										
D.1.g	When individuals are transferred between treatment teams, a psychiatric transfer note shall be completed addressing: review of medical and	Current findings on previous recommendations:									

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	<p>psychiatric course of hospitalization, including medication trials; current target symptoms; psychiatric risk assessment; current barriers to discharge; and anticipated benefits of transfer.</p>	<p>Recommendation 1, November 2007: Provide ongoing feedback and mentoring by senior psychiatrists to ensure that the transfer psychiatric assessments correct the deficiencies outlined by this monitor.</p> <p>Findings: Same as findings for Recommendation 4 in D.1.a. In addition, the facility is in the process of finalizing a new template for the inter-unit transfer assessments.</p> <p>Recommendation 2, November 2007: Monitor this requirement based on a review of at least a 20% sample and provide data analysis regarding low compliance with corrective actions.</p> <p>Findings: PSH used the DMH Physician Inter-Unit Transfer Auditing Form to assess compliance. The average sample was 5% of the individuals who were transferred each month (February to April 2008). The following outlines the indicators with the sub-indicators and corresponding mean compliance rates:</p> <table border="1" data-bbox="991 967 1892 1417"> <tr> <td data-bbox="991 967 1066 1044">1.</td> <td data-bbox="1066 967 1774 1044"><i>Psychiatric course of hospitalization including medication trials:</i></td> <td data-bbox="1774 967 1892 1044"></td> </tr> <tr> <td data-bbox="991 1044 1066 1156">1.a</td> <td data-bbox="1066 1044 1774 1156"><i>There is documentation summarizing the psychiatric course of hospitalization including, if applicable, use of seclusion or restraint.</i></td> <td data-bbox="1774 1044 1892 1156">44%</td> </tr> <tr> <td data-bbox="991 1156 1066 1232">1.b</td> <td data-bbox="1066 1156 1774 1232"><i>If applicable, the individuals PRN/Stat usage is reviewed.</i></td> <td data-bbox="1774 1156 1892 1232">55%</td> </tr> <tr> <td data-bbox="991 1232 1066 1344">1.c</td> <td data-bbox="1066 1232 1774 1344"><i>If applicable, a summary of regular medication trials including response to treatment is documented.</i></td> <td data-bbox="1774 1232 1892 1344">55%</td> </tr> <tr> <td data-bbox="991 1344 1066 1417">1.d</td> <td data-bbox="1066 1344 1774 1417"><i>If applicable, behavior guidelines or PBS plans are reviewed.</i></td> <td data-bbox="1774 1344 1892 1417">0%</td> </tr> </table>	1.	<i>Psychiatric course of hospitalization including medication trials:</i>		1.a	<i>There is documentation summarizing the psychiatric course of hospitalization including, if applicable, use of seclusion or restraint.</i>	44%	1.b	<i>If applicable, the individuals PRN/Stat usage is reviewed.</i>	55%	1.c	<i>If applicable, a summary of regular medication trials including response to treatment is documented.</i>	55%	1.d	<i>If applicable, behavior guidelines or PBS plans are reviewed.</i>	0%
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1.d	<i>If applicable, behavior guidelines or PBS plans are reviewed.</i>	0%															

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	1.e	<i>The current psychopharmacology plan is documented.</i>	69%
	2.	<i>Medical course of hospitalization:</i>	
	2.a	<i>There is documentation summarizing the medical course of hospitalization</i>	67%
	2.b	<i>The current medical conditions and history are discussed</i>	71%
	2.c	<i>If applicable, include the treatment/work-up provided at any acute medical facility and the follow-up required at the DMH hospital.</i>	38%
	3.	<i>Current target symptoms</i>	47%
	4.	<i>Psychiatric risk assessment:</i>	
	4.a	<i>If applicable, summary of triggers is documented.</i>	42%
	4.b	<i>Current psychiatric risks are documented, including suicide, self-injurious behavior, risk factors for seclusion (medical and emotional) risk factors for restraint (medical and emotional), aggression, fire setting, elopement and victimization (as applicable).</i>	20%
	5.	<i>Current barriers to discharge:</i>	20%
	6.	<i>Anticipated benefits of transfer:</i>	
	6.a	<i>The reason for transfer is documented.</i>	80%
	6.b	<i>The anticipated benefits of transfer are documented.</i>	13%
	<p>Recommendation 3, November 2007: Develop a tracking system to facilitate monitoring of inter-unit transfers of individuals who present severe management problems to ensure adequate design and implementation of behavioral guidelines/PBS plans prior to transfer.</p> <p>Findings: PSH reported that high-risk individuals are being currently tracked as they move throughout the hospital in an inter-disciplinary meeting</p>		

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		<p>attended by two Senior Psychiatrists. During the next reporting period, the facility plans to implement a process of merging the names of all inter-unit transfers and cross-referencing these names with the individuals who present severe management problems on the units.</p> <p>Other findings: This monitor reviewed the charts of seven individuals (AAA, EA, GA, JMH, LB, MMS and SF) who were transferred between units during this review period. The following table outlines this review:</p> <table border="1" data-bbox="991 561 1476 868"> <thead> <tr> <th>Initials</th> <th>Date of transfer</th> </tr> </thead> <tbody> <tr> <td>AAA</td> <td>02/05/08</td> </tr> <tr> <td>EA</td> <td>02/29/08</td> </tr> <tr> <td>GA</td> <td>02/19/08</td> </tr> <tr> <td>JMH</td> <td>05/16/08</td> </tr> <tr> <td>LB</td> <td>02/07/08</td> </tr> <tr> <td>MMS</td> <td>04/04/08</td> </tr> <tr> <td>SF</td> <td>12/15/07</td> </tr> </tbody> </table> <p>The review found a pattern of inconsistent and generally inadequate review of course of hospitalization (psychiatric and medical), psychiatric risk assessment, anticipated benefits of transfer and discharge barriers.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement a tracking system to facilitate monitoring of inter-unit transfers of individuals who present severe management problems to ensure adequate design and implementation of behavioral guidelines/PBS plans prior to transfer. 2. Monitor this requirement based on a review of at least a 20% sample. 3. Provide data analysis that evaluates low compliance and delineates 	Initials	Date of transfer	AAA	02/05/08	EA	02/29/08	GA	02/19/08	JMH	05/16/08	LB	02/07/08	MMS	04/04/08	SF	12/15/07
Initials	Date of transfer																	
AAA	02/05/08																	
EA	02/29/08																	
GA	02/19/08																	
JMH	05/16/08																	
LB	02/07/08																	
MMS	04/04/08																	
SF	12/15/07																	

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		areas of relative improvement (during the reporting period and compared to the last period).
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2. Psychological Assessments		
		<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Two individuals : AM and JJB 2. Allison Pate, PhD, Senior Supervising Psychologist 3. Carlos Luna, Executive Director, Patton State Hospital 4. David Haimson, PhD, Chief of Psychology 5. Dominique Kinney, PhD, Psychologist 6. Don Brown, RN, PBS 7. Emmanuel Neizer, (title) 8. Fred Wolfson, Program Director, Enhancement Services 9. Gari-Lyn Richardson, Director, Standards and Compliance 10. Georgiana Vinson, RN., Standards Compliance Auditor 11. Gregory Hargrave, Senior PT 12. Helga Thordarson, PhD, Senior Supervising Psychologist 13. Jacquelyn Williams, PH.D., Psychologist 14. Jana Larmer, PhD, Psychologist, WRP Master Trainer 15. Jeff Chambliss, PT., PBS 16. Jeffrey Weinstisn, PhD, Psychologist 17. Jonas Lunas, RN 18. Julia Fleming, RT, WRP Master Trainer 19. Kira Mellups, PhD, Psychologist 20. LIGHT-Allende Kimberly, PsyD, Psychologist 21. Maria Castillo, RN, PBS 22. Melanie Bye, PhD, Mall Director 23. Sean Evans, PhD, Psychologist, PBS Chair 24. Steven Berman, PhD, Psychologist, BY CHOICE Coordinator <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Charts of the following 66 individuals: AAA, BR, CDS, CG, CN, CS, CT, DJ, DLK, DLP, EC, EJH, EL, FGG, GD, GDL, GN, HPV, JAB, JAM, JC, JCE, JDM, JJ, JJB, JL, JLA, JLB, JT, JTJ, KAM, KDM, KMR, LG,

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		<p>MAA, MAR, MAS, MDH, MM, MMS, MR, MV, MW, NRL, NSC, OWO, RC, RF, RG, RGB, RLW, RR, RS, RW, SAW, SB, SBP, SD, SLH, SO, SQS, TL, TLE, TNS, TT, WI, and YTP</p> <ol style="list-style-type: none"> 2. List of school-age individuals needing cognitive and academic assessments within 30 days of admission 3. List of all psychologists undertaking psychological evaluations 4. List of individuals with diagnostic uncertainties 5. List of all individuals whose primary/preferred language is other than English 6. List of completed consultations for educational/psychological testing 7. Psychological assessments 8. Neuropsychological assessments 9. DSM-IV-TR checklists 10. List of individuals in need of PBS plans 11. Structural assessments 12. Functional assessments 13. Behavioral guidelines 14. Positive behavior support plans 15. Quantitative outcome data on PBS plans 16. Training data on staff responsible for implementing intervention plans 17. Fidelity data on implementation of PBS plans 18. List of individuals with cognitive disorders <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPC for JJB (Program IV, unit 70) 2. WRPC for LBP (Program VI, Unit EB12) 3. Collaborative Recovery Mall Group 4. Relaxation Mall Group 5. Anti-Social—Face It and Pace It Mall Group 6. Mood Management Mall Group 7. Psychology Specialized Services Team Meeting
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<p>D.2.a</p>	<p>Each State hospital shall develop and implement standard psychological assessment protocols, consistent with generally accepted professional standards of care. These protocols shall address, at a minimum, diagnostic neuropsychological assessments, cognitive assessments, and I.Q./achievement assessments, to guide psychoeducational (e.g., instruction regarding the illness or disorder, and the purpose or objectives of treatments for the same, including medications), educational, rehabilitation, and habilitation interventions, and behavioral assessments (including functional assessment of behavior in schools and other settings), and personality assessments, to inform positive behavior support plans and psychiatric diagnoses.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Ensure that revised documents or manuals, where applicable, are aligned across DMH hospitals.</p> <p>Findings: This monitor's documentation review (DMH Psychology Manual, BY CHOICE Manual and PBS manual) and interview of the senior psychology staff at PSH found that the DMH Psychology Manual has been revised to align across DMH hospitals. According to the Chief of Psychology, David Haimson, and the Senior Supervising Psychologist, Helga Thordarson, revision of the BY CHOICE and PBS Manuals has not yet been completed.</p> <p>Recommendation 2, November 2007: Ensure that there are sufficient numbers of psychologists to fulfill all requirements of the EP.</p> <p>Findings: This monitor's interview of the Chief of Psychology found that PSH has 99 allocated psychologist positions, of which 70 are filled (five of the 70 staff function in non-clinical positions), resulting in an overall vacancy rate of 29%. The intermediate and long-term care units have 50% vacancy rates. According to the Chief of Psychology, 26 long-term units have only one psychologist (resulting in a staffing ratio of 1:50), and two units did not have any psychologists.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that revised documents or manuals, where applicable, are aligned across DMH hospitals.
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		2. Ensure that there are sufficient numbers of psychologists to fulfill all requirements of the EP.
D.2.b	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>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Continue current practice.</p> <p>Findings: This monitor's review of documentation (assessment data, progress report, and chart reviews) found that PSH has conducted timely assessments of all individuals under 22 years of age who qualified for the assessments.</p> <p>This monitor reviewed 11 charts of individuals below 22 years of age admitted to PSH in the last six months (CT, EC, EJH, JAM, JDM, JT, MAA, MMS, MV, MW and SD). In all cases, PSH had reviewed the individual's educational information, determined eligibility for testing and completed testing, where needed, within the 30 day requirement.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
D.2.c	Each State hospital shall ensure that all clinicians responsible for performing or reviewing psychological assessments and evaluations are verifiably competent in the methodology required to conduct the assessment.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Fill all vacant psychology positions.</p> <p>Findings: PSH is still short of the required number of psychologists. The</p>

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		<p>Psychology Department had a 29% vacancy rate at the time of this review.</p> <p>Recommendation 2, November 2007: Ensure that senior psychologists have the necessary time to properly mentor and supervise psychology staff.</p> <p>Findings: This monitor's interview of the Chief of Psychology and the Senior Psychologists found that the Senior Psychologists did not have the time to provide the necessary supervision, consultation and support to the psychology staff.</p> <p>The Psychology Department has used its monthly newsletter ("Bugle") to share assessment, services, and EP information with the psychology staff.</p> <p>Recommendation 3, November 2007: Ensure that staff is trained on the Psychology Focused Assessment and fully implemented when the instrument receives DMH approval.</p> <p>Findings: This monitor's interview of the Chief of Psychology and documentation review found that staff education and training for the Psychology Focused Assessment (PFA) is integrated into the New Hire Orientation program. This year, PSH has developed and implemented a brief PFA checklist as a means to address PFA quality. In addition, Senior Psychologists continually review and provide corrective feedback to examiners on the PFAs completed. According to the Chief of Psychology, PSH's audit of the PFAs completed in the last six months showed that 120 of 121 (99%) had used the correct template and followed the correct format.</p> <p>According to the Chief of Psychology, DMH approved the PFA template.</p>
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		<p>However, the system experienced an electronic formatting problem. In the interim, PSH has implemented an interim PFA format mirroring the newly approved DMH PFA template until the electronic version can be implemented.</p> <p>Recommendation 4, November 2007: Conduct regular review of assessments to check for compliance and provide corrective feedback as necessary.</p> <p>Findings: This monitor's interview of the Chief of Psychology and the Senior Psychologists found that the Psychology Department monitors all PFAs and IPAs (Integrated Assessment: Psychology section) for compliance with the EP. Systematic feedback is given for the PFAs; however, the feedback for the IPAs is not always timely due to shortage of staffing and because the two seniors assigned to the task were involved in the WRP Mentoring Project and EP-related tasks.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Fill all vacant psychology positions. 2. Ensure that senior psychologists have the necessary time to properly mentor and supervise psychology staff. 3. Ensure that staff is trained on the Psychology Focused Assessment and fully implemented when the instrument receives DMH approval.
D.2.d	Each State hospital shall ensure that all psychological assessments, consistent with generally accepted professional standards of care, shall:	<p>Compliance: Substantial.</p>

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D.2.d.i	expressly state the clinical question(s) for the assessment;	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Ensure that there is continuity among the various sections that connect referral questions to conclusions to appropriate recommendations and therapies available within PSH.</p> <p>Findings: This monitor reviewed six Psychological Focused Assessments (JJ, LG, RC, RW, SB and TL). There was continuity among the various sections of all six Psychological Focused Assessment reports.</p> <p>Current recommendation: Continue current practice.</p>
D.2.d.ii	include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations;	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Continue with the current practice of including findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations.</p> <p>Findings: PSH audited all Psychological and Neuropsychological Focused Assessments completed in the last six months (121 assessments) using item #4 (<i>All psychological assessments, consistent with generally accepted professional standards of care, shall include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations.</i>) from the DMH Psychology Monitoring Form to address this recommendation, reporting a mean compliance rate of 100%. .</p> <p>This monitor reviewed six Psychological Focused Assessments (JJ, LG,</p>

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		<p>RC, RW, SB and TL). All six assessments, in addition to addressing the clinical question, included information to inform the psychiatric diagnosis, identified the individual's treatment needs, and suggested interventions for consideration by the individuals' WRPT.</p> <p>Current recommendation: Continue with the current practice of including findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations.</p>
D.2.d.iii	Specify whether the individual would benefit from individual therapy or group therapy in addition to attendance at mall groups;	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Ensure that all psychological assessments include findings and recommendations pertaining to the individual's participation in therapeutic services.</p> <p>Findings: PSH audited all Psychological and Neuropsychological Focused Assessments completed in the last six months (121 assessments) using item #5 (<i>All psychological assessments, consistent with generally accepted standards of care, shall specify whether the individual would benefit from individual or group therapy in addition to attendance at mall groups</i>) from the DMH Psychology Monitoring Form to address this recommendation, reporting a mean compliance rate of 96%.</p> <p>This monitor reviewed six Psychological Focused Assessments (JJ, LG, RC, RW, SB and TL). All six assessment reports included findings and recommendations pertaining to the individual's participation in therapeutic services.</p> <p>Current recommendation: Ensure that all psychological assessments include findings and</p>

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		recommendations pertaining to the individual's participation in therapeutic services.
D.2.d.iv	be based on current, accurate, and complete data;	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Continue and improve on current practice.</p> <p>Findings: PSH audited all Psychological and Neuropsychological Focused Assessments completed in the last six months (121 assessments) using item #6 (<i>All psychological assessments, consistent with generally accepted professional standards of care, shall be based on current, accurate, and complete data</i>) from the DMH Psychology Monitoring Form to address this recommendation, reporting a mean compliance rate of 94%.</p> <p>This monitor reviewed six Psychology Focused Assessments (JJ, LG, RC, RW, SB and TL). Five of the six assessments (JJ, RC, RW, SB and TL) met the criteria for this recommendation. Observational data was not included in LG's assessment.</p> <p>Current recommendation: Continue and improve on current practice.</p>
D.2.d.v	determine whether behavioral supports or interventions (e.g., behavior guidelines or mini behavior plans) are warranted or whether a full positive behavior support plan is required;	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Ensure that all psychological assessments of individuals with maladaptive behavior meet this requirement.</p> <p>Findings: PSH audited all Psychological and Neuropsychological Focused</p>

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		<p>Assessments completed in the last six months (121 assessments) using item #7 (<i>All psychological assessments, consistent with generally accepted professional standards of care, shall determine whether behavioral supports or interventions (e.g., behavior guidelines or mini behavior plans) are warranted or whether a full positive behavior support plan is required</i>) from the DMH Psychology Monitoring Form to address this recommendation, reporting a mean compliance rate of 96%.</p> <p>This monitor reviewed six Psychology Focused Assessments (JJ, LG, RC, RW, SB and TL). All six reports addressed whether behavioral supports or interventions were warranted or a full positive behavior support plan was required. None of the individuals assessed had any serious maladaptive behaviors and the examiners appropriately indicated that the individual had no need for such services at the time of the assessments.</p> <p>Current recommendation: Ensure that all psychological assessments of individuals with maladaptive behavior meet this requirement.</p>
D.2.d.vi	include the implications of the findings for interventions;	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Continue current practice.</p> <p>Findings: PSH audited all Psychological and Neuropsychological Focused Assessments completed in the last six months (121 assessments) using item #8 (<i>All psychological assessments, consistent with generally accepted professional standards of care, shall include the implications of the findings for interventions</i>) from the DMH Psychology Monitoring Form to address this recommendation, reporting a mean compliance rate of 98%.</p>

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		<p>This monitor reviewed six Psychology Focused Assessments (JJ, LG, RC, RW, SB and TL). All six reports included the implications of the findings from the assessments for the individual's interventions.</p> <p>Current recommendation: Continue current practice.</p>
D.2.d.vii	<p>identify any unresolved issues encompassed by the assessment and, where appropriate, specify further observations, records review, interviews, or re-evaluations that should be performed or considered to resolve such issues; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1-3, November 2007:</p> <ul style="list-style-type: none"> • Ensure that all psychological assessments meet this requirement. • Ensure that WRPTs review and include appropriate recommendations in the individual's WRP. • Ensure that additional workups are completed as requested. <p>Findings: PSH audited all Psychological and Neuropsychological Focused Assessments completed in the last six months (121 assessments) using item #9 (<i>All psychological assessments, consistent with generally accepted professional standards of care, shall identify any unresolved issues encompassed by the assessment and, where appropriate, specify further observations, record review, interviews, or re-evaluations that should be performed or considered to resolve such</i>) from the DMH Psychology Monitoring Form to address this recommendation, reporting a mean compliance rate of 97%.</p> <p>This monitor reviewed six Psychology Focused Assessments (JJ, LG, RC, RW, SB and TL). All six reports addressed unresolved issues. All but one (LG) indicated a need for further follow-up neuropsychological and medical evaluation and the examiner correctly indicated such in the report. The recommendations were not fully incorporated into LG's WRP. The recommended follow-up evaluation was not found in the chart. However, the timeline to complete the assessment has not expired.</p>

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		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that all psychological assessments meet this requirement. 2. Ensure that WRPTs review and include appropriate recommendations in the individual's WRP. 3. Ensure that additional workups are completed as requested.
<p>D.2.d.vii i</p>	<p>Use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Ensure that the American Psychological Association Ethical Standards and Guidelines for Testing are followed.</p> <p>Findings: PSH audited all Psychological and Neuropsychological Focused Assessments completed in the last six months (121 assessments) using item #10 (<i>All psychological assessments, consistent with generally accepted professional standards of care, shall use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing</i>) from the DMH Psychology Monitoring Form to address this recommendation, reporting a mean compliance rate of 98%.</p> <p>This monitor reviewed six Psychology Focused Assessments (JJ, LG, RC, RW, SB and TL). All six reports made use of assessment tools that were appropriate to address the referral questions and for the individuals assessed. When the assessment tool was not part of the approved list of instruments from the facility's clinical indicator, the examiner provided the rationale for using the assessment tool (for example, TL and RC).</p> <p>Current recommendations: Ensure that the American Psychological Association Ethical Standards and Guidelines for Testing are followed.</p>

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<p>D.2.e</p>	<p>Each State hospital shall ensure that all psychological assessments of all individuals residing at each State hospital who were admitted there before the Effective Date hereof shall be reviewed by qualified clinicians with demonstrated current competency in psychological testing and, as indicated, revised to meet the criteria in § [IV.B.1 and IV.B.2], above.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1-3, November 2007:</p> <ul style="list-style-type: none"> • Ensure that psychological tests are completed in a timely manner, as specified in the EP. • Ensure that reports meet acceptable quality. • 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. <p>Findings:</p> <p>PSH used item #11 from the DMH Psychology Monitoring Form (<i>All psychological assessments of all individuals who were admitted before June 1, 2006, shall be reviewed by qualified clinicians with demonstrated current competency in psychological testing and, as indicated, revised to meet the criteria in § [IV.B.1 and IV.B.2], above</i>) to address this recommendation. The table below showing the number of individuals needing review of their IPAs as of November 2007 (N), and the number of IPAs reviewed each month (n) is a summary of the facility's data.</p> <table border="1" data-bbox="991 932 1906 1084"> <thead> <tr> <th></th> <th>Pre-11/07</th> <th>11/07</th> <th>12/07</th> <th>1/08</th> <th>2/08</th> <th>3/08</th> <th>4/08</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>783</td> <td>715</td> <td>693</td> <td>680</td> <td>613</td> <td>562</td> <td>516</td> </tr> <tr> <td>n</td> <td>68</td> <td>22</td> <td>13</td> <td>67</td> <td>51</td> <td>46</td> <td>74</td> </tr> </tbody> </table> <p>According to the Executive Director, Carlos Luna, he took a number of initiatives to address this recommendation, including asking non-admission unit psychologists to use part of their (four hours per week) Mall facilitating hours to conduct IPAs, and contracted five staff psychologists to provide additional 10-hour shifts per week to complete IPAs for pre-effective date individuals.</p> <p>According to the Chief of Psychology, as of June 3, 2008 PSH had</p>		Pre-11/07	11/07	12/07	1/08	2/08	3/08	4/08	N	783	715	693	680	613	562	516	n	68	22	13	67	51	46	74
	Pre-11/07	11/07	12/07	1/08	2/08	3/08	4/08																			
N	783	715	693	680	613	562	516																			
n	68	22	13	67	51	46	74																			

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		<p>completed 401 of the 783 (51%) required IPAs, with 382 remaining to be completed. PSH found that ninety-eight percent of the completed assessments were accurate and comprehensive.</p> <p>This monitor reviewed 17 charts of individuals admitted to PSH before the effective date (CG, CS, DLP, GD, GDL, JL, JLB, KDM, MAR, MR, NRL, OWO, RGB, SBP, SO, SQS and WI). Seven of them (CG, JLB, MAR, NRL, RGB, SBP and SQS) have had their IPAs reviewed and appropriate action has been taken. The remaining 10 (CS, DLP, GD, GDL, JL, KDM, MR, OWO, SO and WI) has yet to be reviewed. The completed IPAs were accurate and complete.</p> <p>Compliance: Partial.</p> <p>Current 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.
D.2.f	<p>Each State hospital shall ensure that all appropriate psychological assessments shall be provided in a timely manner whenever clinically indicated, consistent with generally accepted professional standards of care, including whenever there has been a significant change in condition, a lack of expected improvement resulting from treatment, or an individual's behavior poses a significant barrier to treatment, therapeutic programming, safety to self or others, or school</p>	<p>Compliance: Partial.</p>

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	programming, and, in particular:																																									
D.2.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>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Ensure that integrated psychological assessments are conducted in a timely manner as required.</p> <p>Findings: PSH used item #12 from the DMH Psychology Monitoring Form (<i>Before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be performed</i>) to address this recommendation, reporting 47% compliance. The table below showing the number of Integrated Assessments due for the month (N), the number of charts reviewed (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.</p> <table border="1" data-bbox="991 821 1906 1015"> <thead> <tr> <th></th> <th>11/07</th> <th>12/07</th> <th>1/08</th> <th>2/08</th> <th>3/08</th> <th>4/08</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>74</td> <td>98</td> <td>99</td> <td>99</td> <td>110</td> <td>91</td> <td></td> </tr> <tr> <td>n</td> <td>73</td> <td>90</td> <td>94</td> <td>94</td> <td>106</td> <td>88</td> <td></td> </tr> <tr> <td>%S</td> <td>99</td> <td>92</td> <td>95</td> <td>95</td> <td>96</td> <td>97</td> <td></td> </tr> <tr> <td>%C #12</td> <td>52</td> <td>47</td> <td>48</td> <td>47</td> <td>46</td> <td>44</td> <td>47</td> </tr> </tbody> </table> <p>According to the Chief of Psychology, follow-up audits showed that 75% of all admission IPAs were completed, though only 47% of them were completed in a timely manner as shown in the table above.</p> <p>This monitor reviewed 11 charts (AAA, DJ, GN, JC, JJB, JTJ, KAM, KMR, NSC, RG and TLE). Eight of the IPAs in the charts (AAA, DJ, GN, JC, JTJ, KAM, KMR and TLE) were timely. The remaining three (JJB, NSC and RG) were untimely.</p>		11/07	12/07	1/08	2/08	3/08	4/08	Mean	N	74	98	99	99	110	91		n	73	90	94	94	106	88		%S	99	92	95	95	96	97		%C #12	52	47	48	47	46	44	47
	11/07	12/07	1/08	2/08	3/08	4/08	Mean																																			
N	74	98	99	99	110	91																																				
n	73	90	94	94	106	88																																				
%S	99	92	95	95	96	97																																				
%C #12	52	47	48	47	46	44	47																																			

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		<p>Current recommendation: Ensure that integrated psychological assessments are conducted in a timely manner as required.</p>																																								
D.2.f.i.1	<p>address the nature of the individual's impairments to inform the psychiatric diagnosis; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Ensure that integrated psychological assessments address the nature of the individual's impairments that inform the psychiatric diagnosis.</p> <p>Findings:</p> <p>PSH used item #13 from the DMH Psychology Monitoring Form (. . . <i>address the nature of the individual's impairments to inform the psychiatric diagnosis</i>) to address this recommendation, reporting 89% compliance. The table below showing the number of Integrated Assessments due for the month (N), the number of assessments completed (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.</p> <table border="1" data-bbox="991 927 1906 1118"> <thead> <tr> <th></th> <th>11/07</th> <th>12/07</th> <th>1/08</th> <th>2/08</th> <th>3/08</th> <th>4/08</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>74</td> <td>98</td> <td>99</td> <td>99</td> <td>110</td> <td>91</td> <td></td> </tr> <tr> <td>n</td> <td>67</td> <td>59</td> <td>69</td> <td>73</td> <td>78</td> <td>65</td> <td></td> </tr> <tr> <td>%S</td> <td>91</td> <td>60</td> <td>70</td> <td>74</td> <td>71</td> <td>71</td> <td></td> </tr> <tr> <td>%C #13</td> <td>76</td> <td>80</td> <td>90</td> <td>93</td> <td>95</td> <td>97</td> <td>89</td> </tr> </tbody> </table> <p>This monitor reviewed ten charts (AAA, DJ, GN, JC, JJB, JTT, KAM, KMR, NSC and TLE). Six of the Integrated Assessments in the charts (AAA, GN, JTT, KAM, KMR and TLE) provided information to inform the psychiatric diagnosis, including the nature and extent of signs and symptoms and their excesses and deficits. Four of them (DJ, JC, JJB, NSC) did not meet the criteria.</p>		11/07	12/07	1/08	2/08	3/08	4/08	Mean	N	74	98	99	99	110	91		n	67	59	69	73	78	65		%S	91	60	70	74	71	71		%C #13	76	80	90	93	95	97	89
	11/07	12/07	1/08	2/08	3/08	4/08	Mean																																			
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%S	91	60	70	74	71	71																																				
%C #13	76	80	90	93	95	97	89																																			

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		<p>Current recommendation: Ensure that integrated psychological assessments address the nature of the individual's impairments that inform the psychiatric diagnosis.</p>																																								
D.2.f.i.2	<p>provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Ensure accurate and complete evaluation of an individual's psychological functioning that informs the WRPTs of the individual's rehabilitation service needs.</p> <p>Findings: PSH used item #14 from the DMH Psychology Monitoring Form (. . . <i>provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process</i>) to address this recommendation, reporting 93% compliance. The table below showing the number of Integrated Assessments due for the month (N), the number of assessments completed (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.</p> <table border="1" data-bbox="991 932 1906 1123"> <thead> <tr> <th></th> <th>11/07</th> <th>12/07</th> <th>1/08</th> <th>2/08</th> <th>3/08</th> <th>4/08</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>74</td> <td>98</td> <td>99</td> <td>99</td> <td>110</td> <td>91</td> <td></td> </tr> <tr> <td>n</td> <td>67</td> <td>59</td> <td>69</td> <td>73</td> <td>78</td> <td>65</td> <td></td> </tr> <tr> <td>%S</td> <td>91</td> <td>60</td> <td>70</td> <td>74</td> <td>71</td> <td>71</td> <td></td> </tr> <tr> <td>%C #14</td> <td>87</td> <td>88</td> <td>91</td> <td>93</td> <td>99</td> <td>97</td> <td>93</td> </tr> </tbody> </table> <p>This monitor reviewed nine charts (AAA, DJ, GN, JC, JJB, JTJ, KAM, KMR and TLE). Five of the Integrated Assessments in the charts (AAA, GN, JTJ, KAM and TLE) provided an accurate evaluation of the individual's psychological functioning that the WRPT can use to determine the nature of the individual's rehabilitation services. The remaining four (DJ, JC, JJB and KMR) did not provide sufficient information to fully address this recommendation.</p>		11/07	12/07	1/08	2/08	3/08	4/08	Mean	N	74	98	99	99	110	91		n	67	59	69	73	78	65		%S	91	60	70	74	71	71		%C #14	87	88	91	93	99	97	93
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%C #14	87	88	91	93	99	97	93																																			

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		<p>Current recommendation: Ensure accurate and complete evaluation of an individual's psychological functioning that informs the WRPTs of the individual's rehabilitation service needs.</p>
D.2.f.ii	<p>if behavioral interventions are indicated, a structural and functional assessment shall be performed, consistent with generally accepted professional standards of care, by a professional having demonstrated competency in positive behavior supports; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Ensure that PBS referrals get timely attention to assist unit staff to manage individuals with significant learned maladaptive behaviors.</p> <p>Findings: This monitor's documentation review (progress report, PBS plans and behavior guidelines), interview of Psychology staff, and attendance at PSH's Psychology Specialized Services Team meeting found that PSH has made a number of changes and taken a number of steps to be responsive to referrals in a timely fashion. For example, PSH has developed and implemented 74 behavior guidelines in the past six months, implemented a system-wide PBS plan, and established a Psychology Specialized Services Committee that meets twice weekly to discuss and follow up on individuals with maladaptive behaviors.</p> <p>PSH's audit data also showed that 67% of the referrals for behavior guidelines or PBS plans arising out of the Integrated Assessment findings and recommendations were completed within three weeks of the completion of the IPAs.</p> <p>Current recommendation: Ensure that PBS referrals get timely attention to assist unit staff to manage individuals with significant learned maladaptive behaviors.</p>
D.2.f.iii	<p>additional psychological assessments shall be performed, as appropriate, where clinical</p>	<p>Current findings on previous recommendations:</p>

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information is otherwise insufficient, and to address unresolved clinical or diagnostic questions, including differential diagnosis, "rule-out," "deferred," "no-diagnosis" and "NOS" diagnoses.

Recommendation 1, November 2007:

Ensure that additional psychological assessments are performed as required.

Findings:

PSH used items #16, #17, #18, #19, #20, and #21 (see below) from the DMH Psychology Monitoring Form to address this recommendation, reporting 37%, 65%, 31%, 31%, 90%, and 35% compliance respectively. The table below with its monitoring indicators showing the number of IPA's audited per month (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

Additional psychological assessments are performed, as appropriate, where psychological information is otherwise insufficient (#16).

Additional psychological assessments are performed, as appropriate for diagnostic questions, specifically "differential diagnosis" (#17).

Additional psychological assessments are performed, as appropriate for diagnostic questions, specifically "rule-out" (#18).

Additional psychological assessments are performed, as appropriate for diagnostic questions, specifically "deferred" (#19).

Additional psychological assessments are performed, as appropriate for diagnostic questions, specifically "no-diagnosis" (#20).

Additional psychological assessments are performed, as appropriate for diagnostic questions, specifically "NOS diagnoses" (#21).

	11/07	12/07	1/08	2/08	3/08	4/08	Mean
n	13	2	20	14	18	22	15
%C #16	46	50	15	43	50	36	37

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n	11	6	1	2	1	2	4	
%C #17	73	50	100	50	100	50	65	
n	13	8	7	8	6	9	8	
%C #18	23	38	14	50	33	33	31	
n	15	12	8	7	3	4	8	
%C #19	13	42	25	43	67	25	31	
n	12	6	12	9	11	10	10	
%C #20	83	100	92	89	91	90	90	
n	13	9	10	5	5	5	8	
%C #21	15	44	80	20	20	40	35	
<p>This monitor reviewed ten charts of individuals with diagnostic uncertainties (BR, DLK, EL, JLA, MM, RF, RLW, SAW, SLH and TNS). Additional assessments were completed for five of them (DLK, MM, RLW, SAW and SLH), and the remaining five (BR, EL, JLA, RF, TNS) did not have the required follow-up assessments completed.</p> <p>Recommendation 2, November 2007: Ensure that the facility's monitoring instrument that addresses "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.</p> <p>Findings: This monitor reviewed six charts of individuals with a "no diagnosis" entered in their DSM IV diagnosis (EL, JLA, MM, RF, SAW and TNS). Four of the diagnoses were backed up with clinical data (JLA, MM, SAW and TNS), and two of them (EL and RF) were not.</p>								

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		<p>Recommendation 3, November 2007: Ensure that supporting documents are recorded and referenced when using previous assessment results to address diagnosis-related matters.</p> <p>Findings: This monitor's interview of David Haimson and Helga Thordarson found that PSH has provided training to staff on referencing documents for diagnostic formulation.</p> <p>The assessments reviewed by this monitor (DLK, JLA, MM, RLW, SAW and SLH) utilized the DSM-IV-TR checklists to clarify the diagnosis and therefore did not need to reference other supporting documents.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that additional psychological assessments are performed as required. 2. Ensure that the facility's monitoring instrument that addresses "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.
D.2.g	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>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Ensure that assessments conducted meet the requirement of this cell.</p> <p>Findings: PSH used item #22 from the DMH Psychology Monitoring Form (<i>For individuals whose primary/preferred language is not English, there is documentation that the psychologist has endeavored to assess them in</i></p>

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		<p><i>their own language</i>) to address this recommendation, reporting 74% compliance. The table below showing the number of individuals identified as having a primary/preferred language other than English (N), the number of IAPs audited (n), and the percentage of individuals assessed in their preferred/primary language (%C) is a summary of the facility's data.</p> <table border="1" data-bbox="991 451 1906 646"> <thead> <tr> <th></th> <th>11/07</th> <th>12/07</th> <th>1/08</th> <th>2/08</th> <th>3/08</th> <th>4/08</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>1</td> <td>4</td> <td>1</td> <td>4</td> <td>6</td> <td>3</td> <td></td> </tr> <tr> <td>n</td> <td>1</td> <td>4</td> <td>1</td> <td>4</td> <td>6</td> <td>3</td> <td></td> </tr> <tr> <td>%S</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td></td> </tr> <tr> <td>%C #22</td> <td>100</td> <td>50</td> <td>0</td> <td>50</td> <td>100</td> <td>100</td> <td>74</td> </tr> </tbody> </table> <p>As shown in the table above, 14 of the 19 individuals with a primary/ preferred language other than English were assessed in their primary/preferred language.</p> <p>This monitor reviewed seven charts of individuals identified as having a primary/preferred language other than English (HPV, JAB, JC, JCE, MDH, RS and TT). Six of them (HPV, JAB, JC, MDH, RS and TT) were assessed in their preferred/primary language. One of them (JCE) did not have an IPA.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Ensure that assessments conducted meet the requirement of this cell.</p>		11/07	12/07	1/08	2/08	3/08	4/08	Mean	N	1	4	1	4	6	3		n	1	4	1	4	6	3		%S	100	100	100	100	100	100		%C #22	100	50	0	50	100	100	74
	11/07	12/07	1/08	2/08	3/08	4/08	Mean																																			
N	1	4	1	4	6	3																																				
n	1	4	1	4	6	3																																				
%S	100	100	100	100	100	100																																				
%C #22	100	50	0	50	100	100	74																																			

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3. Nursing Assessments	
	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Charles Allen, Nursing Coordinator Program 6 2. Diane Farelas, Assistant Coordinator of Nursing Services 3. Joellyn Arce, Nursing Coordinator (MSH) 4. Lidia Lau, Assistant Coordinator of Nursing Services 5. Regina Olender, Nurse Administrator <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. DMH Nursing Assessment monitoring forms and instructions 2. Training outline and rosters for Nursing Assessments 3. Competency-based Nursing training data 4. NP 301, Nursing Assessment: Admission, Integrated, Re-Assessment and Annual 5. NP 303, Recovery Focused Documentation 6. WRP Level I Nursing and Psychiatric Technician training data 7. Memo dated 3/14/08 regarding Evaluation of Staffing Patterns for Attendance at the WRPs 8. PSH Nursing staffing patterns 9. PSH's progress report 10. Nursing Assessments, Integrated Assessments and WRPs for the following 44 individuals: AAR, AHM, AJG, BKP, CMB, DEW, EHS, FA, GJ, HST, JAP, JBD, JBP, JDD, JEM, JG, JGM, JRS, JTF, JTJ, KCS, KLS, KN, LS, MA, MAA, MAG, MFA, MMV, MO, NSB, PHR, PJD, RB, RF, RFE, RT, RWC, SEC, SHW, TDR, VM, WDN and WHG <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. Monthly WRPC for JJ on Program IV, Unit 35 2. Monthly WRPC for RLR on Program VIII, Unit 20

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D.3.a	Each State hospital shall develop standard nursing assessment protocols, consistent with generally accepted professional standards of care. These protocols shall address, at a minimum:	<p>Compliance: Partial.</p>
D.3.a.i	a description of presenting conditions;	<p>Current findings on previous recommendations:</p> <p>Recommendations 1-2, November 2007:</p> <ul style="list-style-type: none"> • Ensure that nursing is provided training on the use of the new admission and integrated assessment forms. • Provide competency data for existing staff regarding protocols addressing this requirement. <p>Findings: Training rosters provided by PSH indicated that initial training was provided regarding the new nursing assessments (admission and integrated) in November 2007. At the time of this review, training regarding these assessments was being provided for all shifts. As of April 2008, PSH's data indicated that 69% of RNs were trained and had passed the competency-based training (276 out of 401 total RNs). Since November 2007, all 10 newly hired RNs at PSH have received and passed the training.</p> <p>Recommendation 3, November 2007: Continue to monitor this requirement.</p> <p>Findings: Because PSH began using the revised monitoring tool for this section, which included different criteria than the previous tool, in January 2008, the data provided by PSH and cited below were collected during the January-April 2008 period.</p> <p>PSH's data from the DMH Nursing Assessment Monitoring form, based</p>

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		<p>on an average sample of 74% of admissions, indicated 1% mean compliance with documentation of the presenting condition on the initial Nursing Admission Assessments. PSH's data from the Integrated Nursing Assessment Monitoring form, based on a 66% mean sample of Integrated Nursing Assessments, indicated 10% mean compliance with documentation of the presenting condition. This monitor's interviews with Nursing found that issues regarding completing the assessment forms and the specific criteria required for compliance by the new monitoring tools have contributed to the low compliance rates in many of the areas reviewed.</p> <p>Other findings: This monitor found that the documentation on the new initial nursing admission assessments was significantly worse than during the last review. The documentation regarding the presenting condition was still superficial and lacked specifics regarding the individual's behaviors and response to the process. There was a decrease in the documentation and a number of sections were left incomplete in the areas of vital signs, allergies, pain assessment, use of assistive devices, activities of daily living, conditions needing immediate nursing interventions and currently prescribed medications, similar to the deficiencies captured by PSH's data. Also, a number of Integrated Nursing Assessments were incomplete and had conflicting dates as to when they were actually completed.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
		<p>The following data is the mean compliance rates reported in PSH's progress report from the Nursing Admission Assessment and Integrated Nursing Assessments monitoring for January-April :</p>

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		Nursing Admission Assessment Monitoring Form (74% mean sample)	Integrated Nursing Assessment Monitoring Form (66% mean sample)
D.3.a.ii	current prescribed medications;	32%	38%
D.3.a.iii	vital signs;	83%	36%
D.3.a.iv	allergies;	71%	42%
D.3.a.v	pain;	63%	27%
D.3.a.vi	use of assistive devices;	34%	31%
D.3.a.vii	activities of daily living;	78%	17%
D.3.a.viii	immediate alerts (e.g., escape risk, physical assault, choking risk, suicidal risk, homicide risk, fall risk, sexual assault, self-injurious behavior, arson, or fire setting); and	91%	42%
D.3.a.ix	conditions needing immediate nursing interventions.	9%	8%
D.3.b	Nursing may use a systems model (e.g., Johnson Behavioral System Model) for the nursing evaluation.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Continue revising Nursing Policies & Procedures to include WRP language.</p> <p>Findings: NP 301, Nursing Assessment: Admission, Integrated, Re-Assessment and Annual; and, NP 303, Recovery-Focused Documentation include WRP language, adequately addressing this recommendation.</p>	

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		<p>Recommendations 2 and 3, November 2007:</p> <ul style="list-style-type: none"> • See C.1.a, Recommendation 3. • Continue to monitor this requirement. <p>Findings: PSH's training rosters indicated that as of May 2008, 93% of RNs, 92% of Psychiatric Technicians (PTs) and 94% of LVNs have been trained in WRP Level I. This is a significant increase from the last review. Previous and current revisions to the Nursing Department Policy and Procedures have demonstrated that PSH is consistently using the Wellness and Recovery Model for Nursing.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
D.3.c	<p>Each State hospital shall ensure that all nurses responsible for performing or reviewing nursing assessments are verifiably competent in performing the assessments for which they are responsible. All nurses shall have graduated from an approved nursing program, shall have passed the NCLEX-RN and shall have a license to practice in the state of California.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Continue to monitor this requirement.</p> <p>Findings: See D.3.a.i, Findings for Recommendation 2. Although the number of nurses who have been trained to competency has been increasing with each review, the quality of the nursing assessments has not increased as noted from PSH's data and this monitor's review of the admission and integrated assessments.</p> <p>Compliance: Partial.</p>

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		<p>Current recommendation: Continue to monitor this requirement.</p>
D.3.d	Each State hospital shall ensure that nursing assessments are undertaken on a timely basis, and in particular, that:	<p>Compliance: Partial.</p>
D.3.d.i	Initial nursing assessments are completed within 24 hours of the individual's admission;	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Continue to monitor this requirement.</p> <p>Findings: PSH's data for January-April 2008, based on a 74% mean sample of Initial Nursing Assessments, indicated that 88% were completed within 24 hours.</p> <p>Review of 44 admission assessments found the 37 were completed timely.</p> <p>Compliance: Partial.</p> <p>Current recommendation: See D.3.a.i.</p>
D.3.d.ii	Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Continue to monitor this requirement.</p> <p>Findings: PSH's data for January-April 2008, based on a 66% mean sample of</p>

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		<p>Integrated Assessments, indicated that 16% were completed within five days. (PSH policy and auditing practices indicate a five-day timeframe for completion of Integrated Nursing Assessments rather than a seven-day time frame).</p> <p>Review of 44 Integrated Assessments found that 16 were completed within five days, three were incomplete and 25 were not completed within five days.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
D.3.d.iii	<p>Nursing assessments are reviewed every 14 days during the first 60 days of admission and every 30 days thereafter and updated as appropriate. The third monthly review shall be a quarterly review and the 12th monthly review shall be the annual review.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, November 2007:</p> <ul style="list-style-type: none"> • See C.1.a, Recommendation 3 re training. • Evaluate staffing patterns and conference schedules to ensure appropriate and consistent staff are present at WRPCs. <p>Findings: Documentation provided by PSH indicated that the facility is critically reviewing issues affecting nursing and PT staffing patterns to facilitate consistent staff attendance at the WRPCs. PSH has taken steps to ensure better assignment of duties to facilitate RN and PT attendance at WRPCs. Rotation of work schedules has been reviewed, adequately addressing this recommendation. However, a number of barriers remain that cannot be modified to allow consistency in staff attendance at the WRPCs.</p> <p>The data from the WRP Observation Monitoring Form for November</p>

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		<p>2007 to April 2008, based on a 10% mean sample of audited WRPCs, indicated 25% mean compliance for RN attendance at the WRPC and 7% mean compliance for PT attendance at the WRPC.</p> <p>Recommendation 3, November 2007: Continue to monitor this requirement.</p> <p>Findings: The data from the WRP Observation Monitoring Form for November 2007 to April 2008, based on a 10% mean sample of audited WRPCs, indicated 30% mean compliance with the requirement that RNs participate in the WRPC by presenting or updating discipline-specific and/or holistic assessment data; 26% mean compliance with the requirement that RNs present MOSES data at the WRPC; 12% mean compliance with the requirement that RNs present relevant and appropriate content for the discipline-specific assessments; and 5% mean compliance with the requirement that the implications of assessments results and consultations for diagnosis, therapy and rehabilitation were communicated by the RN in the WRPC</p> <p>Other findings: In two WRPCs observed by this monitor (monthly reviews for JJ in Program IV, unit 35 and RLR on Program VIII, unit 20), there was minimal participation by the nurse and PT. Since the WRPC process was followed in the case of JJ, the RN did address the MOSES data but very little other information was provided by the RN or PT in either WRPC.</p> <p>Current recommendation: Continue to monitor this requirement</p>
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4. Rehabilitation Therapy Assessments		
		<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Alejandro Fernandez, Supervising Rehabilitation Therapist 2. Billy Mange, Senior Vocational Rehabilitation Counselor 3. Curtis Peters, Supervising Rehabilitation Therapist 4. Debra Taylor-Tatum, Supervising Rehabilitation Therapist 5. Denise Byerly, RN, POST Team Coordinator 6. G. Michelle Reid-Proctor, MD, Physical Medicine and Rehabilitation 7. Greg Siples, Chief of Rehabilitation Services 8. Jacqueline Doss-Haynes, Supervising Rehabilitation Therapist 9. Janet Richards, Occupational Therapist 10. Jerry Marquez, Physical Therapist Assistant 11. Louis F. Lacouette, Physical Therapist 12. Mark Camero, Supervising Rehabilitation Therapist 13. Michael Gomes, Recreation Therapist 14. Stan Hydingler, Supervising Rehabilitation Therapist 15. Victor G. Ruiz, Speech Pathologist <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. PSH Rehabilitation Therapy Organization Charts (revised and implemented 11/15/07) 2. DMH Rehabilitation Therapy Service Manual final draft 3. AD #10.51 Physical Occupational and Speech/Language Pathology (POST) process 4. POST referral form (draft) 5. Rehabilitation Management Committee procedure (draft) 6. Nursing P&P 324 Fall Prevention 7. AD #10.44 Aspiration and Dysphagia Risk Screening 8. Vocational Rehabilitation Screening Tool 9. Integrated Assessment-Rehabilitation Therapy Section 10. Integrated Assessment-Rehabilitation Therapy Section

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		<p>instructions</p> <ol style="list-style-type: none"> 11. DMH Rehabilitation Therapy Monitoring Form and Instructions (D4 monitoring tool for admission assessments) 12. DMH Rehabilitation Therapy Monitoring Tool and Instructions (IA-RTS audit) 13. DMH Rehabilitation Therapy IA-RTS audit data for January-April 2008 14. Focused assessment (Physical, Occupational, Speech Therapy and CIPRTA) audit data for April 2008 15. DMH Vocational Rehabilitation Assessment Tool and Instructions (implemented 3/08) 16. DMH Vocational Rehabilitation Assessment Monitoring Tool and Instructions (implemented 3/08) 17. DMH Occupational Therapy Focused Assessment and Instructions (implemented 3/08) 18. DMH Occupational Therapy Focused Assessment Monitoring Tool and Instructions drafts (implemented 3/08) 19. DMH Speech-Language Focused Assessment and Instructions (implemented 3/08) 20. DMH Speech-Language Focused Assessment Monitoring Tool and Instructions (implemented 3/08) 21. DMH Physical Therapy Focused Assessment and Instructions (implemented 3/08) 22. DMH Physical Therapy Focused Assessment Monitoring Tool and Instructions (implemented 3/08) 23. DMH Comprehensive Integrated Physical Rehabilitation Therapy Assessment and Instructions (implemented 3/08) 24. DMH Comprehensive Integrated Physical Rehabilitation Therapy Assessment Monitoring Tool and Instructions (implemented 3/08) 25. List of individuals who had IA-RTS assessments from January-April 2008 26. Records of the following 19 individuals who had IA-RTS assessments during the January- April 2008 period: AHM, BR,
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		<p>BTH, GSG, HPV, JGM, KEM, KLA, MS, MT, ND, PL, RBS, SJ, SR, TC, VJW, VM and WAO</p> <p>27. Record for the following individual who had a Vocational Rehabilitation Assessment in April 2008: RL</p> <p>28. List of individuals with Physical Therapy assessment/consultation in April 2008</p> <p>29. Records for the following individuals with Physical Therapy assessment in April 2008: EM, NPC</p> <p>30. List of individuals with Occupational Therapy assessment/consultation in April 2008</p> <p>31. Records for the following individuals with Occupational Therapy assessment in April 2008: DCM, DFV</p> <p>32. List of individuals with Speech Therapy assessment/consultation in April 2008</p> <p>33. Records for the following six individuals with Speech Therapy assessment in April 2008: JGP, KLS, LM, NSC, REF and WHG</p> <p>34. List of individuals with Comprehensive Integrated Rehabilitation Assessment in April 2008</p> <p>35. Record for the following individual who had a Comprehensive Integrated Rehabilitation Assessment in April 2008: SM</p> <p>36. Training roster and competency scores for IA-RTS</p> <p>37. California Occupational Therapy Practice Act</p> <p>38. AD #15.45 Key Indicator/Trigger Reporting</p>
D.4.a	<p>Each State hospital shall develop standard rehabilitation therapy assessment protocols, consistent with generally accepted professional standards of care, for satisfying the necessary components of a comprehensive rehabilitation therapy assessment.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Revise and implement Rehabilitation Therapy Manual and organizational chart to reflect changes including departmental integration and restructuring, a description of collaboration among disciplines and therapy teams within the department and any revised or new Rehabilitation Therapy Services procedures. The Rehabilitation Services Manual should be consistent with manuals at the other state</p>

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		<p>facilities.</p> <p>Findings: The Rehabilitation Therapy organizational chart was revised and the changes implemented in November 2007. The chart includes all Rehabilitation Therapy disciplines (Psychosocial Rehabilitation Therapists, Vocational Rehabilitation Services and Physical, Occupational and Speech Therapists) under the Rehabilitation Therapy Services Chief. The draft of the statewide Rehabilitation Therapy Manual has been subsequently updated as procedures and processes have evolved. The current draft (called the final draft) addresses the role of the Rehabilitation Therapist in the WRPT, as well as the role of the RIAT team, POST team, Occupational Therapist, Physical Therapist, Speech Therapist and Vocational Rehabilitation Counselors and Instructors. The manual includes the Rehabilitation Therapist's role in acting as a liaison to report findings of the POST disciplines and Vocational Rehabilitation Services. AD #10.51, Physical Occupational and Speech/Language Pathology (POST) Process, has been written and should be implemented pending development of the POST referral process. The Rehabilitation Therapy Manual has been updated to include newly developed procedures for focused assessments (POST and Vocational Rehabilitation), assessment instructions and monitoring tools and instructions. The Manual should continue to be updated as procedures and systems develop.</p> <p>Recommendation 2, November 2007: Revise and implement Integrated Assessment-Rehabilitation Services assessment, instructions, monitoring tool and instructions.</p> <p>Findings: The IA-RTS and instructions were approved and implemented in January 2008. This was verified by record review of individuals who received IA-RTS assessments during the January-April 2008 period.</p>
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		<p>Currently, all IA-RTS assessments are completed by one assessment team during the assessment clinic. The clinic process appears to meet accepted standards of practice. However, it does not allow for these team members to provide PSR Mall hours and does not give other therapists an opportunity to provide admission assessments. The practice of having therapists complete both assessment and treatment (PSR Mall hours) enables them to provide individuals with better alignment between assessed needs, interests, strengths and motivation and the services provided. It is strongly recommended that more than one team of therapists provide assessments in order to prevent the emergence of other possible issues such as burn-out and rote completion of admission assessments.</p> <p>Recommendation 3, November 2007: Develop and implement a Comprehensive Physical Rehabilitation screening tool to ensure appropriate referral for this service by the WRPT to the POST team.</p> <p>Findings: Currently, the facility continues to use the Dysphagia and Falls risk screening tools for all individuals upon admission. Based on findings from record review and interview, it does not appear that these screening tools are sufficient to trigger a referral to the POST team for a Comprehensive Physical Rehabilitation Therapy Assessment when clinically indicated.</p> <p>In addition, the levels of risk determined by the Falls and Dysphagia risk screening tools do not align with the levels of risk used in the facility Risk Management/Key Indicator system.</p> <p>A draft of the POST referral form listing Occupational, Physical and Speech Therapy services has been developed and is pending</p>
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		<p>implementation. This tool appears to be comprehensive and sufficiently sensitive to generate a referral to the POST team as clinically indicated, if the WRPTs are educated on and oriented to its use.</p> <p>Recommendation 4, November 2007: Develop and implement a Comprehensive Physical Rehabilitation assessment as well as instructions that meet the requirements of the EP, incorporate the principles of the Wellness and Recovery model and are consistent with those of the other state facilities.</p> <p>Findings: The Comprehensive Integrated Physical Rehabilitation Therapy Assessment (CIPRTA), assessment instructions, monitoring tool and monitoring tool instructions were approved statewide and implemented on April 1, 2008. This was verified by review of the one assessment completed in April 2008.</p> <p>Recommendation 5, November 2007: Develop and implement a Vocational Rehabilitation screening tool to ensure appropriate referral for individuals requiring Vocational Rehabilitation/Industrial Therapy services.</p> <p>Findings: A simple screening tool consisting of one question has been developed and implemented. However, this tool does not appear to be sensitive enough to trigger a referral to Vocational Rehabilitation/Industrial Therapy when clinically indicated. According to interview, after the screening question is asked, the WRPT then discusses additional factors prior to generating a Vocational Rehabilitation referral. These team steps and/or questions should be integrated into the current screening tool to ensure a more comprehensive screening process. According to facility report, the Vocational Rehabilitation screen is administered first at each individual's seven-day conference and</p>
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		<p>monthly thereafter.</p> <p>Recommendation 6, November 2007: Develop and implement a Vocational Rehabilitation assessment as well as instructions that meet the requirements of the EP, incorporate the principles of the Wellness and Recovery model and are consistent with those of the other state facilities.</p> <p>Findings: The Vocational Rehabilitation Assessment tool and instructions were approved statewide and were implemented on May 1, 2008. The facility reports that audits of Vocational Rehabilitation Therapy assessments will begin in May 2008.</p> <p>Other findings: Physical Therapy, Speech Therapy, Occupational Therapy and Comprehensive Physical Rehabilitation (POST) assessment tools and instructions have been approved and were implemented in April 2008. Therefore, only assessments completed in April 2008 have been reviewed during this tour.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Revise and implement the Department of Mental Health Rehabilitation Therapy Service Manual draft based on changes, new protocols and procedures and system development; ensure that all discipline-specific service procedures and manuals are integrated into and consistent with Rehabilitation Therapy practice in relation to the Wellness and Recovery model and EP requirements. 2. Develop and implement a plan to ensure that individuals (both new admissions and individuals residing at PSH) who would benefit from
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		<p>a Comprehensive Physical Rehabilitation Therapy assessment or a Vocational Rehabilitation assessment are referred for this service by the WRPT.</p> <p>3. Revise and implement the Vocational Rehabilitation screening tool to ensure a more comprehensive tool for Vocational Rehabilitation referrals.</p>
D.4.b	Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:	<p>Compliance: Partial.</p>
D.4.b.i	Is accurate and comprehensive as to the individual's functional abilities;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Develop and implement monitoring tool(s) for Physical, Occupational and Speech Therapy Assessments, Vocational Rehabilitation Assessments and Comprehensive Physical Rehabilitation Assessments (POST) to ensure that all assessments are timely and provide a thorough assessment of functional ability as opposed to a focus on dysfunction and disability.</p> <p>Findings: Physical Therapy, Speech Therapy, Occupational Therapy and Comprehensive Physical Rehabilitation (POST) assessment audit tools and instructions and D.4 monitoring tools for focused assessments have been approved and were implemented in April 2008. Therefore, facility only audit data for April is available for review for all POST focused assessments. The Vocational Rehabilitation audit was implemented in May 2008 and thus no audit data for Vocational Rehabilitation assessments is available for review at this time.</p>

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		<p>Recommendation 2, November 2007: Revise and implement Integrated Assessment- Rehabilitation Therapy Section Monitoring Tool and instructions in collaboration with other state facilities and ensure alignment between monitoring tool, assessment and EP requirements.</p> <p>Findings: The MH-C 9044 Rehabilitation Therapy Assessment Monitoring Form and Instructions developed to monitor D.4 admission (IA-RTS) assessments were approved in February 2008 but implemented in May 2008, so the audit data presented during this review was derived from the previous auditing tool. According to facility data, 96% of admission assessments were audited, which almost meets the 100% sample size auditing requirement for admission assessments.</p> <p>Recommendation 3, November 2007: Establish inter-rater reliability for all audit/monitoring tools prior to implementation.</p> <p>Findings: This recommendation has not been addressed.</p> <p>Recommendation 4, November 2007: Ensure that all Rehabilitation Services assessments are accurate and comprehensive as to the individual's functional abilities.</p> <p>Findings: According to facility audit data for January-April 2008 IA-RTS assessments, 93% of assessments were timely and 71% of assessments were accurate and comprehensive as to the individual's functional abilities.</p> <p>Record review of January-April 2008 IA-RTS assessments found that</p>
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		<p>89% of assessments were timely, 100% of IA-RTS assessments were complete, 79% were comprehensive and 79% addressed functional abilities.</p> <p>According to facility audit data for April 2008, only 7% of Physical Therapy assessments were completed on time (and only one was completed) and this assessment addressed functional abilities.</p> <p>Record review of Physical Therapy Assessments completed in April 2008 found that one out of two assessments was timely and both assessments were complete, comprehensive and addressed functional abilities.</p> <p>According to facility audit data for April 2008, 100% of Speech Therapy assessments were completed on time and 25% of audited assessments addressed functional abilities. The facility audit data shows that four Speech Therapy assessments were due and completed in April 2008, but the list provided by the facility showed that six assessments were due and completed.</p> <p>Review of Speech Therapy Assessments found that 50% of assessments were timely, 100% of assessments were complete, 50% were comprehensive and 50% addressed functional abilities.</p> <p>According to facility audit data for April 2008, one out of two Occupational Therapy assessments was completed on time (only one was completed) and this assessment addressed functional abilities. The facility audit data shows that two Occupational Therapy assessments were due and completed in April 2008, but the list provided by the facility showed that four assessments were due and completed.</p> <p>Record review of the Occupational Therapy Assessment completed in April 2008 found that the assessment was not timely, though it was</p>
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		<p>complete, comprehensive and addressed functional abilities.</p> <p>According to facility audit data for April 2008, one CIPRTA assessment was due and this assessment was completed on time but did not address functional abilities.</p> <p>This monitor's review of the CIPRTA assessment completed in April 2008 found that the assessment was timely, complete, comprehensive and addressed functional abilities.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement D.4 monitoring tool(s) for admission and focused assessments that report data on EP cells pertaining to all Rehabilitation Therapy assessments (Integrated admission and Focused) according to DMH format/standards. 2. Ensure that auditors have received training on monitoring tools and that inter-rater agreement has been established for Integrated Assessment-Rehabilitation Services section and focused assessments monitoring prior to implementation. 3. Ensure that all Rehabilitation Services admission and focused assessments are accurate and comprehensive as to the individual's functional abilities.
D.4.b.ii	Identifies the individual's current functional status and the skills and supports needed to facilitate transfer to the next level of care; and	<p>Current findings on previous recommendation:</p> <p>Recommendation: Ensure that all assessments identify the individual's current functional status and the skills and supports needed to facilitate transfer to the next level of care.</p> <p>Findings: According to audit data for January-April 2008 IA-RTS assessments, 92% addressed functional status and 96% identified skills and supports</p>

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		<p>needed to transfer to the next level of care.</p> <p>Record review of January-April 2008 IA-RTS assessments found that 100% of assessments identified current functional status and identified skills and supports needed to facilitate transfer to the next level of care.</p> <p>According to facility audit data for April 2008, the one Physical Therapy assessment audited addressed functional status and skills and supports needed to transfer to the next level of care.</p> <p>Record review of Physical Therapy Assessments completed in April 2008 found that both assessments addressed functional status and skills and supports needed to transfer to the next level of care.</p> <p>According to facility audit data for April 2008, 50% of Speech Therapy assessments audited addressed functional status and 75% identified skills and supports needed to transfer to the next level of care.</p> <p>Record review of Speech Therapy Assessments completed in April 2008 found that 50% of assessments addressed functional status and 67% identified skills and supports needed to transfer to the next level of care.</p> <p>According to facility audit data for April 2008, the one Occupational Therapy assessment audited did not address functional status and skills and supports needed to transfer to the next level of care. This monitor's review of that assessment found that it did address functional status and identified skills and supports needed to transfer to the next level of care.</p> <p>According to facility audit data for April 2008, the one CIPRTA</p>
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		<p>assessment audited addressed functional status and skills and supports needed to transfer to the next level of care. This is consistent with the monitor's findings upon review of the assessment.</p> <p>Current recommendation: Ensure that all Rehabilitation Services admission and focused assessments identify the individual's current functional status and the skills and supports needed to facilitate transfer to the next level of care.</p>
D.4.b.iii	Identifies the individual's life goals, strengths and motivation for engaging in wellness activities.	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Ensure that all assessments identify the individual's life goals, strengths and motivation for engaging in wellness activities.</p> <p>Findings: According to facility audit data regarding January-April 2008 IA-RTS assessments, 93% of assessments identified the individual's life goals, 69% addressed strengths and 74% identified motivation for engaging in wellness activities.</p> <p>Record review of January-April 2008 IA-RTS assessments found that 79% of assessments identified the individual's life goals, 68% addressed strengths and 79% identified motivation for engaging in wellness activities.</p> <p>According to facility audit data for April 2008, the one Physical Therapy assessment audited identified the individual's goals but did not address strengths or the individual's motivation for engaging in wellness activities. This monitor's review of that assessment found that the assessment identified goals, strengths and motivation.</p>

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		<p>According to facility audit data for Speech Therapy assessments completed in April 2008, 75% of assessments identified the individual's goals and none addressed strengths or identified motivation for engaging in wellness activities. This monitor's review of Speech Therapy assessments found that 83% of assessments identified individual's goals and 100% addressed strengths and identified motivation for engaging in wellness activities.</p> <p>According to facility audit data for April 2008, the one CIPRTA assessment audited identified the individual's goals, strengths and identified motivation for engaging in wellness activities. This is consistent with this monitor's review of the assessment.</p> <p>Current recommendation: Ensure that all Rehabilitation Services admission and focused assessments identify the individual's life goals, strengths and motivation for engaging in wellness activities.</p>
D.4.c	Each State hospital shall ensure that all clinicians responsible for performing or reviewing rehabilitation therapy assessments are verifiably competent in performing the assessments for which they are responsible	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Provide competency-based training to all Rehabilitation Services staff regarding changes in departmental procedures and to appropriate staff regarding developed/ revised assessment protocols and instructions and monitoring tools/instructions on a discipline-/team-specific basis.</p> <p>Findings: According to review of training database and competency scores, 70 out of 71 Rehabilitation Therapists have been trained to at least 90% competency on the Integrated Assessment-Rehabilitation Services section; three out of five POST team members have been trained to competency on the CIPRTA; all (two) Occupational Therapists have been trained to competency on the OT assessment; the Physical</p>

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		<p>Therapist has not yet been trained to competency on the PT assessment; and the Speech Therapist has been trained to competency on the SLP assessment. This was verified by review of training rosters and post-test raw data.</p> <p>A system for trend analysis of IA-RTS audit findings and resultant group mentoring and trend-based training has not been initiated. Upon facility report, individual training based on audit data analysis has been ongoing, though appears to be informal at this time.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that staff who are performing assessments (admission and focused) have been trained to competency. 2. Develop and implement a system to analyze audit data for focused assessments (Vocational Rehabilitation, Occupational, Physical and Speech Therapy assessments and Comprehensive Physical Rehabilitation assessments) and provide feedback to staff regarding performance improvement and recommendations for training/CEU courses based on these findings and track CEU courses attended by Rehabilitation Therapy staff. 3. Develop and implement a system to analyze IA-RTS audit data and provide group trend-based training.
D.4.d	<p>Each State hospital shall ensure that all rehabilitation therapy assessments of all individuals who were admitted to each State hospital before the Effective Date hereof shall be reviewed by qualified clinicians and, as indicated, revised to meet the criteria in § [IV.D.2], above.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Ensure that all individuals admitted to PSH prior to June 1, 2006 receive an Integrated Assessment-Rehabilitation Therapy Section assessment within the next twelve months.</p>

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		<p>Findings: According to facility report, 245 out of 794 (31%) of IA-RTS assessments for individuals admitted prior to June 1, 2006 have been completed. The facility plan is to complete D.4.d assessments on the anniversary date for these individuals.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Ensure that all individuals admitted to PSH prior to June 1, 2006 receive an Integrated Assessment-Rehabilitation Therapy Section Assessment within the next twelve months.</p>
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5. Nutrition Assessments		
D.5	<p>Each State hospital shall provide nutrition assessments, reassessments and interventions consistent with generally accepted professional standards of care. A comprehensive nutrition assessment will include the following:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Dolores Otto-Moreno, Assistant Director of Nutrition Services 2. Grace Ferris, Assistant Director of Nutrition Services 3. Kitchie Miana, Assistant Director of Nutrition Services 4. Tai Kim, Director of Nutrition Services <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Nutrition Care Monitoring audit data for November 2007-April 2008 for each assessment type 2. Lists of individuals with Nutrition Care Assessments due from November 2007-April 2008 for each assessment type 3. Record for the following individual with type D.5.a assessment from November 2007-April 2008: RZ 4. Records for the following seven individuals with type D.5.d assessments from November 2007-April 2008: GP, GR, LCB, MAT, MLB, RWT and SEL 5. Records for the following four individuals with type D.5.e assessments from November 2007-April 2008: KJ, SM, SRB and VM 6. Records for the following seven individuals with type D.5.f assessments from November 2007-April 2008: CMG, EFM, KEM, MMS, PAB, SH and VM 7. Records for the following 14 individuals with type D.5.g assessments from November 2007-April 2008: ABT, ADY, AM, CP, DRH, EJH, HJL, JSC, LGH, LP, NMM, PLA, RLG and ZCJ 8. Records for the following 18 individuals with type D.5.i assessments from November 2007-April 2008: BK, DAR, DIT, DQ, EMN, JDC, JIM, JJP, LJS, LMB, MJO, PC, PSP, RAR, RP, RWT, WPW and WSD 9. Records for the following 11 individuals with type D.5.j.i assessments from November 2007-April 2008: BLB, BS, CS, EW,

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		<p>JC, JJS, LP, RF, RYM, SJP and WK</p> <p>10. Records for the following 22 individuals with type D.5.j.ii assessments from November 2007-April 2008: AB, AMC, CCH, DCG, DGA, ECF, GB, HP, JB, JDM, JJD, JJK, LB, LS, MS, OWV, RCP, RE, RLP, TCS, TCW and VEB</p>
<p>D.5.a</p>	<p>For new admissions with high risk referral (e.g., type I diabetes mellitus, enteral/parenteral feeding, dysphagia/recent choking episode), or upon request by physician, a comprehensive Admission Nutrition Assessment will be completed within 24 hours of notification to the dietitian.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Continue current practice.</p> <p>Findings: According to facility report, one individual was scheduled for a type D.5.a assessment during the November 2007-April 2008 review period and one record was audited using the Nutrition Care Monitoring Tool. This meets the sample size requirement of 100%.</p> <p>According to Nutrition Assessment audit data for the November 2007-April 2008 review period, the assessment was completed on time and had complete subjective findings, complete objective findings, a correctly formulated nutrition diagnosis, individualized and measurable goals and appropriate recommendations.</p> <p>Record review for this individual also found that the assessment was completed on time and had complete subjective findings, complete objective findings, a correctly formulated nutrition diagnosis, individualized and measurable goals and appropriate recommendations.</p> <p>Compliance: Partial (sample too small to determine Substantial).</p> <p>Current recommendation: Continue current practice.</p>

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D.5.b	For new admissions directly into the medical-surgical unit, a comprehensive Admission Nutrition Assessment will be completed within 3 days of admission.	Not applicable. PSH does not have a medical-surgical unit.
D.5.c	For new admissions directly into the skilled nursing facility unit, a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.	Not applicable. PSH does not have a skilled nursing facility unit.
D.5.d	For new admissions with identified nutritional triggers from Nursing Admission Assessment or physician's consult (e.g., for severe food allergies, tube feeding, extensive dental problems or dental surgery, NPO/clear liquid diet for more than three days, uncontrolled diarrhea/vomiting more than 24hrs and MAOI, as clinically indicated), a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Continue current practice.</p> <p>Findings: According to facility report, 60 individuals were scheduled for type D.5.d assessments during the November 2007-April 2008 review period and 60 records were audited using the Nutrition Care Monitoring Tool. This meets the sample size requirement of 100%.</p> <p>According to Nutrition Assessment audit data for the November 2007-April 2008 review period, 77% of assessments were completed on time, 82% had complete subjective findings, 78% had complete objective findings, 90% had a correctly formulated nutrition diagnosis, 88% had individualized and measurable goals and 75% had appropriate recommendations.</p> <p>Record review of a sample of individuals requiring type D.5.d assessments during the November 2007-April 2008 review period found that 71% of assessments were completed on time, 100% had complete subjective findings, complete objective findings and a</p>

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		<p>correctly formulated nutrition diagnosis, 57% had individualized and measurable goals and 86% had appropriate recommendations.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Continue current practice.</p>
D.5.e	<p>For new admissions with therapeutic diet orders for medical reasons, a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Continue current practice.</p> <p>Findings: According to facility report, 23 individuals were scheduled for type D.5.e assessments during the November 2007-April 2008 review period and 23 records were audited using the Nutrition Care Monitoring Tool. This meets the sample size requirement of 100%.</p> <p>According to Nutrition Assessment audit data for the November 2007-April 2008 review period, 52% of assessments were completed on time, 74% had complete subjective findings, 70% had complete objective findings, 96% had a correctly formulated nutrition diagnosis, 96% had individualized and measurable goals and 80% had appropriate recommendations.</p> <p>Record review of a sample of individuals requiring type D.5.e assessments during the November 2007-April 2008 review period found that 75% of assessments were completed on time and 100% had complete subjective findings, complete objective findings, a correctly formulated nutrition diagnosis, individualized and measurable goals and appropriate recommendations.</p>

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		<p>Compliance: Partial.</p> <p>Current recommendation: Continue current practice.</p>
D.5.f	<p>For individuals with therapeutic diet orders for medical reason after admission, a comprehensive Admission Nutrition Assessment will be completed within 7 days of the therapeutic diet order but no later than 30 days of admission.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Continue current practice.</p> <p>Findings: According to facility report, 72 individuals were scheduled for type D.5.f assessments during the November 2007-April 2008 review period and 72 records were audited using the Nutrition Care Monitoring Tool. This meets the sample size requirement of 100%.</p> <p>According to Nutrition Assessment audit data for the November 2007-April 2008 review period, 68% of assessments were completed on time, 89% had complete subjective findings, 84% had complete objective findings, 94% had a correctly formulated nutrition diagnosis, 90% had individualized and measurable goals and 70% had appropriate recommendations.</p> <p>Record review of a sample of individuals requiring type D.5.f assessments during the November 2007-April 2008 review period found that 57% of assessments were completed on time, 100% had complete subjective findings and complete objective findings, 86% had a correctly formulated nutrition diagnosis, 86% had individualized and measurable goals and 100% had appropriate recommendations.</p>

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		<p>Compliance: Partial.</p> <p>Current recommendation: Continue current practice.</p>
D.5.g	<p>For all other individuals, a comprehensive Admission Nutrition Assessment will be completed within 30 days of admission.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Continue current practice.</p> <p>Findings: According to facility report, 380 individuals were scheduled for type D.5.g assessments during the November 2007-April 2008 review period and 79 records were audited using the Nutrition Care Monitoring Tool (21%). This meets the sample size requirement of 20% or N=n if N less than 20.</p> <p>According to Nutrition Assessment audit data for the November 2007-April 2008 review period, 96% of assessments were completed on time, 90% had complete subjective findings, 87% had complete objective findings, 88% had a correctly formulated nutrition diagnosis, 83% had individualized and measurable goals and 67% had appropriate recommendations.</p> <p>Record review of a sample of individuals requiring type D.5.g assessments during the November 2007-April 2008 review period found that 71% of assessments were completed on time, 100% had complete subjective findings and complete objective findings, 93% had a correctly formulated nutrition diagnosis, 79% had individualized and measurable goals and 100% had appropriate recommendations.</p>

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		<p>Compliance: Partial.</p> <p>Current recommendation: Continue current practice.</p>
D.5.h	<p>Acuity level of an individual at nutritional risk will be determined by Nutritional Status Type ("NST") which defines minimum services provided by a registered dietitian.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Recruit and retain additional staff dietitians for Nutrition Department.</p> <p>Findings: One new Dietitian has been hired and trained to competency. However, only 10 positions are filled out of 16.4 allotted and the facility reports that one Dietitian will be leaving next week and staffing will be down to nine full time positions.</p> <p>Recommendation 2, November 2007: Continue current practice.</p> <p>Findings: According to facility database for records of all assessment types completed from November 2007-April 2008 and audited, (581 assessments audited out of 2218 assessments completed for a 26% sample), it is noted that that an average (weighted mean) of 90% of Nutrition Care assessments had evidence of a correctly assigned NST level.</p> <p>Record review of a random sample of completed Nutrition Care assessments across assessment subtypes (a total of 67 out of 84 reviewed) found that an average (weighted mean) of 99% of assessments audited had evidence of a correctly assigned NST level.</p>

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		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
D.5.i	<p>The frequency of a comprehensive Nutrition Assessment Update will be determined by the NST. Updates should include, but not be limited to: subjective data, weight, body-mass index ("BMI"), waist circumference, appropriate weight range, diet order, changes in pertinent medication, changes in pertinent medical/psychiatric problems, changes in nutritional problem(s), progress toward goals/objectives, effectiveness of interventions, changes in goals/plan, recommendations and follow-up as needed.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Recruit and retain additional staff dietitians for Nutrition Department.</p> <p>Findings: See D5.h, Findings for Recommendation 1 for information relating to this recommendation.</p> <p>Recommendation 2, November 2007: Continue current practice.</p> <p>Findings: According to facility report, 898 individuals were scheduled for type D.5.i assessments during the November 2007-April 2008 review period and 181 records were audited using the Nutrition Care Monitoring Tool (20%). This meets the sample size requirement of 20% or N=n if N less than 20.</p> <p>According to Nutrition Assessment audit data for the November 2007-April 2008 review period, 30% of assessments were completed on time, 95% had complete subjective findings, 87% had complete objective findings, 93% had a correctly formulated nutrition diagnosis, 88% had individualized and measurable goals and 76% had appropriate recommendations.</p> <p>Record review of a sample of individuals requiring type D.5.i</p>

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		<p>assessments during the November 2007-April 2008 review period found that 22% of assessments had not been completed, 39% of assessments were completed on time, 93% had complete subjective findings, 100% had complete objective findings, 100% had a correctly formulated nutrition diagnosis, 93% had individualized and measurable goals and 82% had appropriate recommendations.</p> <p>According to facility report, poor compliance with timeliness and completion of type D.5.i assessments is attributable to low staffing ratios.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Continue current practice.</p>
D.5.j.i	Individuals will be reassessed when there is a significant change in condition.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Recruit and retain additional staff dietitians for Nutrition Department.</p> <p>Findings: See D5.h, Findings for Recommendation 1 for information relating to this recommendation.</p> <p>Recommendation 2, November 2007: Continue current practice.</p> <p>Findings: According to facility report, 260 individuals were scheduled for type D.5.j.i assessments during the November 2007-April 2008 review period and 59 records were audited using the Nutrition Care</p>

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		<p>Monitoring Tool (23%). This meets the sample size requirement of 20% or N=n if N less than 20.</p> <p>According to Nutrition Assessment audit data for November 2007-April 2008, for type D.5.j.i referral assessments, 71% of assessments were completed on time, 86% had complete subjective findings, 80% had complete pertinent objective findings, 83% had a correctly formulated nutrition diagnosis, 85% had individualized and measurable goals and 73% had appropriate recommendations.</p> <p>Record review of a sample of individuals receiving type D.5.j.i assessments from the review period of November 2007-April 2008 found that 73% of assessments were completed on time, 82% had complete subjective findings, 91% had complete pertinent objective findings, 82% had a correctly formulated nutrition diagnosis, 45% had individualized and measurable goals and 82% had appropriate recommendations.</p> <p>According to facility report, Dietitians continue to receive referrals for significant weight changes and weight status. All significant weight changes and problems with weight status such as obesity are addressed during monthly weight monitoring, with review and contact note provided by the Dietitian and discussion by the WRPT as needed. Currently, response to referrals for significant weight changes appears to be affecting the timeliness of other assessment types and of higher acuity or priority referrals. In addition, these referrals appear to be redundant, as the current hospital process for monthly weight monitoring addresses significant weight changes and concerns regarding weight status without the need for referral.</p> <p>Compliance: Partial.</p>
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		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue current practice. 2. Ensure that referrals for type j.i assessments are sent and answered in accordance with facility procedures.
D.5.j.ii	Every individual will be assessed annually.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Recruit and retain additional staff dietitians for Nutrition Department.</p> <p>Findings: See D5.h, Findings for Recommendation 1 for information relating to this recommendation.</p> <p>Recommendation 2, November 2007: Continue current practice.</p> <p>Findings: According to facility report, 525 individuals were scheduled for type D.5.j.ii assessments during the November 2007-April 2008 review period and 106 records were audited using the Nutrition Care Monitoring Tool (20%). This meets the sample size requirement of 20% or N=n if N less than 20.</p> <p>According to Nutrition Assessment audit data for the November 2007-April 2008 review period, 35% of assessments were completed on time, 95% had complete subjective findings, 92% had complete objective findings, 97% had a correctly formulated nutrition diagnosis, 97% had individualized and measurable goals and 78% had appropriate recommendations.</p> <p>Record review of a sample of individuals with completed type D.5.j.ii assessments during the November 2007-April 2008 found that 59% of</p>

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		<p>assessments were not completed, 36% of assessments were completed on time, 89% had complete subjective findings, 100% had complete objective findings, 78% had a correctly formulated nutrition diagnosis, 78% had individualized and measurable goals and 78% had appropriate recommendations.</p> <p>According to facility report, poor compliance with timeliness and completion of type D.5.j.ii assessments is attributable to low staffing ratios.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Continue current practice.</p>
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6. Social History Assessments		
	<p>Each State hospital shall ensure that each individual has a social history evaluation that, consistent with generally accepted professional standards of care:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Doris Ayers, LCSW, Acting Supervising Social Worker 2. Rachel Strydom, LCSW, Acting Supervising Social Worker 3. Tiffany Rector, LCSW, Acting Supervising Social Worker 4. Veronica Kaufman, LCSW, Chief of Social Work <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Charts of the following 31 individuals: AAM, AP, AV, BW, CCB, DJ, DJB, DK, DLK, EL, GJ, JC, JEH, JVH, KF, KM, MR, NC, NHK, NMK, NSC, RCH, RF, RG, RLW, RS, SB, SD, SDP, SH, VM, VW, and WM 2. DMH Integrated Assessment: Social Work Section 3. DMH Integrated Assessment: Social Work Section Instructions 4. DMH 30-Day Psychosocial Assessment 5. DMH 30-Day Psychosocial Assessment Instructions 6. Social Work Assessment Monitoring form Instruction Sheet 7. PSH Progress Report Data 8. Family Education Assessment Tool <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPC for JJB (Program IV, unit 70) 2. WRPC for LBP (Program VI, unit EB12)
D.6.a	<p>Is, to the extent reasonably possible, accurate, current and comprehensive;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Ensure that the five-day and 30-day Social History Assessments are timely, accurate, and comprehensive.</p> <p>Findings: PSH audited items #1, #2, and #3 (see below) from the DMH Social</p>

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History Assessment Audit Form (5-Day) to address this recommendation, reporting 78%, 66%, and 85% compliance respectively. The table below with its monitoring indicators showing the number of Social Work Integrated Assessments due for the month (N), the number of Social Work Integrated Assessments audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

Is, to the extent reasonably possible accurate (#1), current (#2), and comprehensive (#3).

	2/08	3/08	4/08	Mean
N	99	110	91	
n	75	82	79	
%S	76	75	87	
%C #1	89	81	63	78
%C #2	93	55	51	66
%C #3	87	85	82	85

This monitor reviewed seven Social Work Integrated Assessments (DJ, GJ, JC, NSC, RG, VW and WM). Three of the Social Work Integrated Assessments in the charts (RG, VW and WM) were current, accurate and comprehensive. The remaining four (DJ, GJ, JC and NSC) were not current, accurate and/or comprehensive.

PSH also audited items #1, #2, and #3 (see below) from the DMH Social History Assessment Audit Form (30-Day) to address this recommendation, reporting 81%, 68%, and 80% compliance respectively. The table below with its monitoring indicators showing the number of Social Work Social History Assessments (30-Day) due for the month (N), the number of Social Work Social History Assessments audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

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		<p><i>Is to the extent reasonably possible accurate (#1), current (#2), and comprehensive (#3).</i></p> <table border="1" data-bbox="991 337 1759 609"> <thead> <tr> <th></th> <th>2/08</th> <th>3/08</th> <th>4/08</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>86</td> <td>102</td> <td>93</td> <td></td> </tr> <tr> <td>n</td> <td>26</td> <td>21</td> <td>15</td> <td></td> </tr> <tr> <td>%S</td> <td>30</td> <td>21</td> <td>16</td> <td></td> </tr> <tr> <td>%C #1</td> <td>73</td> <td>91</td> <td>80</td> <td>81</td> </tr> <tr> <td>%C #2</td> <td>77</td> <td>62</td> <td>60</td> <td>68</td> </tr> <tr> <td>%C #3</td> <td>69</td> <td>80</td> <td>100</td> <td>80</td> </tr> </tbody> </table> <p>This monitor reviewed seven Social Work Social History Assessments (DJ, GJ, JC, NSC, RG, VW and WM). Four of the Social Work Assessments in the charts (GJ, RG, VW and WM) were current, accurate, and comprehensive. The remaining three (DJ, JC and NSC) were not current, accurate, and/or comprehensive.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Ensure that the five-day and 30-day Social History Assessments are timely, accurate, and comprehensive.</p>		2/08	3/08	4/08	Mean	N	86	102	93		n	26	21	15		%S	30	21	16		%C #1	73	91	80	81	%C #2	77	62	60	68	%C #3	69	80	100	80
	2/08	3/08	4/08	Mean																																	
N	86	102	93																																		
n	26	21	15																																		
%S	30	21	16																																		
%C #1	73	91	80	81																																	
%C #2	77	62	60	68																																	
%C #3	69	80	100	80																																	
D.6.b	Expressly identifies factual inconsistencies among sources, resolves or attempts to resolve inconsistencies, and explains the rationale for the resolution offered;	<p>Current findings on previous recommendations:</p> <p>Recommendations 1-3, November 2007:</p> <ul style="list-style-type: none"> • Ensure that Social History assessments contain all relevant information. • Ensure that social workers identify and address the inconsistencies in current assessments. • Monitor factual inconsistencies in social histories and revise to 																																			

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		<p>correct the inconsistencies.</p> <p>Findings: PSH used items #4, #5, and #6 (see below) from the DMH Social History Assessment Audit Form (30-Day) to address this recommendation, reporting 85%, 85%, and 83% compliance respectively. The table below with its monitoring indicators showing the number of 30-Day Assessments due for the month (N), the number of 30-Day Assessments audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.</p> <p><i>Expressly identifies factual inconsistencies among sources (#4).</i></p> <p><i>Resolves or attempts to resolve inconsistencies (#5).</i></p> <p><i>Explains the rationale for the resolution offered (#6).</i></p> <table border="1" data-bbox="991 820 1755 1089"> <thead> <tr> <th></th> <th>2/08</th> <th>3/08</th> <th>4/08</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>86</td> <td>102</td> <td>93</td> <td></td> </tr> <tr> <td>n</td> <td>26</td> <td>21</td> <td>15</td> <td></td> </tr> <tr> <td>%S</td> <td>30</td> <td>21</td> <td>16</td> <td></td> </tr> <tr> <td>%C #4</td> <td>73</td> <td>95</td> <td>92</td> <td>85</td> </tr> <tr> <td>%C #5</td> <td>77</td> <td>91</td> <td>92</td> <td>85</td> </tr> <tr> <td>%C #6</td> <td>69</td> <td>95</td> <td>92</td> <td>83</td> </tr> </tbody> </table> <p>This monitor reviewed 11 charts (BW, CCB, DJB, DLK, GJ, JC, MR, NC, NSC, RG and WM). Factual inconsistencies were addressed and resolved in six of the assessments in the charts (BW, CCB, DJB, DLK, GJ and MR); factual inconsistencies in the remaining five assessments (JC, NC, NSC, RG and WM) were not addressed or when identified, resolutions were not offered.</p>		2/08	3/08	4/08	Mean	N	86	102	93		n	26	21	15		%S	30	21	16		%C #4	73	95	92	85	%C #5	77	91	92	85	%C #6	69	95	92	83
	2/08	3/08	4/08	Mean																																	
N	86	102	93																																		
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%C #5	77	91	92	85																																	
%C #6	69	95	92	83																																	

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		<p>Compliance: Partial.</p> <p>Current 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.
D.6.c	<p>Is included in the 7-day integrated assessment and fully documented by the 30th day of an individual's admission; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1 and 2, November 2007:</p> <ul style="list-style-type: none"> • Ensure that all social history integrated assessments are completed in a timely fashion and made available to the individual's WRPT before the seven-day WRPC. • Ensure that all 30-day social histories are completed and available to the individual's WRPT by the thirtieth day of admission. <p>Findings: PSH used items #7, #7a, and #7b (see below) from the DMH Social History Assessment Audit Form (5-Day) to address this recommendation, reporting 69%, 72%, and 92% compliance respectively. The table below with its monitoring indicators showing the number of 7-Day Integrated Assessments due for the month (N), the number of 7-Day Integrated Assessments audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.</p> <p><i>Is included in the 7-day integrated assessment (#7).</i></p> <p><i>The assessment was completed within five calendar days of the</i></p>

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individual's admission (#7a) and filed in the medical record (#7b).

	2/08	3/08	4/08	Mean
N	99	110	91	
n	75	94	89	
%S	76	82	98	
%C #7	76	73	60	69
%C #7.a	n/a	80	64	72
%C #7.b	n/a	91	93	92

This monitor reviewed seven Social Work Integrated Assessments (DJ, GJ, JC, NSC, RG, VW and WM). Three of them (RG, VW and WM) were timely and were filed in the medical record, and the remaining four were not timely (DJ, GJ, JC and NSC).

PSH used items #8, #8a, and #8b (see below) from the DMH Social History Assessment Audit Form (30-Day) to address this recommendation, reporting 62%, 69%, and 83% compliance respectively. The table below with its monitoring indicators showing the number of 30-Day Psychosocial History Assessments due for the month (N), the number of 30-Day Psychosocial History Assessments audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

Is fully documented by the 30th day of an individual's admission (#8).

Completed no earlier than the first work day after the 7-day WRPC and no later than the thirtieth calendar day after admission (#8a) and filed in the medical record (#8b).

	2/08	3/08	4/08	Mean
N	86	102	93	
n	26	26	25	

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		<table border="1"> <tr> <td>%S</td> <td>30</td> <td>25</td> <td>27</td> <td></td> </tr> <tr> <td>%C #8</td> <td>62</td> <td>69</td> <td>56</td> <td>62</td> </tr> <tr> <td>%C #8.a</td> <td>n/a</td> <td>69</td> <td>68</td> <td>69</td> </tr> <tr> <td>%C #8.b</td> <td>n/a</td> <td>95</td> <td>70</td> <td>83</td> </tr> </table>	%S	30	25	27		%C #8	62	69	56	62	%C #8.a	n/a	69	68	69	%C #8.b	n/a	95	70	83	
%S	30	25	27																				
%C #8	62	69	56	62																			
%C #8.a	n/a	69	68	69																			
%C #8.b	n/a	95	70	83																			
D.6.d	Reliably informs the individual's interdisciplinary team about the individual's relevant social factors and educational status.	<p>This monitor reviewed 20 charts (AAM, AP, AV, BW, CCB, DJ, DJB, GJ, JC, JEH, NC, NSC, RCH, RG, RLW, SB, SDP, VM, VW and WM) containing the 30-Day Psychosocial Assessments. Fourteen of the assessments (AAM, AP, AV, BW, DJ, DJB, GJ, JEH, RCH, RG, RLW, SDP, VM and WM) were timely and were filed in the medical record. Five were present but untimely (CCB, JC, NC, NSC and SB), and one (VW) was not present in the medical record.</p> <p>This monitor also reviewed 11 charts (DK, EL, JVH, KF, KM, NHK, RF, RS, SD, SH and VM) containing the 5-Day Integrated Assessment: Social Work section. Nine of the assessments (DK, EL, KF, NHK, RF, RS, SD, SH and VM) were timely, and two of them (JVH and KM) were untimely.</p> <p>Compliance: Partial.</p> <p>Current 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 individual's WRPT before the seven-day WRPC. 2. Ensure that all 30-day social histories are completed and available to the individual's WRPT by the 30th day of admission. 	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Ensure that social history assessments contain sufficient information</p>																				

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on the individual's social factors and educational status to reliably inform the individual's WRPT.

Findings:

PSH used items #10 and #10a (see below) from the DMH Social History Assessment Audit Form (5-Day) to address this recommendation, reporting 97% and 98% compliance respectively. The table below with its monitoring indicators showing the number of 5-Day Social Work Integrated Assessments due for the month (N), the number of 5-Day Social Work Integrated Assessments audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

Educational status (#10).

Education includes education level(s) by the individual and subject of any degrees or focus of any vocational training OR 'Unknown' is checked (#10a).

	2/08	3/08	4/08	Mean
N	99	110	91	
n	75	94	89	
%S	76	82	98	
%C #10	92	98	99	97
%C #10.a	n/a	98	99	98

PSH also used items #10, #10a, and #10b (see below) from the DMH Social History Assessment Audit Form (30-Day) to address this recommendation, reporting 49%, 44%, and 52% compliance respectively. The table below with its monitoring indicators showing the number of 30-Day Psychosocial History Assessments due for the month (N), the number of 30-Day Psychosocial History Assessments audited (n), and the percentage of compliance obtained (%C) is a

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		<p>summary of the facility's data.</p> <p><i>Educational status (#10).</i></p> <p><i>Education includes recommendations for learning accommodations and testing, or states if none are needed (#10a), and discusses the impact of the individual's education on his/her wellness and recovery (#10b).</i></p> <table border="1" data-bbox="991 483 1755 755"> <thead> <tr> <th></th> <th>2/08</th> <th>3/08</th> <th>4/08</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>86</td> <td>102</td> <td>93</td> <td></td> </tr> <tr> <td>n</td> <td>26</td> <td>21</td> <td>15</td> <td></td> </tr> <tr> <td>%S</td> <td>30</td> <td>21</td> <td>16</td> <td></td> </tr> <tr> <td>%C #10</td> <td>73</td> <td>40</td> <td>21</td> <td>49</td> </tr> <tr> <td>%C #10.a</td> <td>X</td> <td>55</td> <td>29</td> <td>44</td> </tr> <tr> <td>%C #10.b</td> <td>X</td> <td>50</td> <td>54</td> <td>52</td> </tr> </tbody> </table> <p>This monitor reviewed seven charts (DJ, GJ, MR, NSC, RG, VW and WM). Four of the seven Psychosocial History Assessments in the charts (GJ, RG, VW and WM) contained sufficient information on the individual's social factors and educational status to reliably inform the individual's WRPT. One of them (DJ) provided information on the individual's educational status but not the social factors. The remaining two (MR and NSC) did not provide information on the individuals' educational status or their social factors.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Ensure that social history assessments contain sufficient information on the individual's social factors and educational status to reliably inform the individual's WRPT.</p>		2/08	3/08	4/08	Mean	N	86	102	93		n	26	21	15		%S	30	21	16		%C #10	73	40	21	49	%C #10.a	X	55	29	44	%C #10.b	X	50	54	52
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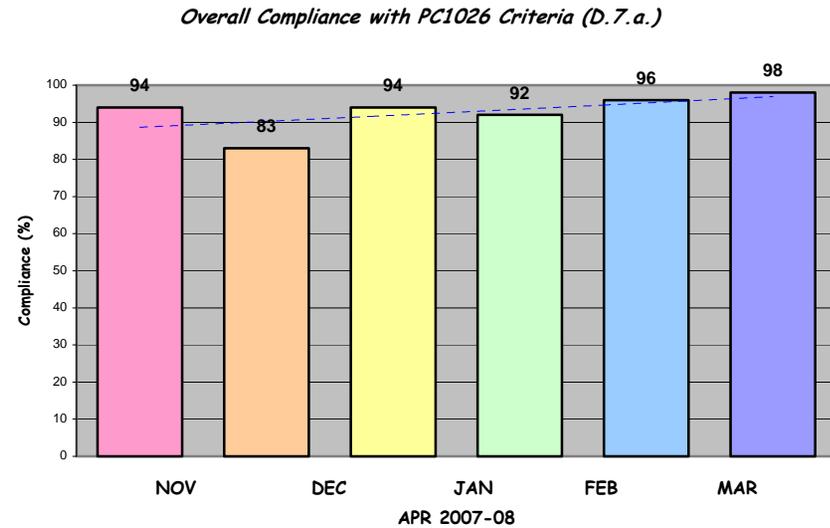
7. Court Assessments		
		<p>Methodology:</p> <p><u>Interviewed:</u> Ai-Li Arias, MD, Chair, Forensic Review Panel (FRP)</p> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Charts of the following six individuals who were admitted under PC 1026: AG, AT, JMK, RAD, RGS and VA 2. Charts of the following six individuals who were admitted under PC 1370: FLD, JS, LEM, SDR, SM and SRF) 3. DMH Manual for the Preparation of PC 1026 and PC 1370 Court Reports 4. Minutes of the FRP (November 2007 to April 2008) 5. Examples of e-mails containing feedback from FRP to WRPTs. 6. Court Report PC 1026 Audit Tool 7. Court Report PC 1026 summary data (November 2007 to April 2008) 8. Court Report PC 1370 Audit Tool 9. Court Report PC 1370 summary data (November 2007 to April 2008)
D.7.a	Each State hospital shall develop and implement policies and procedures to ensure an interdisciplinary approach to the development of court submissions for individuals adjudicated "not guilty by reason of insanity" ("NGI") pursuant to Penal Code Section 1026, based on accurate information, and individualized risk assessments. The forensic reports should include the following, as clinically indicated:	<p>Compliance: Substantial.</p>
D.7.a.i	clinical progress and achievement of stabilization of signs and symptoms of mental	<p>Current findings on previous recommendations:</p>

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	<p>illness that were the cause, or contributing factor in the commission of the crime (i.e., instant offense);</p>	<p>Recommendations 1, 2 and 3, November 2007:</p> <ul style="list-style-type: none"> • Continue current practice and ensure ongoing training of WRPTs regarding compliance with EP requirements. • Ensure that 1026 reports are written in a consistent format. • Continue to monitor this requirement based on a 100% sample. <p>Findings:</p> <p>PSH has continued to provide court report-writing training to all clinicians who write PC 1026 court reports. The next training will be offered on June 18, 2008. During this training, clinicians are given copies of the <i>DMH Manual for the Preparation of PC 1026 and PC 1370 Court Reports</i>, in which a PC 1026 court report template and sample report can be found.</p> <p>The clinicians who write these reports roughly follow the PC 1026 court report template, as it can be found on the shares drive of Patton State Hospital's intranet.</p> <p>The facility has continued to monitor 100% of the 1026 reports using the standardized DMH tool. The following details the number of reports reviewed by the FRP each month during this reporting period:</p> <table border="1" data-bbox="991 1003 1524 1273"> <thead> <tr> <th>Month</th> <th>Reports reviewed</th> </tr> </thead> <tbody> <tr> <td>November 2007</td> <td>100% (83/83)</td> </tr> <tr> <td>December 2007</td> <td>100% (91/91)</td> </tr> <tr> <td>January 2008</td> <td>100 % (67/67)</td> </tr> <tr> <td>February 2008</td> <td>100% (78/78)</td> </tr> <tr> <td>March 2008</td> <td>100% (99/99)</td> </tr> <tr> <td>April 2008</td> <td>100% (105/105)</td> </tr> </tbody> </table> <p>PSH reported an overall mean compliance rate of 93% for the requirements in this section (November 2007 to April 2008). The following demonstrates the compliance rates per month during this</p>	Month	Reports reviewed	November 2007	100% (83/83)	December 2007	100% (91/91)	January 2008	100 % (67/67)	February 2008	100% (78/78)	March 2008	100% (99/99)	April 2008	100% (105/105)
Month	Reports reviewed															
November 2007	100% (83/83)															
December 2007	100% (91/91)															
January 2008	100 % (67/67)															
February 2008	100% (78/78)															
March 2008	100% (99/99)															
April 2008	100% (105/105)															

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reporting period:



PSH reported that the decrease in compliance noted in December 2007 was due to the fact that many of the experienced court report-writers were promoted to senior positions, which left relatively inexperienced clinicians writing these reports. With feedback from the FRP, compliance rose above 90% in the following month.

The facility's mean compliance rate for this requirement was 97%.

Other findings:

This monitor reviewed the charts of six individuals who were admitted under PC 1026 (AG, AT, JMK, RAD, RGS and VA). The review found compliance in four charts (AT, JMK, RGS and VA) and partial compliance in two (AG and RAD).

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		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue current practice and ensure ongoing training of WRPTs regarding compliance with EP requirements. 2. Continue to monitor this requirement based on a 100% sample.
D.7.a.ii	acts of both verbal and physical aggression and property destruction during the past year of hospitalization and, if relevant, past acts of aggression and dangerous criminal behavior;	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Same as above.</p> <p>Findings: PSH reported a mean compliance rate of 96% for this requirement.</p> <p>Other findings: Chart reviews by this monitor found compliance in all six charts.</p> <p>Current recommendations: Same as above.</p>
D.7.a.iii	understanding of potential for danger and precursors of dangerous/criminal behavior, including instant offense;	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Same as above.</p> <p>Findings: The facility's mean compliance rate was 93%.</p> <p>Other findings: This monitor found compliance in four (AG, AT, RAD and RGS), partial compliance in one (VA) and noncompliance in one (JMK).</p> <p>Current recommendations: Same as above.</p>

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D.7.a.iv	<p>acceptance of mental illness and understanding of the need for treatment, both psychosocial and biological, and the need to adhere to treatment;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Same as above.</p> <p>Findings: PSH reported the following mean compliance rates:</p> <table border="1" data-bbox="993 488 1887 602"> <tr> <td>1.</td> <td><i>Acceptance of mental illness</i></td> <td>97%</td> </tr> <tr> <td>2.</td> <td><i>Understanding of the need for treatment</i></td> <td>98%</td> </tr> <tr> <td>3.</td> <td><i>Understanding of the need to adhere to treatment</i></td> <td>95%</td> </tr> </table> <p>Other findings: This monitor found compliance in four charts (AG, AT, RAD and VA) and partial compliance in two (JMK and RGS).</p> <p>Current recommendations: Same as above.</p>	1.	<i>Acceptance of mental illness</i>	97%	2.	<i>Understanding of the need for treatment</i>	98%	3.	<i>Understanding of the need to adhere to treatment</i>	95%
1.	<i>Acceptance of mental illness</i>	97%									
2.	<i>Understanding of the need for treatment</i>	98%									
3.	<i>Understanding of the need to adhere to treatment</i>	95%									
D.7.a.v	<p>development of relapse prevention plan (i.e., Personal Wellness Recovery Plan or Wellness Recovery Action Plan) for mental illness symptoms, including the individual's recognition of precursors and warning signs and symptoms and precursors for dangerous acts;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Same as above.</p> <p>Findings: The facility reported a mean compliance rate of 96%.</p> <p>Other findings: This monitor found compliance in all six charts.</p> <p>Current recommendations: Same as above.</p>									

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D.7.a.vi	willingness to achieve understanding of substance abuse issues and to develop an effective relapse prevention plan (as defined above);	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Same as above.</p> <p>Findings: The facility reported a mean compliance rate of 97%.</p> <p>Other findings: Chart reviews by this monitor found compliance in three charts (AG, AT and VA) and partial compliance in one (JMK). The requirements did not apply to the charts of RAD and RGS.</p> <p>Current recommendations: Same as above.</p>
D.7.a.vii	previous community releases, if the individual has had previous CONREP revocations;	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Same as above.</p> <p>Findings: The facility's mean compliance rate was 90%.</p> <p>Other findings: This monitor found compliance in all three charts to which this requirement applied (JMK, RAD and RGS).</p> <p>Current recommendations: Same as above.</p>
D.7.a.viii	social support, financial resources, family conflicts, cultural marginalization, and history	<p>Current findings on previous recommendation:</p>

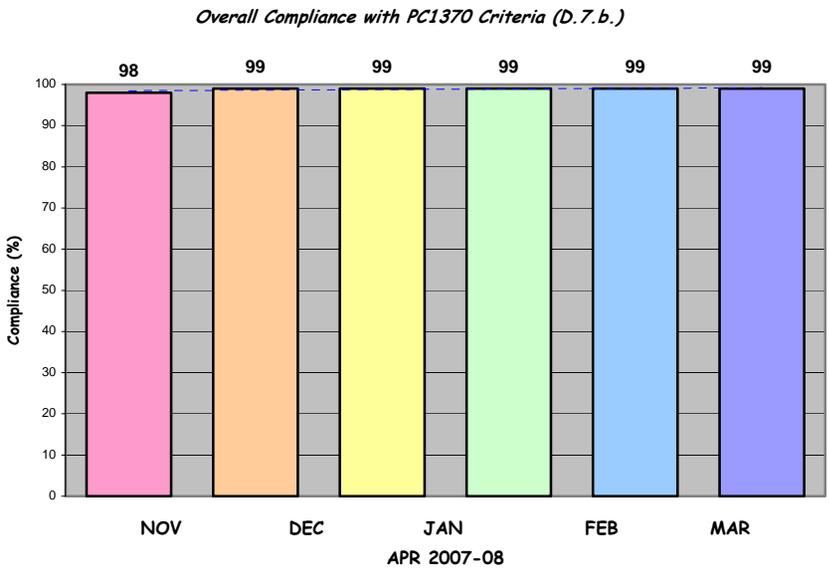
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	<p>of sexual and emotional abuse, if applicable; and</p>	<p>Recommendation, November 2007: Same as above.</p> <p>Findings: PSH reported a mean compliance rate of 85%.</p> <p>Other findings: This monitor found compliance in all six charts.</p> <p>Current recommendations: Same as above.</p>
D.7.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>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Same as above.</p> <p>Findings: PSH reported a mean compliance rate of 80%.</p> <p>Other findings: This monitor found compliance in all six charts.</p> <p>Current recommendations: Same as above.</p>
D.7.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</p>	<p>Compliance: Substantial. Continued compliance will require ongoing vigilance in preparing thoughtful, complete and detailed reports.</p>

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	<p>assessments. Consistent with the right of an individual accused of a crime to a speedy trial, the focus of the IST hospitalization shall be the stabilization of the symptoms of mental illness so as to enable the individual to understand the legal proceedings and to assist his or her attorney in the preparation of the defense. The forensic reports should include the following:</p>															
<p>D.7.b.i</p>	<p>relevant clinical description of initial presentation, if available, which caused the individual to be deemed incompetent to stand trial by the court;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Same as D.7.a.i (as applicable to PC 1370).</p> <p>Findings: Same as in D.7.a.i, relevant to 1370 reports. The following table outlines the number of 1370 reports reviewed by the FRP each month during this reporting period:</p> <table border="1" data-bbox="991 894 1526 1166"> <thead> <tr> <th>Month</th> <th>Reports reviewed</th> </tr> </thead> <tbody> <tr> <td>November 2007</td> <td>100% (106/106)</td> </tr> <tr> <td>December 2007</td> <td>100% (118/118)</td> </tr> <tr> <td>January 2008</td> <td>100 % (107/107)</td> </tr> <tr> <td>February 2008</td> <td>100% (120/120)</td> </tr> <tr> <td>March 2008</td> <td>100% (125/125)</td> </tr> <tr> <td>April 2008</td> <td>100% (120/120)</td> </tr> </tbody> </table> <p>PSH reported an overall mean compliance rate of 99% for the requirements in this section. The following demonstrates the trend in compliance during this reporting period:</p>	Month	Reports reviewed	November 2007	100% (106/106)	December 2007	100% (118/118)	January 2008	100 % (107/107)	February 2008	100% (120/120)	March 2008	100% (125/125)	April 2008	100% (120/120)
Month	Reports reviewed															
November 2007	100% (106/106)															
December 2007	100% (118/118)															
January 2008	100 % (107/107)															
February 2008	100% (120/120)															
March 2008	100% (125/125)															
April 2008	100% (120/120)															

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		<p style="text-align: center;"><i>Overall Compliance with PC1370 Criteria (D.7.b.)</i></p>  <table border="1" style="margin-left: auto; margin-right: auto;"> <caption>Overall Compliance with PC1370 Criteria (D.7.b.)</caption> <thead> <tr> <th>Month</th> <th>Compliance (%)</th> </tr> </thead> <tbody> <tr> <td>NOV</td> <td>98</td> </tr> <tr> <td>DEC</td> <td>99</td> </tr> <tr> <td>JAN</td> <td>99</td> </tr> <tr> <td>FEB</td> <td>99</td> </tr> <tr> <td>MAR</td> <td>99</td> </tr> </tbody> </table> <p style="text-align: center;">APR 2007-08</p> <p>Other findings: This monitor reviewed the charts of six individuals who were admitted under PC 1370 (FLD, JS, LEM, SDR, SM and SRF). The review found compliance in five charts (FLD, JS, LEM, SDR and SRF) and partial compliance in one (SM).</p> <p>Current recommendations: Same as above.</p>	Month	Compliance (%)	NOV	98	DEC	99	JAN	99	FEB	99	MAR	99
Month	Compliance (%)													
NOV	98													
DEC	99													
JAN	99													
FEB	99													
MAR	99													
D.7.b.ii	clinical description of the individual at the time of admission to the hospital;	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Same as above.</p> <p>Findings: PSH reported a mean compliance rate of 100%.</p>												

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		<p>Other findings: This monitor found compliance in all six charts reviewed.</p> <p>Current recommendations: Same as above.</p>												
D.7.b.iii	<p>course of hospital stay, describing any progress or lack of progress, response to treatment, current relevant mental status, and reasoning to support the recommendation; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Same as above.</p> <p>Findings: PSH reported the following mean compliance rates:</p> <table border="1" data-bbox="991 711 1890 865"> <tr> <td>1.</td> <td><i>Description of any progress or lack of progress</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>Individual's response to treatment</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>Current relevant mental status</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Reasoning to support the recommendations</i></td> <td>97%</td> </tr> </table> <p>Other findings: This monitor found compliance in three charts (FLD, SM and SRF) and partial compliance in three (JS, LEM and SDR).</p> <p>Current recommendations: Same as above.</p>	1.	<i>Description of any progress or lack of progress</i>	100%	2.	<i>Individual's response to treatment</i>	100%	3.	<i>Current relevant mental status</i>	100%	4.	<i>Reasoning to support the recommendations</i>	97%
1.	<i>Description of any progress or lack of progress</i>	100%												
2.	<i>Individual's response to treatment</i>	100%												
3.	<i>Current relevant mental status</i>	100%												
4.	<i>Reasoning to support the recommendations</i>	97%												
D.7.b.iv	<p>all self-harm behaviors and relevant medical issues, to inform the courts and the facility where the individual will be housed after discharge.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Same as above.</p> <p>Findings: The facility reported a mean compliance rate of 97%.</p>												

Section D: Integrated Assessments

		<p>Other findings: This monitor found compliance in five charts (FLD, JS, LEM, SM and SRF) and partial compliance in one (SDR).</p> <p>Current recommendations: Same as above.</p>
D.7.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>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: The Chair of the FRP should have supervisory responsibilities and administrative support to ensure coordination of the FRP process, tracking of the status of all PC 1370 and 1026 reports, prioritization of reports for review by the FRP, keeping minutes of the FRP meetings and provision of feedback to psychiatrists (and other clinicians) and follow-up corrective actions. These essential enhancements would ensure that a full array of forensic services that meet generally accepted professional standards are provided in the California DMH State Hospitals.</p> <p>Findings: The Chair of the FRP has been assigned supervisory status as of September 2007. However, the facility has yet to provide administrative support to facilitate completion of the tasks outlined in the recommendation.</p> <p>Other findings: PSH has maintained a functional FRP that provides oversight of forensic services, including the review and approval of all forensic submissions by the WRPTs.</p> <p>Compliance: Substantial.</p>

Section D: Integrated Assessments

		<p>Current recommendations: The Chair of the FRP should have supervisory responsibilities and administrative support to ensure coordination of the FRP process, tracking of the status of all PC 1370 and 1026 reports, prioritization of reports for review by the FRP, keeping minutes of the FRP meetings and provision of feedback to psychiatrists (and other clinicians) and follow-up corrective actions. These essential enhancements would ensure that a full array of forensic services that meet generally accepted professional standards are provided in the California DMH State Hospitals.</p>
D.7.c.i	<p>The membership of the FRP shall include Director of Forensic Psychiatry, Facility Director or designee, Medical Director or designee, Chief of Psychology or designee, Chief of Social Services or designee, Chief of Nursing Services or designee, and Chief of Rehabilitation Services or designee. The Director of Forensic Psychiatry shall serve as the chair and shall be a board certified forensic psychiatrist. A quorum shall consist of a minimum of four FRP members or their designee.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Continue current practice.</p> <p>Findings: PSH has maintained current practice regarding this requirement.</p> <p>Compliance: Substantial.</p> <p>Current recommendations: Continue current practice.</p>

Section E: Discharge Planning and Community Integration

E. Discharge Planning and Community Integration		
		<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. PSH has identified and implemented Focus Advisors and Focus Coordinators for Focus 11 (Community Integration). 2. PSH now has assigned a mentor to each WRPT to assist with improving the process and procedures of the WRPCs. 3. PSH has developed a "Resource Identification" algorithm to assist individuals with needed resources upon transition to the new setting. 4. PSH has established a Clothing Room where individuals can choose from a variety of clothing to "improve their image and quality of life" when leaving the facility. 5. PSH has implemented the family education sessions to enable family-individual integration and improve the odds of maintenance in the new setting.
E	<p>Taking into account the limitations of court-imposed confinement, the State shall pursue actively the appropriate discharge of individuals under the State's care at each State hospital and, subject to legal limitations on the state's control of the placement process, provide services in the most integrated, appropriate setting in which they reasonably can be accommodated, as clinically appropriate, that is consistent with each individual's needs.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Doris Ayers, LCSW, Acting Supervising Social Worker 2. Rachel Strydom, LCSW, Acting Supervising Social Worker 3. Tiffany Rector, LCSW, Acting Supervising Social Worker 4. Veronica Kaufman, LCSW, Chief of Social Work <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Charts of the following 39 individuals: AR, AV, BGW, BT, BW, CCB, DJB, DL, DMK, DR, JAS, JBB, JD, JGC, JJ, JJB, JP, KAZ, LB, LBP, LLH, LQ, MHK, MK, NC, NM, NMM, NWJ, OC, OL, PHL, PLA, PT, RD, RF, RKS, RP, RPV, and SDC 2. Community Integration Lesson Plans (Focus 11) 3. Community Integration Training 4. CONREP Contact Information List 5. Discharge Planning and Community Integration Training Module

Section E: Discharge Planning and Community Integration

		<ol style="list-style-type: none"> 6. List of community resource forms 7. List of individuals assessed to need family education 8. List of individuals who met discharge criteria and are still hospitalized. 9. PSH Progress Report (November 2007 to April 2008). <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPC for JJB (Program IV, unit 70) 2. WRPC for LBP (Program VI, Unit EB12) 3. Collaborative Recovery Mall Group 4. Relaxation Mall Group 5. Anti-Social—Face It and Pace It Mall Group 6. Mood Management Mall Group
E.1	<p>Each State hospital shall identify at the 7-day therapeutic and rehabilitation service planning conference, and address at all subsequent planning conferences, the particular considerations for each individual bearing on discharge, including:</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Achieve continuity of the discharge process from admission to discharge through the WRP and WRPT process.</p> <p>Findings: PSH used items #10, #10a, and #10b (see below) from the DMH WRP Observation Monitoring Form to address this recommendation, reporting 3%, 18%, and 0% compliance respectively. The table below with its monitoring indicators showing the number of WRPCs due each month (N), the number of WRPCs observed (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.</p> <p><i>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(#10)</i></p> <p><i>The team reviews all Foci that are barriers to discharge (#10a).</i></p>

Section E: Discharge Planning and Community Integration

The team reviews the PSR Mall Facilitator's Monthly Notes for all objectives related to discharge (#10b).

	11/07	12/07	1/08	2/08	3/08	4/08	Mean
N	1616	1604	1759	1721	1753	1760	
n	147	149	194	185	207	180	
%S	9	9	11	11	12	10	
%C							
10.	1	9	5	2	3	3	3
10.a	17	16	19	17	25	22	18
10.b	0	0	0	1	0	1	0

This monitor observed two WRPCs (JJB and LPB). Both teams reviewed the individual's discharge criteria. However, the teams were not able to use any quantitative/qualitative data to determine the individual's progress towards discharge because the teams did not have progress notes with sufficient information to make such discussions and decisions.

This monitor also reviewed eight charts (BW, CCB, DJB, JAS, LB, MK, NC and NM). None of the WRPs in the charts discussed the individual's progress/barriers to discharge for each discharge criteria. There was no documented quantitative/qualitative integration of information from the Monthly Mall Progress Notes in the Present Status section.

Recommendation 2, November 2007:

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).

Findings:

PSH used items #6, #6a, #6b, #6c, and #6d (see below) from the DMH

Section E: Discharge Planning and Community Integration

		<p>WRP Observation Monitoring Form to address this recommendation, reporting 2%, 8%, 2%, 17%, and 22% compliance respectively. The table below with its monitoring indicators showing the number of WRPCs due each month (N), the number of WRPCs observed (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.</p> <p><i>Individuals have substantive input into the therapeutic and rehabilitation service planning process, including but not limited to input as to mall groups and therapies appropriate to their WRP (#6).</i></p> <p><i>The WRPT asks the individual for his or her input into the evaluation of progress on each objective, as clinically indicated (#6a).</i></p> <p><i>When the individual has achieved an objective, at the current WRPC, the WRPT discusses with the individual the groups available for the next objective. The individual makes a choice from several equivalent options (#6b)</i></p> <p><i>The WRPT reviews the By Choice points, preferences and allocation with the individual. The individual determines how he or she will allocate the points between WRPCs (#6c).</i></p> <p><i>When the individual identifies cultural preferences, the team updates the case formulation and may incorporate them into the individual's WRP objectives and interventions, as relevant (#6d).</i></p> <table border="1" data-bbox="989 1149 1908 1421"> <thead> <tr> <th></th> <th>11/07</th> <th>12/07</th> <th>1/08</th> <th>2/08</th> <th>3/08</th> <th>4/08</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>1616</td> <td>1604</td> <td>1759</td> <td>1721</td> <td>1753</td> <td>1760</td> <td></td> </tr> <tr> <td>n</td> <td>147</td> <td>149</td> <td>194</td> <td>185</td> <td>207</td> <td>180</td> <td></td> </tr> <tr> <td>%S</td> <td>9</td> <td>9</td> <td>11</td> <td>11</td> <td>12</td> <td>10</td> <td></td> </tr> <tr> <td>%C</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>6.</td> <td>0</td> <td>0</td> <td>1</td> <td>2</td> <td>2</td> <td>5</td> <td>2</td> </tr> <tr> <td>6.a</td> <td>21</td> <td>7</td> <td>10</td> <td>7</td> <td>8</td> <td>7</td> <td>8</td> </tr> </tbody> </table>		11/07	12/07	1/08	2/08	3/08	4/08	Mean	N	1616	1604	1759	1721	1753	1760		n	147	149	194	185	207	180		%S	9	9	11	11	12	10		%C								6.	0	0	1	2	2	5	2	6.a	21	7	10	7	8	7	8
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6.a	21	7	10	7	8	7	8																																																			

Section E: Discharge Planning and Community Integration

		6.b	1	0	3	3	2	0	2
		6.c	22	6	5	22	30	24	17
		6.d	4	4	15	24	18	24	22
		<p>This monitor observed two WRPCs (JJB and LPB). Both teams followed the sequence of steps in an organized manner and functioned in an interdisciplinary manner. However, the individuals chose not to participate in their WRPCs. Thus, this monitor was unable to evaluate the teams' ability to involve the individual during the conference.</p> <p>This monitor reviewed nine charts (BW, CCB, DJB, JAS, LB, MK, NC, NM and NMM). Documentation in two of WRPs in the charts (DJB and NMM) showed that the individuals participated in the conference and the remaining seven (BW, CCB, JAS, LB, MK, NC and NM) did not.</p> <p>Recommendation 3, November 2007: Social workers must review discharge status with the WRPT and the individual at all scheduled WRPCs involving the individual.</p> <p>Findings: This monitor's interview with the Chief of Social Work found that PSH has assigned mentors to WRPTs to provide feedback to improve the WRPC process and functioning.</p> <p>This monitor observed two WRPCs (JJB and LPB). There was a Social Work staff member in one team (JJB), and the SW staff actively participated in the conference and presented information regarding the individual's discharge status. The other team did not have a Social Work staff member in attendance.</p> <p>This monitor reviewed 10 charts (DL, JAS, JBB, JJB, LB, LBP, MK, NM, OC and RPV). Three of the WRPs in the charts (LB, MK and NM) contained documentation to show that discharge status was reviewed</p>							

Section E: Discharge Planning and Community Integration

		<p>with the individual at the conference. The remaining seven (DL, JAS, JBB, JJB, LBP, OC and RPV) did not have such documentation.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Achieve continuity of the discharge process from admission to discharge through the WRP and WRPT 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 WRPT and the individual at all scheduled WRPCs involving the individual.
E.1.a	those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Ensure that the individual's strengths and preferences are utilized to achieve discharge goals. These should be linked to the interventions that impact the individual's discharge criteria.</p> <p>Findings: PSH used items #1, #1a, and #1b (see below) from the DMH WRP Discharge Planning & Community Integration Auditing Form to address this recommendation, reporting 2%, 14%, and 7% compliance respectively. The table below with its monitoring indicators showing the number of WRPCs due each month (N), the number of WRPCs observed (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.</p> <p><i>Those factors that likely would foster successful discharge, including the</i></p>

Section E: Discharge Planning and Community Integration

		<p><i>individual's strengths, preferences and personal life goals (#1).</i></p> <p><i>There is at least one objective aligned with the individual's personal life goals that are stated on the first pages of the WRP (#1a).</i></p> <p><i>The interventions will use the individual's strengths and preferences to achieve the respective objective (1b).</i></p> <table border="1" data-bbox="991 485 1906 792"> <thead> <tr> <th></th> <th>11/07</th> <th>12/07</th> <th>1/08</th> <th>2/08</th> <th>3/08</th> <th>4/08</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>1222</td> <td>1262</td> <td>1300</td> <td>1246</td> <td>1268</td> <td>1263</td> <td></td> </tr> <tr> <td>n</td> <td>52</td> <td>15</td> <td>30</td> <td>43</td> <td>159</td> <td>201</td> <td></td> </tr> <tr> <td>%S</td> <td>4</td> <td>1</td> <td>2</td> <td>10</td> <td>13</td> <td>16</td> <td></td> </tr> <tr> <td>%C</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>1.</td> <td>8</td> <td>20</td> <td>3</td> <td>0</td> <td>3</td> <td>2</td> <td>2</td> </tr> <tr> <td>1.a</td> <td>X</td> <td>43</td> <td>23</td> <td>35</td> <td>10</td> <td>10</td> <td>14</td> </tr> <tr> <td>1.b</td> <td>X</td> <td>21</td> <td>3</td> <td>7</td> <td>4</td> <td>8</td> <td>7</td> </tr> </tbody> </table> <p>This monitor reviewed 10 charts (JAS, LB, LBP, MK, NM, NMM, NWJ, PHL, RF and RKS). None of the WRPs in the charts had appropriate strengths identified in the intervention sections. Many of them did not have any strengths stated (NWJ, PHL and RKS). In other cases, the same statements were repeated multiple times within and between WRPs (for example, "desire to get out of PSH"), for example LBP, NMM and RF.</p> <p>Recommendation 2, November 2007: The individual's life goals should be linked to one or more focus/foci of hospitalization, with associated objectives and interventions.</p> <p>Findings: This monitor reviewed seven charts (JAS, JJB, LB, MK, NM, RKS and RPV). None of the WRPs in the charts had a focus of hospitalization with associated objectives and interventions linked to the individual's life goals.</p>		11/07	12/07	1/08	2/08	3/08	4/08	Mean	N	1222	1262	1300	1246	1268	1263		n	52	15	30	43	159	201		%S	4	1	2	10	13	16		%C								1.	8	20	3	0	3	2	2	1.a	X	43	23	35	10	10	14	1.b	X	21	3	7	4	8	7
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		<p>Recommendation 3, November 2007: Ensure that the individual's current WRP satisfies the necessary conditions to successfully meet discharge criteria.</p> <p>Findings: This monitor reviewed six charts (AJV, JJB, JP, MHK, OC and RKS). The documentation in all six WRPs had a number of weaknesses. Many of them did not have appropriate interventions that facilitators can utilize to help individuals achieve their discharge goals. In some, the same objectives were written across foci (for example, JJB), discharge criteria are not observable/measurable (for example, JP), the same statements were entered as objectives and interventions (JJB), and in others the case formulation was poor. For example, the Present Status section in RKS's WRP contained numerous conflicting statements, including:</p> <ul style="list-style-type: none"> • "She knows her crime, illness, and symptoms . . ." • "She has no insight into her illness and their relationship to crime . . ." • "Patient was in altercation" • "She has not been into altercation with her peers . . ." • "She attends her groups with FP" • "She has been attending her groups with minimal participation" <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the individual's strengths and preferences are utilized to achieve discharge goals. These should be linked to the interventions that impact the individual's discharge criteria. 2. The individual's life goals should be linked to one or more focus/foci of hospitalization, with associated objectives and interventions.
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Section E: Discharge Planning and Community Integration

		<p>3. Ensure that the individual's current WRP satisfies the necessary conditions to successfully meet discharge criteria.</p>																																																
E.1.b	the individual's level of psychosocial functioning;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Ensure that the level of psychosocial functioning (functional status) is included in the individual's present status section of the case formulation section of the WRP.</p> <p>Findings: PSH used items #2, #2a, and #2b (see below) from the DMH WRP Discharge Planning & Community Integration Auditing Form to address this recommendation, reporting 28%, 56%, and 28% compliance respectively. The table below with its monitoring indicators showing the number of WRPCs due each month (N), the number of WRPCs observed (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.</p> <p><i>The individual's level of psychosocial functioning (#2).</i></p> <p><i>The individual's level of psychosocial functioning is mentioned in the present status (#2a).</i></p> <p><i>The interventions linked to discharge criteria are provided at the level of the individual's psycho-social functioning (#2b).</i></p> <table border="1" data-bbox="991 1192 1906 1421"> <thead> <tr> <th></th> <th>11/07</th> <th>12/07</th> <th>1/08</th> <th>2/08</th> <th>3/08</th> <th>4/08</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>1222</td> <td>1262</td> <td>1300</td> <td>1246</td> <td>1268</td> <td>1263</td> <td></td> </tr> <tr> <td>n</td> <td>52</td> <td>15</td> <td>30</td> <td>43</td> <td>160</td> <td>203</td> <td></td> </tr> <tr> <td>%S</td> <td>4</td> <td>1</td> <td>2</td> <td>10</td> <td>13</td> <td>16</td> <td></td> </tr> <tr> <td>%C</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>2.</td> <td>54</td> <td>20</td> <td>13</td> <td>51</td> <td>18</td> <td>31</td> <td>28</td> </tr> </tbody> </table>		11/07	12/07	1/08	2/08	3/08	4/08	Mean	N	1222	1262	1300	1246	1268	1263		n	52	15	30	43	160	203		%S	4	1	2	10	13	16		%C								2.	54	20	13	51	18	31	28
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Section E: Discharge Planning and Community Integration

		2.a	X	14	30	65	39	73	56
		2.b	X	13	13	58	14	35	28
		<p>This monitor reviewed eight charts (BT, JAS, JP, LB, LQ, MK, NM and RP). Five of the eight WRPs in the charts (BT, JP, LQ, NM and RP) included the individual's level of psychosocial functioning in the Present Status section. The remaining three (JAS, LB and MK) did not adequately address the individual's psychosocial functioning.</p> <p>Recommendation 2, November 2007: Ensure that team members are aware of and trained in elements to consider in updating GAF scores.</p> <p>Findings: This monitor's interview of the Chief of Social Work found that PSH plans on including this recommendation in the discharge planning and community integration training module, in addition to consulting with the medical staff to determine approaches to training and implementation.</p> <p>This monitor observed two WRPCs (JJB and LPB). In both cases, the WRPTs discussed the individual's GAF scores. In one case, the team went about the process systematically with the psychiatrist looking up the GAF score scale and having the team members discuss the individual's functional behaviors. The psychiatrist then identified the score that best fit the summary of the functional behaviors presented by the team, and helped to document in the Present Status section. This is a good process that all teams across the facilities may want to follow. The process is educational to the other team members, matches the individual's behaviors to his/her functions, specifies the level of GAF scores and clarifies proper documentation.</p> <p>Compliance: Partial.</p>							

Section E: Discharge Planning and Community Integration

		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the level of psychosocial functioning (functional status) is included in the individual's present status section of the case formulation section of the WRP. 2. Ensure that team members are aware of and trained in elements to consider in updating GAF scores.
E.1.c	<p>any barriers preventing the individual from transitioning to a more integrated environment, especially difficulties raised in previously unsuccessful placements; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, November 2007:</p> <ul style="list-style-type: none"> • Ensure that discharge barriers, especially difficulties in previously unsuccessful placements, are discussed with the individual at scheduled WRPCs. • Include all skills training and supports in the WRP so that the individual can overcome barriers and meet discharge criteria. <p>Findings:</p> <p>PSH used items #3, #3a, and #3b (see below) from the DMH WRP Discharge Planning & Community Integration Auditing Form to address this recommendation, reporting 7%, 44%, and 7% compliance respectively. The table below with its monitoring indicators showing the number of WRPCs due each month (N), the number of quarterly WRPC observed (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.</p> <p><i>Any barriers preventing the individual from transitioning to a more integrated environment, especially difficulties raised in previously unsuccessful placements (#3).</i></p> <p><i>The individual's barriers to discharge including difficulties encountered in previous placement are mentioned in the present status section of the WRP (#3a).</i></p>

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These barriers, if any, are listed in focus 11 with the appropriate objective interventions (#3b).

	11/07	12/07	1/08	2/08	3/08	4/08	Mean
N	1222	1262	1300	1246	1268	1263	
n	52	15	30	43	159	201	
%S	4	1	2	10	13	16	
%C							
3.	23	13	17	9	8	3	7
3.a	X	14	55	49	51	36	44
3.b	X	13	16	9	7	5	7

This monitor reviewed nine charts (BT, JAS, JBB, JP, LB, LQ, MK, NM and RP). Three of the WRPs in the charts (LB, LQ and MK) contained documentation that discharge barriers were discussed with the individual. The remaining six (BT, JAS, JBB, JP, NM and RP) did not.

This monitor did not get the opportunity to observe this aspect of the WRPC process, because the individuals who were the subjects of the conferences attended by this monitor refused to participate in their WRPCs (JJB and LPB).

This monitor reviewed eight charts (JAS, JP, LB, LQ, MK, NM, PT and RP). In three of the cases (LQ, NM and PT), each discharge barrier had an objective and an intervention to provide the skills or supports needed to overcome the discharge barrier. The remaining five (JAS, JP, LB, MK and RP) failed to address all the skills and supports the individual needed to overcome the discharge barriers.

Compliance:
Partial.

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		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that discharge barriers, especially difficulties in previously unsuccessful placements, are discussed with the individual at scheduled WRPCs. 2. Include all skills training and supports in the WRP so that the individual can overcome barriers and meet discharge criteria.
E.1.d	<p>the skills and supports necessary to live in the setting in which the individual will be placed.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1-3, November 2007:</p> <ul style="list-style-type: none"> • Assess the skills and supports that will be needed by the individual for a successful transition to the identified setting. • Include these skills and supports in the individual's WRP and use this information to guide appropriate services for the individual. • Ensure that WRPT members focus on this requirement and update the individual's WRP as necessary. <p>Findings:</p> <p>PSH used items #4, #4a, and #4b (see below) from the DMH WRP Discharge Planning & Community Integration Auditing Form to address this recommendation, reporting 10%, 15%, and 21% compliance respectively. The table below with its monitoring indicators showing the number of WRPCs due each month (N), the number of quarterly WRPC observed (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.</p> <p><i>The skills and supports necessary to live in the setting in which the individual will be placed (#4).</i></p> <p><i>Present status section includes the anticipated discharge placement (#4a).</i></p> <p><i>Scheduled PSR groups listed in the interventions include skills and</i></p>

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		<p><i>supports the individual will need in the anticipated placement. (#4b).</i></p> <table border="1" data-bbox="991 264 1906 573"> <thead> <tr> <th></th> <th>11/07</th> <th>12/07</th> <th>1/08</th> <th>2/08</th> <th>3/08</th> <th>4/08</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>1222</td> <td>1262</td> <td>1300</td> <td>1246</td> <td>1268</td> <td>1263</td> <td>1222</td> </tr> <tr> <td>n</td> <td>52</td> <td>15</td> <td>30</td> <td>43</td> <td>159</td> <td>201</td> <td>52</td> </tr> <tr> <td>%S</td> <td>4</td> <td>1</td> <td>2</td> <td>10</td> <td>13</td> <td>16</td> <td>4</td> </tr> <tr> <td>%C</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>4.</td> <td>8</td> <td>13</td> <td>3</td> <td>5</td> <td>6</td> <td>16</td> <td>10</td> </tr> <tr> <td>4.a</td> <td>X</td> <td>21</td> <td>7</td> <td>9</td> <td>8</td> <td>23</td> <td>15</td> </tr> <tr> <td>4.b</td> <td>X</td> <td>14</td> <td>17</td> <td>5</td> <td>14</td> <td>30</td> <td>21</td> </tr> </tbody> </table> <p>This monitor reviewed eight charts (BT, JAS, JP, LB, LQ, MK, NM and RP). Two of the WRPs (BT and LQ) had documentation on the individual's needed skills and support. The information was included in the WRP and had objectives and interventions for the individual to achieve the skills and supports necessary. The remaining six (JAS, JP, LB, MK, NM and RP) did not have the skills and/or the supports needed for the individual's successful transition to the identified setting.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Assess the skills and supports that will be needed by the individual for a successful transition to the identified setting. 2. Include these skills and supports in the individual's WRP and use this information to guide appropriate services for the individual. 3. Ensure that WRPT members focus on this requirement and update the individual's WRP as necessary. 		11/07	12/07	1/08	2/08	3/08	4/08	Mean	N	1222	1262	1300	1246	1268	1263	1222	n	52	15	30	43	159	201	52	%S	4	1	2	10	13	16	4	%C								4.	8	13	3	5	6	16	10	4.a	X	21	7	9	8	23	15	4.b	X	14	17	5	14	30	21
	11/07	12/07	1/08	2/08	3/08	4/08	Mean																																																											
N	1222	1262	1300	1246	1268	1263	1222																																																											
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4.b	X	14	17	5	14	30	21																																																											
E.2	Each State hospital shall ensure that, beginning at the time of admission and continuously throughout the individual's stay, the individual is an active	Current findings on previous recommendations:																																																																

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participant in the discharge planning process, to the fullest extent possible, given the individual's level of functioning and legal status.

Recommendation 1, November 2007:

Ensure that the individual is an active participant in the discharge planning process.

Findings:

PSH used items #12, #12a, and #12b (see below) from the DMH WRP Observation Monitoring Form to address this recommendation, reporting 7%, 10%, and 17% compliance respectively. The table below with its monitoring indicators showing the number of WRPCs due each month (N), the number of quarterly WRPC observed (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

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 (#12).

The WRPT asks the individual for his or her input into the evaluation of progress on each objective related to discharge (#12a).

The WRPT asks the individual if he or she is able to easily understand the materials presented in the PSR Mall groups or individual therapy that are related to the discharge criteria (#12b).

	11/07	12/07	1/08	2/08	3/08	4/08	Mean
N	1616	1604	1759	1721	1753	1760	
n	152	148	176	163	188	159	
%S	9	9	10	9	11	9	
%C							
12.	8	4	12	6	5	5	7
12.a	9	8	16	10	9	7	10
12.b	11	6	17	10	23	29	17

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		<p>This monitor reviewed nine charts (BT, JAS, JP, KAZ, LB, LLH, MK, NM and RP). Two of the WRPs in the charts (NM and BT) had documentation to show that the individual was an active participant in the discharge process. The remaining seven (JAS, JP, KAZ, LB, LLH, MK and RP) did not.</p> <p>Recommendation 2, November 2007: Prioritize objectives and interventions related to the discharge process.</p> <p>Findings: This monitor reviewed eight charts (BT, JAS, JP, LB, LQ, MK, NM and RP). Five of the WRPs in the charts (BT, LB, LQ, MK and NM) prioritized the objectives and interventions related to the discharge process. The remaining three (JAS, JP, and RP) did not.</p> <p>Recommendation 3, November 2007: Ensure that the individual understands all of the discharge requirements before leaving the WRPC.</p> <p>Findings: This monitor reviewed eight charts (BT, JP, LBP, LQ, NWJ, RF, RP and RPV). Two WRPs in the charts (BT and LQ) discussed the individual's response to discharge matters. The remaining six (JP, LBP, NWJ, RF, RP and RPV) did not.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the individual is an active participant in the discharge planning process. 2. Prioritize objectives and interventions related to the discharge process.
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		<p>3. Ensure that the individual understands all of the discharge requirements before leaving the WRPC.</p>
<p>E.3</p>	<p>Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge considerations, and that includes:</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Continue and strengthen training to WRPTs to ensure consistent implementation of this requirement.</p> <p>Findings: This monitor's documentation review (training documents and PSH's progress report) and interview of the Chief of Social Work found that WRPTs received training on addressing the discharge process in the WRPC and documenting conference findings appropriately. The discipline mentors started their mentoring with WRPTs after receiving training with Dr. Ronald Boggio in January 2008. The Social Work staff also attended training in March 2008.</p> <p>Recommendation 2, November 2007: 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).</p> <p>Findings: This monitor's review of information found that this recommendation is addressed through item C.2.b.iii in the DMH WRP Clinical Chart Auditing Form ("The WRP was reviewed and revised as per WRP schedule"). 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 twelfth monthly review is the annual review.</p>

		<p>Recommendation 3, November 2007: 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.</p> <p>Findings: This monitor's chart reviews found that, as presented in the various recommendations in this section, the discharge planning process in most cases does not meet the standards of the DMH WRP criteria or the EP. PSH's own findings, as presented in its progress report, are in close agreement with this monitor's findings. For example, PSH reported a mean of 0% compliance for item #8 (<i>The case formulation enables the interdisciplinary teams 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</i>).</p> <p>A number of common deficits were evident in the WRPs reviewed:</p> <ol style="list-style-type: none"> 1. The Present Status section is not regularly updated and the information not well presented. 2. Discharge criteria are not written in an observable/measurable manner. 3. Objectives generally do not include all the required elements, including how the outcome is to be measured. 4. The match between focus and objectives is weak. 5. The match between objectives and interventions is weak. 6. The interventions do not consistently identify the best environment for the individual to build the skills and supports necessary to overcome the discharge barriers. <p>A focus and emphasis on these elements would help the teams develop a proper discharge plan for the individual.</p>
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		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue and strengthen training to WRPTs 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.
E.3.a	measurable interventions regarding these discharge considerations:	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Write all interventions, including those dealing with discharge criteria, in behavioral and measurable terms as outlined in the DMH WRP Manual.</p> <p>Findings: PSH used items #6, #6a, and #6b (see below) from the DMH WRP Discharge Planning & Community Integration Auditing Form to address this recommendation, reporting 12%, 34%, and 28% compliance respectively. The table below with its monitoring indicators showing the number of WRPCs due each month (N), the number of quarterly WRPC observed (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.</p> <p><i>Measurable interventions regarding these discharge considerations (#6)</i></p>

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		<p><i>The interventions are aligned with their respective objectives (#6a).</i></p> <p><i>Objectives are written in a way that explains what the individual will do or learn and how they will be measured (#6b).</i></p> <table border="1" data-bbox="991 375 1906 683"> <thead> <tr> <th></th> <th>11/07</th> <th>12/07</th> <th>1/08</th> <th>2/08</th> <th>3/08</th> <th>4/08</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>1222</td> <td>1262</td> <td>1300</td> <td>1246</td> <td>1268</td> <td>1263</td> <td></td> </tr> <tr> <td>n</td> <td>51</td> <td>15</td> <td>30</td> <td>43</td> <td>159</td> <td>201</td> <td></td> </tr> <tr> <td>%S</td> <td>4</td> <td>1</td> <td>2</td> <td>10</td> <td>13</td> <td>16</td> <td></td> </tr> <tr> <td>%C</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>6.</td> <td>33</td> <td>20</td> <td>13</td> <td>44</td> <td>3</td> <td>11</td> <td>12</td> </tr> <tr> <td>6.a</td> <td>X</td> <td>36</td> <td>47</td> <td>78</td> <td>24</td> <td>32</td> <td>34</td> </tr> <tr> <td>6.b</td> <td>X</td> <td>57</td> <td>37</td> <td>83</td> <td>25</td> <td>17</td> <td>28</td> </tr> </tbody> </table> <p>This monitor reviewed 13 charts (BT, DL, JAS, JGC, JJ, JP, LB, LQ, MK, NM, PLA, RP and SDC). Four of the WRPs in the charts (BT, JP, LQ and NM) had the interventions written in behavioral and measurable terms. The remaining nine (DL, JAS, JGC, JJ, LB, MK, PLA, RP and SDC) had one or more interventions not written in a behavioral and measurable terms.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Write all interventions, including those dealing with discharge criteria, in behavioral and measurable terms as outlined in the DMH WRP Manual.</p>		11/07	12/07	1/08	2/08	3/08	4/08	Mean	N	1222	1262	1300	1246	1268	1263		n	51	15	30	43	159	201		%S	4	1	2	10	13	16		%C								6.	33	20	13	44	3	11	12	6.a	X	36	47	78	24	32	34	6.b	X	57	37	83	25	17	28
	11/07	12/07	1/08	2/08	3/08	4/08	Mean																																																											
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6.	33	20	13	44	3	11	12																																																											
6.a	X	36	47	78	24	32	34																																																											
6.b	X	57	37	83	25	17	28																																																											
E.3.b	the staff responsible for implementing the interventions; and	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Confirm that the staff to be listed in the WRP is actually involved in facilitating the activity, group, or intervention.</p>																																																																

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		<p>Findings: PSH did not audit this recommendation. This monitor's interview of the Chief of Social Work found that PSH did not have a way to track and monitor this requirement at this time. According to the Chief of Social Work, this task will be taken up once the MaPP system is linked to the WRP program.</p> <p>This monitor reviewed 13 charts (AR, BGW, BT, CCB, DMK, DR, JD, JP, LQ, NC, OL, RD and RP). The staff listed in eight of the WRPs (BT, DR, JD, JP, LQ, NC, RD and RP) were aligned with the staff actually involved in facilitating the activity, group, or intervention. The listed providers in the remaining five (AR, BGW, CCB, DMK and OL) had discrepancies.</p> <p>Recommendation 2, November 2007: Ensure that all elements required for fulfilling the intervention section of the WRP are completed.</p> <p>Findings: PSH used item #7 of the DMH WRP Discharge Planning & Community Integration Auditing Form (<i>The staff responsible for implementing the intervention</i>) to address this recommendation, reporting 51% compliance. The table below with its monitoring indicators showing the number of WRPCs due each month (N), the number of quarterly WRPCs observed (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.</p> <table border="1" data-bbox="989 1149 1906 1344"> <thead> <tr> <th></th> <th>11/07</th> <th>12/07</th> <th>1/08</th> <th>2/08</th> <th>3/08</th> <th>4/08</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>1222</td> <td>1262</td> <td>1300</td> <td>1246</td> <td>1268</td> <td>1263</td> <td></td> </tr> <tr> <td>n</td> <td>52</td> <td>15</td> <td>30</td> <td>43</td> <td>159</td> <td>201</td> <td></td> </tr> <tr> <td>%S</td> <td>4</td> <td>1</td> <td>2</td> <td>10</td> <td>13</td> <td>16</td> <td></td> </tr> <tr> <td>%C #7</td> <td>48</td> <td>73</td> <td>90</td> <td>88</td> <td>34</td> <td>51</td> <td>51</td> </tr> </tbody> </table> <p>This monitor reviewed 11 charts (AV, BT, JP, LQ, MHK, MK, NM, NWJ,</p>		11/07	12/07	1/08	2/08	3/08	4/08	Mean	N	1222	1262	1300	1246	1268	1263		n	52	15	30	43	159	201		%S	4	1	2	10	13	16		%C #7	48	73	90	88	34	51	51
	11/07	12/07	1/08	2/08	3/08	4/08	Mean																																			
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%C #7	48	73	90	88	34	51	51																																			

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		<p>OC, RKS and RP). Two of the WRPs in the charts (JP and NM) contained interventions that included the necessary elements. The remaining nine (AV, BT, LQ, MHK, MK, NWJ, OC, RKS and RP) did not. Most of the interventions that did not meet criteria were ones that did not include strengths in the interventions.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Confirm that the staff to be listed in the WRP is actually involved in facilitating the activity, group, or intervention. 2. Ensure that all elements required for fulfilling the intervention section of the WRP are completed. 																								
E.3.c	The time frames for completion of the interventions.	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Ensure that the review date for each objective is the same as the individual's next scheduled WRPC.</p> <p>Findings: PSH used item #8 DMH WRP Discharge Planning & Community Integration Auditing Form (<i>Time frames for completion of the interventions</i>) to address this recommendation, reporting 38% compliance. The table below with its monitoring indicators showing the number of WRPCs due each month (N), the number of quarterly WRPCs observed (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.</p> <table border="1" data-bbox="991 1302 1906 1416"> <thead> <tr> <th></th> <th>11/07</th> <th>12/07</th> <th>1/08</th> <th>2/08</th> <th>3/08</th> <th>4/08</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>1222</td> <td>1262</td> <td>1300</td> <td>1246</td> <td>1268</td> <td>1263</td> <td></td> </tr> <tr> <td>n</td> <td>52</td> <td>15</td> <td>30</td> <td>43</td> <td>159</td> <td>199</td> <td></td> </tr> </tbody> </table>		11/07	12/07	1/08	2/08	3/08	4/08	Mean	N	1222	1262	1300	1246	1268	1263		n	52	15	30	43	159	199	
	11/07	12/07	1/08	2/08	3/08	4/08	Mean																			
N	1222	1262	1300	1246	1268	1263																				
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		<table border="1"> <tr> <td>%S</td> <td>4</td> <td>1</td> <td>2</td> <td>10</td> <td>13</td> <td>16</td> <td></td> </tr> <tr> <td>%C #8</td> <td>60</td> <td>33</td> <td>87</td> <td>26</td> <td>21</td> <td>42</td> <td>38</td> </tr> </table> <p>This monitor reviewed eight charts (BT, JAS, JP, LB, LQ, MK, NM and RP). Seven of the WRPs in the charts reviewed (JAS, JP, LB, LQ, MK, NM and RP) had appropriate time frames for each objective and one of them (BT) did not.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Ensure that the review date for each objective is the same as the individual's next scheduled WRPC.</p>	%S	4	1	2	10	13	16		%C #8	60	33	87	26	21	42	38
%S	4	1	2	10	13	16												
%C #8	60	33	87	26	21	42	38											
E.4	Each State hospital shall provide transition supports and services consistent with generally accepted professional standards of care. In particular, each State hospital shall ensure that:	<p>Compliance: Partial.</p>																
E.4.a	individuals who have met discharge criteria are discharged expeditiously, subject to the availability of suitable placements; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Use objective data for all discharge criteria and planning.</p> <p>Findings: PSH used items #8 and #8c (see below) from the DMH WRP Clinical Chart Auditing Form to address this recommendation, reporting 0% and 14% compliance respectively. The table below with its monitoring indicators showing the number of WRPs due each month (N), the number of WRPs audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.</p> <p><i>The case formulation enables the interdisciplinary teams to reach sound</i></p>																

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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 (#8).

The case formulation documents the pathway to the discharge setting (#8c).

	11/07	12/07	1/08	2/08	3/08	4/08	Mean
N	283	303	419	366	380	481	
n	86	87	134	115	86	27	
%S	30	28	31	31	23	6	
%C							
8.	0	0	0	0	0	7	0
8.c	0	1	0	0	0	82	14

This monitor reviewed eight charts (BT, JAS, JP, LB, LQ, MK, NM and RP). None of the WRPs in the charts used objective data consistently for all discharge criteria and planning. For example, the Social Work note and the WRP for NM is not a match. NM has been referred for discharge but the WRP did not indicate as such.

This monitor reviewed the list of individuals who met discharge criteria and are still hospitalized. The list showed that 102 individuals referred for discharged were still at PSH. A majority of the individuals (90) were referred within the last six months. The remaining 12 have been at PSH for more than a year since the referral for discharge was made. According to the Chief of Social Work, the individuals continue to be at PSH due to external factors, including non-availability of placement.

Current recommendation:

Use objective data for all discharge criteria and planning.

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E.4.b	Individuals receive adequate assistance in transitioning to the new setting.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Document specific assistance provided to the individual when transitioned to a new setting.</p> <p>Findings: PSH used items #10, #10a, and #10b (see below) from the DMH WRP Discharge Planning & Community Integration Auditing Form to address this recommendation, reporting 2%, 3%, and 1% compliance respectively. The table below with its monitoring indicators showing the number of WRPCs due each month (N), the number of WRPCs audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.</p> <p><i>Individuals receive adequate assistance in transitioning to the new setting (#10)</i></p> <p><i>The present status section describes the assistance needed to transition to the new setting (#10a).</i></p> <p><i>The present status section identifies the person responsible for providing assistance (#10b).</i></p> <table border="1" data-bbox="991 1079 1906 1388"> <thead> <tr> <th></th> <th>11/07</th> <th>12/07</th> <th>1/08</th> <th>2/08</th> <th>3/08</th> <th>4/08</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>1222</td> <td>1262</td> <td>1300</td> <td>1246</td> <td>1268</td> <td>1263</td> <td></td> </tr> <tr> <td>n</td> <td>52</td> <td>14</td> <td>19</td> <td>42</td> <td>117</td> <td>42</td> <td></td> </tr> <tr> <td>%S</td> <td>4</td> <td>1</td> <td>2</td> <td>10</td> <td>13</td> <td>16</td> <td></td> </tr> <tr> <td>%C</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>10.</td> <td>2</td> <td>21</td> <td>0</td> <td>0</td> <td>0</td> <td>2</td> <td>2</td> </tr> <tr> <td>10.a</td> <td>X</td> <td>23</td> <td>0</td> <td>2</td> <td>0</td> <td>7</td> <td>3</td> </tr> <tr> <td>10.b</td> <td>X</td> <td>23</td> <td>0</td> <td>0</td> <td>0</td> <td>2</td> <td>1</td> </tr> </tbody> </table>		11/07	12/07	1/08	2/08	3/08	4/08	Mean	N	1222	1262	1300	1246	1268	1263		n	52	14	19	42	117	42		%S	4	1	2	10	13	16		%C								10.	2	21	0	0	0	2	2	10.a	X	23	0	2	0	7	3	10.b	X	23	0	0	0	2	1
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Section E: Discharge Planning and Community Integration

		<p>This monitor reviewed eight charts (BT, JAS, JP, LB, LQ, MK, NM and RP). One of the WRPs in the charts (RP) had documentation on the assistance that was provided to RP. The remaining seven (BT, JAS, JP, LB, LQ, MK and NM) did not have any documentation on assistance provided to the individuals.</p> <p>Recommendation 2, November 2007: Ensure that early in the discharge process, support and assistance that an individual may need to transition to the new setting is discussed with the individual, and documented in the individual's WRP.</p> <p>Findings: This monitor reviewed eight charts (BT, JAS, JP, LB, LQ, MK, NM and RP). None of the eight WRPs in the charts had documentation to show that any discussion was held with the individual on what specific support and assistance the individual might need when transitioning to the new setting.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Document specific assistance provided to the individual when transitioned to a new setting. 2. Ensure that early in the discharge process, support and assistance that an individual may need to transition to the new setting is discussed with the individual, and documented in the individual's WRP.
E.5	For all children and adolescents it serves, each State hospital shall:	The requirements of Section E.5 are not applicable to PSH because it does not serve children or adolescents.
E.5.a	develop and implement policies and protocols that identify individuals with lengths of stay exceeding six months; and	
E.5.b	establish a regular review forum, which includes senior administration staff, to assess the children	

Section E: Discharge Planning and Community Integration

	<p>and adolescents identified in § V.E.1 above, to review their treatment plans, and to create an individualized action plan for each such child or adolescent that addresses the obstacles to successful discharge to the most integrated, appropriate placement as clinically and legally indicated.</p>	
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F. Specific Therapeutic and Rehabilitation Services	
	<p data-bbox="989 269 1587 297">Summary of Progress on Psychiatric Services:</p> <ol data-bbox="989 305 1793 483" style="list-style-type: none"><li data-bbox="989 305 1793 410">1. PSH has implemented the DMH standardized tools regarding medication management, which improved data gathering, presentation and alignment with each requirement in F.1.a.<li data-bbox="989 418 1793 483">2. PSH has conducted several Drug Utilization Evaluations that comport with generally accepted standards in this area. <p data-bbox="989 529 1608 557">Summary of Progress on Psychological Services:</p> <ol data-bbox="989 565 1881 854" style="list-style-type: none"><li data-bbox="989 565 1608 592">1. PSH has implemented a system-wide PBS plan.<li data-bbox="989 600 1881 665">2. PSH has established the Psychology Specialized Services Team and conducted meetings to address high-risk cases.<li data-bbox="989 673 1881 777">3. PSH has refined the trigger system, and integration of Trigger threshold with services through behavioral guidelines/PBs plans has improved.<li data-bbox="989 786 1818 854">4. PBS plan assessments, data collection, and fidelity checks have improved. <p data-bbox="989 899 1545 927">Summary of Progress on Nursing Services:</p> <p data-bbox="989 935 1881 1000">PSH has significantly increased the number of staff who received WRP Level I training this review period.</p> <p data-bbox="989 1045 1734 1073">Summary of Progress on Rehabilitation Therapy Services:</p> <ol data-bbox="989 1081 1881 1403" style="list-style-type: none"><li data-bbox="989 1081 1881 1222">1. Lesson plans have been developed for many Rehabilitation Therapy PSR Mall groups. However, most lesson plans list more than one focus, rather than one focus as indicated by PSR Manual and EP requirements.<li data-bbox="989 1230 1881 1372">2. Lesson plans for two Vocational Rehabilitation groups have been developed based on literature review and research into best practices. The facility is currently piloting these two classes, with individuals giving feedback to further develop the curricula.<li data-bbox="989 1380 1745 1403">3. An F.4 Monitoring tool has been developed and is pending

	<p>implementation.</p> <p>Summary of Progress on Nutrition Services:</p> <ol style="list-style-type: none">1. The Meal Accuracy report has been implemented and review of data shows Substantial with tray accuracy.2. PSR Mall Nutrition lesson plans have been developed, implemented and appear to meet EP requirements. <p>Summary of Progress on Pharmacy Services:</p> <p>The facility has provided regular in-service training to pharmacists with the objective of enhancing pharmacists' recommendations to physicians.</p> <p>Summary of Progress on General Medical Services:</p> <ol style="list-style-type: none">1. PSH has revised its ADs and Policies and Procedures; the revised documents adequately address the process deficiencies outlined in previous reports.2. PSH has implemented a new requirement for routine quarterly reassessment of individuals who have medical diagnoses.3. PSH implemented the DMH standardized tools regarding management of specific medical conditions and conducted adequate analysis of its self-assessment data. <p>Summary of Progress on Infection Control:</p> <ol style="list-style-type: none">1. The Infection Control Department has integrated its compliance data into the Infection Control Committee Meetings, the Department of Medicine and Psychiatry Meetings, and the Performance Improvement Committee Meetings.2. The Infection Control Department has added a nurse liaison to the department to assist with addressing low compliance rates at the unit level.3. Infection Control has reached substantial compliance in a number of departmental areas.
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Section F: Specific Therapeutic and Rehabilitation Services

	<p>Summary of Progress on Dental Services</p> <ol style="list-style-type: none"> 1. PSH has implemented the statewide Dental Monitoring tool. 2. The Dental Department has clarified requirements for documentation that facilitates interpretation of the dental treatment and treatment plan. 3. The data provided by the Dental Department for this review is in alignment with current practices.
<p>1. Psychiatric Services</p>	
	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. George Christison, Acting Chief of Psychiatry 2. John Thiel, MD, Chairman of the P&T Committee 3. Steven Mauer, MD, Chief of Medical Staff 4. Wadsworth Murad, MD, Acting Medical Director <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Charts of the following 33 individuals: AD, ADT, AJM, ARB, AW, BRA, CJ, CTS, DLW, DM, DRL, EG, EW, FS, HR, JIM, JW, LML, MO, PAB, RA, RAS, RD, RP, RPJ, RS, RTH, SRB, SWD, TME, TN, TR and TS 2. California Department of Mental Health (DMH) Psychotropic Medication Policies and Guidelines (June 2007) 3. PSH Staff Psychiatrist Manual 4. PSH list of individuals with Psychotropic Medications, Diagnoses and Attending Physicians 5. PSH database regarding intra-class and inter-class polypharmacy 6. DMH Admission Psychiatric Assessment Auditing Form 7. PSH Admission Psychiatric Assessment summary data (February to April 2008) 8. DMH Integrated Assessment: Psychiatry Section Auditing Form

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		<ol style="list-style-type: none"> 9. PSH Integrated Psychiatric Assessment Auditing summary data (February to April 2008) 10. DMH Monthly Physician Progress Note (PPN) Auditing Form 11. PSH Physician PPN Auditing summary data (February to April 2008) 12. Administrative Directive #15.14, Section 14.1 regarding time limits of PRN orders 13. DMH Nursing Services Monitoring Form (PRN medications) 14. PSH PRN medications auditing summary data (January to April 2008) 15. DMH Nursing Services Monitoring Form (Stat medications) 16. PSH Stat medications auditing summary data (January to April 2008) 17. DMH Benzodiazepine Auditing Form 18. PSH Benzodiazepine Auditing summary data (dates??) 19. DMH Anticholinergic Auditing Form 20. PSH Anticholinergic Auditing summary data (dates??) 21. DMH Polypharmacy Auditing Form 22. PSH Polypharmacy Auditing summary data (dates??) 23. PSH Medication Monitoring New Generation Antipsychotics Auditing Form 24. New Generation Antipsychotics Auditing summary data (December 2007 to April 2008) 25. PSH database regarding individuals suffering from tardive dyskinesia 26. DMH Tardive Dyskinesia Auditing Form 27. Tardive dyskinesia auditing summary data (April 2008) 28. PSH Nursing Policy and Procedure #537 A, Adverse Drug Reactions 29. Adverse Drug Reaction Reports (November 2007 to April 2008) 30. PSH data regarding Drug Utilization Evaluations (November 2007 to April 2008) 31. PSH summary reports regarding DUEs conducted during this reporting period 32. PSH AD G10.48 Medication Variances (November 12, 2007)
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Section F: Specific Therapeutic and Rehabilitation Services

		<p>33. Nursing Policy and Procedure #511, Medication Variances 34. Pharmacy and Therapeutics Medication Variance Policy 35. PSH data regarding medication variances (November 2007 to April 2008)</p>
<p>F.1.a</p>	<p>Each State hospital shall develop and implement policies and procedures to ensure system-wide monitoring of the safety, efficacy, and appropriateness of all psychotropic medication use, consistent with generally accepted professional standards of care. In particular, policies and procedures shall require monitoring of the use of psychotropic medications to ensure that they are:</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Implement individualized medication guidelines that include specific information regarding indications, contraindications, clinical and laboratory monitoring and adverse effects for all psychotropic and anticonvulsant medications in the formulary. The guidelines must be derived from current literature, relevant clinical experience and current generally accepted professional practice guidelines.</p> <p>Findings: The Department of Mental Health Medication Policy, including individualized medication guidelines, was implemented statewide in March 2007. PSH continues to follow this policy and has been in the process of incorporating it into the PSH Pharmacy and Therapeutics Manual. No updates to these guidelines were made during this reporting period. These guidelines do not include the mood stabilizers lithium and carbamazepine and the antidepressants venlafaxine, bupropion and mirtazapine.</p> <p>Recommendation 2, November 2007: Finalize statewide efforts to standardize all medication monitoring instruments.</p> <p>Findings: In January 2008, the DMH has finalized the following tools:</p> <ol style="list-style-type: none"> 1. DMH Anticholinergic Auditing Form

Section F: Specific Therapeutic and Rehabilitation Services

		<ol style="list-style-type: none"> 2. DMH Benzodiazepine Audit Form 3. DMH Polypharmacy Auditing Form 4. DMH Tardive Dyskinesia Auditing Form <p>PSH implemented these tools in February 2008. The use of the DMH standardized tools has improved data gathering, presentation and alignment with each requirement in F.1.a.</p> <p>The DMH has yet to finalize the auditing tool regarding the use of new generation antipsychotic medications.</p> <p>Recommendation 3, November 2007: Continue to monitor this requirement based on at least a 20% sample, using standardized indicators, and provide data analysis regarding low compliance with corrective actions.</p> <p>Findings: PSH used the new standardized DMH Admission Psychiatric Assessment, Integrated Assessment: Psychiatry and Monthly Physician Progress Note (PPN) Audit forms to assess compliance (February to April). The average sample sizes were 48%, 70% and 11%, respectively. The compliance rates are presented for each sub-cell below. The monitoring indicators/sub-indicators are listed, as necessary.</p> <p>PSH conducted data analysis, which emphasized the following:</p> <ol style="list-style-type: none"> 1. Variability of data on the admission psychiatric assessment was due to cross-coverage of the only psychiatrist who currently staffs the admission suite. The facility plans to recruit a second admission suite psychiatrist during the next reporting period. 2. Overall performance has improved on the Integrated Assessment after the DMH-approved template was distributed to the Admission Units in February 2008.
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		<p>3. Compliance on some items was decreased disproportionately by a few outlying practitioners; training and mentoring will address this issue.</p> <p>4. The monthly notes reflected improved scores in April 2008, which in turn reflected mandatory meetings on March 26 and April 16 for all psychiatrists who write monthly progress notes. Increased emphasis on coaching by the senior team regarding the quality of the monthly PPN has also contributed to improved scores. Seniors have provided individual and Program-level feedback in some cases. As mentioned earlier, the facility is in the process of finalizing a template for the monthly PPN.</p> <p>Recommendation 4, November 2007: Present data regarding the use of anticholinergics, benzodiazepines, polypharmacy and new generation antipsychotic medications in corresponding cells (F.1.c and F.1.d).</p> <p>Findings: PSH has implemented this recommendation.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Finalize individualized guidelines for all psychotropic and anticonvulsant medications listed in the formulary. 2. Ensure that the individualized medication guidelines are continually revised, as appropriate, to reflect current literature, relevant clinical experience and professional practice guidelines. 3. Finalize the DMH auditing form regarding the use of new generation antipsychotic medications. 4. Monitor these requirements using the standardized DMH tools based on at least a 20% sample.
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		5. Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).																																																						
F.1.a.i	specifically matched to current, clinically justified diagnoses or clinical symptoms;	<table border="1"> <tr> <td colspan="3" data-bbox="989 378 1887 418">Admission Psychiatric Assessment</td> </tr> <tr> <td data-bbox="989 418 1066 456">8.</td> <td data-bbox="1066 418 1774 456"><i>Plan of care includes:</i></td> <td data-bbox="1774 418 1887 456"></td> </tr> <tr> <td data-bbox="989 456 1066 493">8.a</td> <td data-bbox="1066 456 1774 493"><i>Regular psychotropic medications, with rationale</i></td> <td data-bbox="1774 456 1887 493">85%</td> </tr> <tr> <td data-bbox="989 493 1066 566">8.b</td> <td data-bbox="1066 493 1774 566"><i>PRN and/or Stat medication as applicable, with specific behavioral indications</i></td> <td data-bbox="1774 493 1887 566">86%</td> </tr> <tr> <td data-bbox="989 566 1066 639">8.c</td> <td data-bbox="1066 566 1774 639"><i>Special precautions to address risk factors, as indicated</i></td> <td data-bbox="1774 566 1887 639">94%</td> </tr> <tr> <td colspan="3" data-bbox="989 680 1887 721">Integrated Psychiatric Assessment</td> </tr> <tr> <td data-bbox="989 721 1066 758">7.</td> <td data-bbox="1066 721 1774 758"><i>Diagnostic formulation</i></td> <td data-bbox="1774 721 1887 758">88%</td> </tr> <tr> <td data-bbox="989 758 1066 795">10.</td> <td data-bbox="1066 758 1774 795"><i>Psychopharmacology treatment plan includes:</i></td> <td data-bbox="1774 758 1887 795">53%</td> </tr> <tr> <td data-bbox="989 795 1066 833">10.a</td> <td data-bbox="1066 795 1774 833"><i>Current target symptoms</i></td> <td data-bbox="1774 795 1887 833">69%</td> </tr> <tr> <td data-bbox="989 833 1066 870">10.b</td> <td data-bbox="1066 833 1774 870"><i>Specific medication to be used</i></td> <td data-bbox="1774 833 1887 870">91%</td> </tr> <tr> <td data-bbox="989 870 1066 907">10.c</td> <td data-bbox="1066 870 1774 907"><i>Dosage titration schedules, if indicated.</i></td> <td data-bbox="1774 870 1887 907">81%</td> </tr> <tr> <td data-bbox="989 907 1066 945">10.d</td> <td data-bbox="1066 907 1774 945"><i>Adverse reactions to monitor for</i></td> <td data-bbox="1774 907 1887 945">67%</td> </tr> <tr> <td data-bbox="989 945 1066 1018">10.e</td> <td data-bbox="1066 945 1774 1018"><i>Rationale for anticholinergics, benzodiazepines, polypharmacy and new generation</i></td> <td data-bbox="1774 945 1887 1018">48%</td> </tr> <tr> <td data-bbox="989 1018 1066 1091">10.f</td> <td data-bbox="1066 1018 1774 1091"><i>Response to medication since admission, if applicable, including PRN and Stat medications.</i></td> <td data-bbox="1774 1018 1887 1091">55%</td> </tr> <tr> <td data-bbox="989 1091 1066 1128">10.g</td> <td data-bbox="1066 1091 1774 1128"><i>Medication consent issues were addressed</i></td> <td data-bbox="1774 1091 1887 1128">96%</td> </tr> <tr> <td colspan="3" data-bbox="989 1169 1887 1209">Monthly PPN</td> </tr> <tr> <td data-bbox="989 1209 1066 1282">2.b</td> <td data-bbox="1066 1209 1774 1282"><i>The current target symptoms which are the focus of treatment are identified in the progress note.</i></td> <td data-bbox="1774 1209 1887 1282">70%</td> </tr> <tr> <td data-bbox="989 1282 1066 1399">6.a.1</td> <td data-bbox="1066 1282 1774 1399"><i>The risks, benefits and rationale for the current psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented.</i></td> <td data-bbox="1774 1282 1887 1399">38%</td> </tr> </table>	Admission Psychiatric Assessment			8.	<i>Plan of care includes:</i>		8.a	<i>Regular psychotropic medications, with rationale</i>	85%	8.b	<i>PRN and/or Stat medication as applicable, with specific behavioral indications</i>	86%	8.c	<i>Special precautions to address risk factors, as indicated</i>	94%	Integrated Psychiatric Assessment			7.	<i>Diagnostic formulation</i>	88%	10.	<i>Psychopharmacology treatment plan includes:</i>	53%	10.a	<i>Current target symptoms</i>	69%	10.b	<i>Specific medication to be used</i>	91%	10.c	<i>Dosage titration schedules, if indicated.</i>	81%	10.d	<i>Adverse reactions to monitor for</i>	67%	10.e	<i>Rationale for anticholinergics, benzodiazepines, polypharmacy and new generation</i>	48%	10.f	<i>Response to medication since admission, if applicable, including PRN and Stat medications.</i>	55%	10.g	<i>Medication consent issues were addressed</i>	96%	Monthly PPN			2.b	<i>The current target symptoms which are the focus of treatment are identified in the progress note.</i>	70%	6.a.1	<i>The risks, benefits and rationale for the current psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented.</i>	38%
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		6.a. 2	<i>There is a clear description of the reasoning for continuing the current medication regiment and the proposed future plans, such as augmentation, dose tapering, change in medication, etc.</i>	31%												
F.1.a.ii	prescribed in therapeutic amounts, as dictated by the needs of the individual served;	2.h. 2	<i>Current psychotropic medication dosage/laboratory monitoring/diagnostic testing and consultation protocols are followed as indicated (as per DMH Psychotropic guidelines.)</i>	50%												
F.1.a.iii	tailored to each individual's symptoms;	Same as in F.1.a.i.														
F.1.a.iv	monitored for effectiveness against clearly identified target variables and time frames;	<table border="1"> <tr> <td colspan="3">Monthly PPN</td> </tr> <tr> <td>2.b</td> <td><i>The current target symptoms which are the focus of treatment are identified in the progress note.</i></td> <td>70%</td> </tr> <tr> <td>2.c</td> <td><i>There is a comment about the individual's level of participation in the Wellness and Recovery Plan.</i></td> <td>67%</td> </tr> <tr> <td>2.d</td> <td><i>The monthly note addresses, in behavioral terms, the overall progress towards the current objectives, particularly foci 1, 3 and 5 (if applicable)</i></td> <td>56%</td> </tr> </table>			Monthly PPN			2.b	<i>The current target symptoms which are the focus of treatment are identified in the progress note.</i>	70%	2.c	<i>There is a comment about the individual's level of participation in the Wellness and Recovery Plan.</i>	67%	2.d	<i>The monthly note addresses, in behavioral terms, the overall progress towards the current objectives, particularly foci 1, 3 and 5 (if applicable)</i>	56%
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F.1.a.v	monitored appropriately for side effects;	<table border="1"> <tr> <td colspan="3">Monthly PPN</td> </tr> <tr> <td>6.b</td> <td><i>There is a description of any side effects caused by medications, including sedation and cognitive impairment.</i></td> <td>54%</td> </tr> <tr> <td>6.c</td> <td><i>The AIMS was done annually for all individuals and quarterly if there is a positive AIMS or a current</i></td> <td>77%</td> </tr> </table>			Monthly PPN			6.b	<i>There is a description of any side effects caused by medications, including sedation and cognitive impairment.</i>	54%	6.c	<i>The AIMS was done annually for all individuals and quarterly if there is a positive AIMS or a current</i>	77%			
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Section F: Specific Therapeutic and Rehabilitation Services

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	<i>diagnosis or history of Tardive Dyskinesia.</i>													
F.1.a.vi	modified based on clinical rationales;	<table border="1"> <tr> <td colspan="3">Monthly PPN</td> </tr> <tr> <td>6.a.1</td> <td><i>The risks, benefits and rationale for the current psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented.</i></td> <td>45%</td> </tr> <tr> <td>6.a.2</td> <td><i>There is a clear description of the reasoning for continuing the current medication regimen and the proposed future plans, such as augmentation, dose tapering, change in medication, etc.</i></td> <td>31%</td> </tr> </table>	Monthly PPN			6.a.1	<i>The risks, benefits and rationale for the current psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented.</i>	45%	6.a.2	<i>There is a clear description of the reasoning for continuing the current medication regimen and the proposed future plans, such as augmentation, dose tapering, change in medication, etc.</i>	31%			
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6.a.1	<i>The risks, benefits and rationale for the current psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented.</i>	45%												
6.a.2	<i>There is a clear description of the reasoning for continuing the current medication regimen and the proposed future plans, such as augmentation, dose tapering, change in medication, etc.</i>	31%												
F.1.a.vii	are not inhibiting individuals from meaningfully participating in treatment, rehabilitation, or enrichment and educational services as a result of excessive sedation; and	<table border="1"> <tr> <td colspan="3">Monthly PPN</td> </tr> <tr> <td>2.c</td> <td><i>There is a comment about the individual's level of participation in the Wellness and Recovery Plan.</i></td> <td>67%</td> </tr> <tr> <td>6.b</td> <td><i>There is a description of any side effects caused by medications, including sedation and cognitive impairment.</i></td> <td>54%</td> </tr> <tr> <td>6.c</td> <td><i>The AIMS was done annually for all individuals and quarterly if there is a positive AIMS or a current diagnosis or history of Tardive Dyskinesia.</i></td> <td>77%</td> </tr> </table>	Monthly PPN			2.c	<i>There is a comment about the individual's level of participation in the Wellness and Recovery Plan.</i>	67%	6.b	<i>There is a description of any side effects caused by medications, including sedation and cognitive impairment.</i>	54%	6.c	<i>The AIMS was done annually for all individuals and quarterly if there is a positive AIMS or a current diagnosis or history of Tardive Dyskinesia.</i>	77%
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6.c	<i>The AIMS was done annually for all individuals and quarterly if there is a positive AIMS or a current diagnosis or history of Tardive Dyskinesia.</i>	77%												
F.1.a.viii	Properly documented.	<p>The facility provided the following weighted means for all items above:</p> <table border="1"> <tr> <td>Admission Psychiatric Assessment</td> <td>83%</td> </tr> <tr> <td>Integrated Assessment (Psychiatry)</td> <td>72%</td> </tr> <tr> <td>Monthly PPN</td> <td>59%</td> </tr> </table>	Admission Psychiatric Assessment	83%	Integrated Assessment (Psychiatry)	72%	Monthly PPN	59%						
Admission Psychiatric Assessment	83%													
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<p>F.1.b</p>	<p>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>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Implement current procedure to ensure that all PRN orders for psychotropic medications are limited to no more than 15 days of use before the orders are reviewed and rewritten as necessary. This time limit should be gradually shortened to three days of use.</p> <p>Findings: PSH has implemented this recommendation. The limit of 15 days for psychotropic medications was incorporated into AD #15.14, Section 14.1. This was followed up in March 2008 by a reminder memo to all medical staff.</p> <p>Recommendations 2 and 3, November 2007:</p> <ul style="list-style-type: none"> • Monitor the use of PRN and Stat medications based on at least a 20% sample and provide data analysis regarding low compliance with corrective actions. • Continue to report data regarding PRN and Stat medications to address EP requirements regarding each of the following: <ul style="list-style-type: none"> ○ Psychiatric documentation of PRN medication use; ○ Psychiatric documentation of Stat medication use; ○ Nursing documentation of PRN medication use; and ○ Nursing documentation of Stat medication use. <p>Findings: PSH used the DMH standardized Monthly PPN tool to audit this requirement. The average sample size was 11% of individuals who have been hospitalized for 90 or more days (February to April 2008). The following summarizes the data:</p>
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		Monthly PPN	
7.	<i>Timely review of the use of "pro re nata" or "as needed" ("PRN") and "Stat" (i.e., emergency psychoactive) medications and adjustment of regular treatment, as indicated, based on such use:</i>		
7.a	<i>Describes the rationale/specific indications for all PRN orders.</i>		44%
7.b	<i>Reviews the PRNs and Stats during the interval period.</i>		47%
7.c	<i>Discusses use of PRN/STAT as indicated to reduce the risk of restrictive interventions.</i>		29%
7.d	<i>Describes modification of regularly scheduled medication regimen based on the use of PRN/STAT medications.</i>		21%
<p>The facility also reported data based on the DMH Nursing Services Monitoring Form. The average samples were 6% of PRN medications and 12% of Stat medications given each month (January to April 2008).</p>			
		<i>Safe administration of PRN medication</i>	97%
		<i>Documentation of the circumstances requiring PRN medication</i>	55%
		<i>Documentation of the individual's response to PRN medication</i>	3%
		<i>Safe administration of Stat medications</i>	92%
		<i>Documentation of the circumstance requiring Stat administration of medications</i>	57%
		<i>Documentation of the individual's response to Stat medication</i>	20%
<p>PSH reported that the facility's expectations regarding the use of PRN and Stat medications were reviewed with practitioners at Medical</p>			

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		<p>Staff meetings, joint Psychiatry and Medicine meetings and Department of Psychiatry meetings during this reporting period. The facility recognized that these attempts did not result in improved compliance and plans to emphasize individual feedback to psychiatrists, including the sharing of individualized audit data.</p> <p>PSH also reported that training was provided to nursing staff in November 2007 and February and March 2008, but compliance has to yet to improve in response to this training.</p> <p>Recommendation 4, November 2007: Provide ongoing feedback and mentoring by Senior Psychiatrists to ensure correction of the deficiencies noted by this monitor.</p> <p>Findings: Same as findings for Recommendation 4 in D.1.a. In addition, PSH has begun to distribute the daily hospital-wide nursing report (HSS Report) to the senior psychiatrists to review with their staff psychiatrists. The HSS report includes information on all recent Stat and PRN medications that were administered.</p> <p>Other findings: See Other Findings in D.1.f.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Monitor the use of PRN and Stat medications based on at least a 20% sample and provide data analysis regarding low compliance with accompanying corrective actions.2. Continue to report data regarding PRN and Stat medications to address EP requirements regarding each of the following:
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		<ul style="list-style-type: none"> ○ Psychiatric documentation of PRN medication use; ○ Psychiatric documentation of Stat medication use; ○ Nursing documentation of PRN medication use; and ○ Nursing documentation of Stat medication use. <p>3. Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).</p>
F.1.c	<p>Each State hospital shall monitor the psychiatric use of benzodiazepines, anticholinergics, and polypharmacy to ensure clinical justification and attention to associated risks.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Standardize monitoring instruments regarding the use of benzodiazepines, anticholinergics and polypharmacy for use across facilities and ensure that these instruments are aligned with the DMH medication guidelines.</p> <p>Findings: The facility has implemented this recommendation.</p> <p>Recommendation 2, November 2007: Continue monitoring of the use of benzodiazepines, anticholinergics and polypharmacy based on at least a 20% sample, using standardized indicators, and provide data analysis regarding low compliance with corrective actions.</p> <p>Findings: PSH used the DMH Benzodiazepine, Anticholinergics and Polypharmacy Audit Forms to assess compliance (February to April 2008). The following is a summary outline of the monitoring indicators and corresponding mean compliance rates:</p> <p><u>Benzodiazepines</u> Source of data: DMH Benzodiazepine Audit Form</p>

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		<p>Average %S varied from 9% to 18% of the individuals receiving benzodiazepines, depending on the applicable indicator.</p> <table border="1"> <tr> <td data-bbox="989 302 1066 378">1.</td> <td data-bbox="1066 302 1774 378"><i>Indication for regularly scheduled use of benzodiazepine clearly documented in Medical Record.</i></td> <td data-bbox="1774 302 1885 378">34%</td> </tr> <tr> <td data-bbox="989 378 1066 453">2.</td> <td data-bbox="1066 378 1774 453"><i>Benzodiazepine used for individuals with alcohol / drug use problems justified in PPN</i></td> <td data-bbox="1774 378 1885 453">22%</td> </tr> <tr> <td data-bbox="989 453 1066 527">3.</td> <td data-bbox="1066 453 1774 527"><i>Benzodiazepine used for individuals with cognitive disorders justified in PPN</i></td> <td data-bbox="1774 453 1885 527">14%</td> </tr> <tr> <td data-bbox="989 527 1066 602">4.</td> <td data-bbox="1066 527 1774 602"><i>Clearly document in PPN risks of Drug abuse / dependence (used for more than two month).</i></td> <td data-bbox="1774 527 1885 602">14%</td> </tr> <tr> <td data-bbox="989 602 1066 677">5.</td> <td data-bbox="1066 602 1774 677"><i>Clearly document in PPN risks of cognitive impairment (used for more than two month).</i></td> <td data-bbox="1774 602 1885 677">8%</td> </tr> <tr> <td data-bbox="989 677 1066 716">6.</td> <td data-bbox="1066 677 1774 716"><i>Clearly document in PPN risks of sedation.</i></td> <td data-bbox="1774 677 1885 716">10%</td> </tr> <tr> <td data-bbox="989 716 1066 790">7.</td> <td data-bbox="1066 716 1774 790"><i>Clearly document in PPN risks of gait unsteadiness (used for more than two month).</i></td> <td data-bbox="1774 716 1885 790">2%</td> </tr> <tr> <td data-bbox="989 790 1066 865">8.</td> <td data-bbox="1066 790 1774 865"><i>Clearly document in PPN risks of respiratory depression (used for more than two month).</i></td> <td data-bbox="1774 790 1885 865">6%</td> </tr> <tr> <td data-bbox="989 865 1066 940">9.</td> <td data-bbox="1066 865 1774 940"><i>Toxicity if used in individuals with liver impairment (if using long acting agents)</i></td> <td data-bbox="1774 865 1885 940">33%</td> </tr> <tr> <td data-bbox="989 940 1066 1053">10.</td> <td data-bbox="1066 940 1774 1053"><i>Treatment modified in an appropriate and timely manner to ensure proper indications and to minimize risk.</i></td> <td data-bbox="1774 940 1885 1053">35%</td> </tr> </table> <p><u>Anticholinergics</u> Source of data: DMH Anticholinergic Audit Form Average %S varied from 13% to 19% of individuals receiving anticholinergics, depending on the applicable indicator.</p> <table border="1"> <tr> <td data-bbox="989 1279 1066 1354">1.</td> <td data-bbox="1066 1279 1774 1354"><i>Indication for the regular use of anticholinergic is clearly documented in PPN</i></td> <td data-bbox="1774 1279 1885 1354">12%</td> </tr> <tr> <td data-bbox="989 1354 1066 1425">2.</td> <td data-bbox="1066 1354 1774 1425"><i>Address the risk of cognitive impairment (if used for individuals over age 60 with cognitive impairment for</i></td> <td data-bbox="1774 1354 1885 1425">18%</td> </tr> </table>	1.	<i>Indication for regularly scheduled use of benzodiazepine clearly documented in Medical Record.</i>	34%	2.	<i>Benzodiazepine used for individuals with alcohol / drug use problems justified in PPN</i>	22%	3.	<i>Benzodiazepine used for individuals with cognitive disorders justified in PPN</i>	14%	4.	<i>Clearly document in PPN risks of Drug abuse / dependence (used for more than two month).</i>	14%	5.	<i>Clearly document in PPN risks of cognitive impairment (used for more than two month).</i>	8%	6.	<i>Clearly document in PPN risks of sedation.</i>	10%	7.	<i>Clearly document in PPN risks of gait unsteadiness (used for more than two month).</i>	2%	8.	<i>Clearly document in PPN risks of respiratory depression (used for more than two month).</i>	6%	9.	<i>Toxicity if used in individuals with liver impairment (if using long acting agents)</i>	33%	10.	<i>Treatment modified in an appropriate and timely manner to ensure proper indications and to minimize risk.</i>	35%	1.	<i>Indication for the regular use of anticholinergic is clearly documented in PPN</i>	12%	2.	<i>Address the risk of cognitive impairment (if used for individuals over age 60 with cognitive impairment for</i>	18%
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			<i>any duration).</i>	
		3.	<i>Address the risk of sedation, as indicated (if used for individuals over age 60 with cognitive impairment for any duration).</i>	22%
		4.	<i>Address the risk of gait unsteadiness / falls, as indicated (if used for individuals over age 60 with cognitive impairment for any duration).</i>	0%
		5.	<i>Address the risk of blurred vision, constipation, urinary retention (if used for individuals over age 60 with cognitive impairment for any duration).</i>	0%
		6.	<i>Address the risk of worsening narrow angle glaucoma, if present (if used for individuals over age 60 with cognitive impairment for any duration).</i>	NA
		7.	<i>Risks of cognitive impairment (are documented if used for more than two months)</i>	8%
		8.	<i>Risks of sedation (are documented if used for more than two months)</i>	3%
		9.	<i>Risks of gait unsteadiness / falls, as indicated ((are documented if used for more than two months))</i>	5%
		10.	<i>Risks of blurred vision, constipation, urinary retention (are documented if used for more than two months).</i>	0%
		11.	<i>Risks of worsening narrow angle glaucoma, if present (are documented if used for more than two months).</i>	0%
		12.	<i>Risks of substance abuse/dependence if listed on Axis I (are documented if used for more than two months).</i>	39%
		13.	<i>Risks of worsening TD, if present.</i>	0%
		14.	<i>Dosage is within DMH psychotropic medication policy (unless TRC/MRC consult was obtained)</i>	92%
		15.	<i>Treatment modified in an appropriate and timely manner to ensure proper indications and to minimize risk (if used for more than two months.</i>	33%

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		<p><u>Polypharmacy</u> Source of data: DMH Polypharmacy Audit Form Average %S varied from 11 %to 12% of individuals receiving intra and/or inter-class polypharmacy, depending on the applicable indicator.</p> <table border="1" data-bbox="991 375 1887 716"> <tr> <td data-bbox="991 375 1066 451">1.</td> <td data-bbox="1066 375 1774 451"><i>Target symptoms were clearly identified (individuals on intra and inter-class)</i></td> <td data-bbox="1774 375 1887 451">34%</td> </tr> <tr> <td data-bbox="991 451 1066 527">2.</td> <td data-bbox="1066 451 1774 527"><i>Documentation in physician progress notes justifies the need for interclass polypharmacy</i></td> <td data-bbox="1774 451 1887 527">17%</td> </tr> <tr> <td data-bbox="991 527 1066 604">3.</td> <td data-bbox="1066 527 1774 604"><i>Documentation in physician progress notes justifies the need for intra-class polypharmacy.</i></td> <td data-bbox="1774 527 1887 604">21%</td> </tr> <tr> <td data-bbox="991 604 1066 716">4.</td> <td data-bbox="1066 604 1774 716"><i>Documentation in the PPN includes the risks of the polypharmacy including cumulative side-effects (individuals on intra and inter-class).</i></td> <td data-bbox="1774 604 1887 716">9%</td> </tr> </table> <p>PSH reported that the PPN template currently in process includes an attachment that specifically addresses the risks of benzodiazepine, anticholinergic and polypharmacy use and that psychopharmacology and documentation training will be provided during the next reporting period to improve compliance. In addition, the facility plans to implement an audit master plan to facilitate prompt analysis and distribution of data to seniors and practitioners. The facility provided monthly PPN training in late March and mid-April, which is reflected in improved scores in the March and April polypharmacy data (intra-class).</p> <p>Recommendation 3, November 2007: Provide ongoing feedback and mentoring by Senior Psychiatrists to ensure correction of deficiencies noted by this monitor.</p> <p>Findings: Same as findings for Recommendation 4 in D.1.a. However, the facility reported that the senior psychiatrists have yet to address these deficiencies.</p>	1.	<i>Target symptoms were clearly identified (individuals on intra and inter-class)</i>	34%	2.	<i>Documentation in physician progress notes justifies the need for interclass polypharmacy</i>	17%	3.	<i>Documentation in physician progress notes justifies the need for intra-class polypharmacy.</i>	21%	4.	<i>Documentation in the PPN includes the risks of the polypharmacy including cumulative side-effects (individuals on intra and inter-class).</i>	9%
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4.	<i>Documentation in the PPN includes the risks of the polypharmacy including cumulative side-effects (individuals on intra and inter-class).</i>	9%												

		<p>Recommendation 4, November 2007: Identify patterns and trends regarding high-risk medication uses and implement corrective and educational actions.</p> <p>Findings: PSH has yet to implement this recommendation. The facility currently has three months of data that allow initial trend and pattern analysis and plans to conduct this analysis and implement corrective actions during the next reporting period.</p> <p>Other findings: This monitor reviewed the charts of individuals receiving long-term treatment with benzodiazepines (#9) and/or anticholinergic medications (#8) and individuals receiving various forms of polypharmacy (#5).</p> <p>The reviews found evidence of an apparent decrease in the use of benzodiazepines for individuals with substance use and cognitive disorders and in the use of anticholinergic medications for individuals with cognitive disorders. However, the reviews found that too many individuals are still receiving long-term regular treatment with benzodiazepines (lorazepam and/or clonazepam) and/or anticholinergic medications (benztropine and/or diphenhydramine) without documented justification.</p> <p>Regarding polypharmacy, there was general evidence of inadequate documentation of the rationale for polypharmacy, associated risks including drug-drug interactions, and/or attempts to simplify/optimize the regimen.</p> <p>The following tables outlines the reviews, with the diagnoses being listed only if they signify conditions that increase the risk of continued</p>
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		<p>use:</p> <p><u>Benzodiazepine use</u></p> <table border="1"> <thead> <tr> <th>Individual</th> <th>Medication(s)</th> <th>Diagnosis</th> </tr> </thead> <tbody> <tr> <td>BRA</td> <td>Lorazepam</td> <td>Polysubstance Dependence</td> </tr> <tr> <td>DM</td> <td>Clonazepam</td> <td>Alcohol Dependence, Cocaine Dependence and Moderate Mental Retardation</td> </tr> <tr> <td>LML</td> <td>Lorazepam</td> <td>Cocaine Dependence and Cognitive Disorder NOS</td> </tr> <tr> <td>MO</td> <td>Lorazepam</td> <td>Other (Unknown) Substance Abuse</td> </tr> <tr> <td>RP</td> <td>Clonazepam</td> <td>Polysubstance Dependence</td> </tr> <tr> <td>RPJ</td> <td>Clonazepam</td> <td>Alcohol Dependence, Cannabis Dependence and Cognitive Disorder NOS</td> </tr> <tr> <td>SRB</td> <td>Lorazepam</td> <td>Alcohol Dependence and Cannabis Abuse</td> </tr> <tr> <td>SWD</td> <td>Clonazepam</td> <td>Alcohol Dependence, Polysubstance Dependence and Borderline Intellectual Functioning</td> </tr> <tr> <td>TR</td> <td>Clonazepam</td> <td>Polysubstance Dependence</td> </tr> </tbody> </table> <p><u>Anticholinergic use</u></p> <table border="1"> <thead> <tr> <th>Individual</th> <th>Medication(s)</th> <th>Diagnosis</th> </tr> </thead> <tbody> <tr> <td>AJM</td> <td>Hydroxyzine</td> <td>Dementia</td> </tr> <tr> <td>ARB</td> <td>Benztropine</td> <td>Tardive Dyskinesia</td> </tr> <tr> <td>ARB</td> <td>Benztropine</td> <td>Dementia Due to General Medical Condition without Behavioral Disturbance</td> </tr> <tr> <td>DLW</td> <td>Benztropine</td> <td>Mental Retardation, Severity Unspecified</td> </tr> <tr> <td>RA</td> <td>Benztropine</td> <td>Mild Mental Retardation</td> </tr> </tbody> </table>	Individual	Medication(s)	Diagnosis	BRA	Lorazepam	Polysubstance Dependence	DM	Clonazepam	Alcohol Dependence, Cocaine Dependence and Moderate Mental Retardation	LML	Lorazepam	Cocaine Dependence and Cognitive Disorder NOS	MO	Lorazepam	Other (Unknown) Substance Abuse	RP	Clonazepam	Polysubstance Dependence	RPJ	Clonazepam	Alcohol Dependence, Cannabis Dependence and Cognitive Disorder NOS	SRB	Lorazepam	Alcohol Dependence and Cannabis Abuse	SWD	Clonazepam	Alcohol Dependence, Polysubstance Dependence and Borderline Intellectual Functioning	TR	Clonazepam	Polysubstance Dependence	Individual	Medication(s)	Diagnosis	AJM	Hydroxyzine	Dementia	ARB	Benztropine	Tardive Dyskinesia	ARB	Benztropine	Dementia Due to General Medical Condition without Behavioral Disturbance	DLW	Benztropine	Mental Retardation, Severity Unspecified	RA	Benztropine	Mild Mental Retardation
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		RS	Benztropine	Mild Mental Retardation
		RD	Hydroxyzine	Borderline Intellectual Functioning
		<u>Polypharmacy use</u>		
		Individual	Medication(s)	Diagnosis
		CTS	Paliperidone, olanzapine, ziprasidone, risperidone (consta), topiramate, divalproex and lithium	XXXXX
		JS	Chlorpromazine, paliperidone, risperidone, buspirone, paroxetine, lorazepam, diphenhydramine (PRN) and chlorpromazine (PRN)	Polysubstance Dependence
		JW	Lamotrigine, topiramate, lithium, fluoxetine, quetiapine and phenytoin	XXXXX
		RTH	Quetiapine, ziprasidone, lamotrigine, bupropion, clonazepam, buspirone, lorazepam (PRN), haloperidol (PRN) and benztropine (PRN)	Other (or Unknown) Substance Abuse
		TME	Loxapine, lorazepam, lithium, divalproex, lorazepam (PRN), haloperidol (PRN) and benztropine (PRN)	Polysubstance Dependence
		Compliance: Partial.		
		Current recommendations:		
		1. Monitor this requirement using the DMH standardized tools based on at least a 20% sample.		
		2. Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).		
		3. Provide ongoing feedback and mentoring by senior psychiatrists to		

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		<p>ensure correction of deficiencies noted by this monitor.</p> <p>4. Identify patterns and trends regarding high-risk medication uses and implement corrective and educational actions.</p>
<p>F.1.d</p>	<p>Each State hospital shall ensure the monitoring of the metabolic and endocrine risks associated with the use of new generation antipsychotic medications.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Review all individuals who are diagnosed with diabetes mellitus and are receiving new generation antipsychotic agents to determine: a) type of medication used; b) rationale for use (if individuals are receiving clozapine, olanzapine, risperidone and/or quetiapine) and c) status of diabetes management (as assessed by the monitoring tool used in section F.7).</p> <p>Findings: The Psychiatry Department at PSH conducted a database query in April 2008 that showed that 165 individuals at the facility were diagnosed with Diabetes Mellitus and were also receiving new generation antipsychotic medications. Of these, 123 individuals were determined to be receiving the high-risk medications clozapine, olanzapine, quetiapine, and risperidone. A study to evaluate documentation of rationale for use of these high-risk medications in this population was undertaken. The results of that study are presented as a DUE in section F.1.g. A separate analysis was done for individuals receiving olanzapine and this data was incorporated into a second DUE report discussed in cell F.1.g.</p> <p>Results from both studies revealed the need for corrective actions, including:</p> <ol style="list-style-type: none"> 1. Improved documentation for this item; 2. Revision of the medical monitoring tool to include information about the type of psychotropic medication the individual is taking.

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		<p>PSH plans to assign to all senior psychiatrists the tasks of mentoring staff psychiatrists and facilitating communications between attending psychiatrists and medical/surgical physicians managing individuals with diabetes.</p> <p>Recommendation 2, November 2007: Standardize the monitoring instruments relevant to this requirement for use across facilities and ensure that the indicators are aligned with the standards in the individualized medication guidelines.</p> <p>Findings: The DMH has yet to implement this recommendation.</p> <p>Recommendation 3, November 2007: Monitor this requirement based on at least a 20% sample of the appropriate total target population and provide data analysis and update regarding corrective actions.</p> <p>Findings: PSH used the PSH New Generation Antipsychotic Auditing Form to assess compliance (December 2007 to April 2008). The average sample was 11% of individuals receiving new generation antipsychotic medications. The following outlines the indicators and corresponding mean compliance rates:</p> <table border="1" data-bbox="991 1149 1871 1416"> <tr> <td>1.</td> <td><i>Family/personal risk factors documented in chart</i></td> <td>44%</td> </tr> <tr> <td>2.</td> <td><i>Indications for use are present</i></td> <td>91%</td> </tr> <tr> <td>3.</td> <td><i>Absolute contraindications are absent</i></td> <td>86%</td> </tr> <tr> <td>4.</td> <td><i>Precautions are absent unless benefit outweighs risk with documentation</i></td> <td>78%</td> </tr> <tr> <td>5.</td> <td><i>PPN documentation of potential and actual risk for each medication used</i></td> <td>26%</td> </tr> </table>	1.	<i>Family/personal risk factors documented in chart</i>	44%	2.	<i>Indications for use are present</i>	91%	3.	<i>Absolute contraindications are absent</i>	86%	4.	<i>Precautions are absent unless benefit outweighs risk with documentation</i>	78%	5.	<i>PPN documentation of potential and actual risk for each medication used</i>	26%
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	6.	<i>Was justification documented in PPN</i>	25%
	6.a.	<i>for individual with a diagnosis of dyslipidemia</i>	29%
	6.b.	<i>for individual with a diagnosis of diabetes</i>	23%
	6.c.	<i>for individual with a diagnosis of obesity</i>	27%
	7.	<i>Dose initiation meets requirements</i>	86%
	8.	<i>Dose iteration meets requirements</i>	89%
	9.	<i>If side effects present, was treatment modified appropriately and time to reduce side effects</i>	62%
	10.	<i>FBS</i>	68%
	10.a.	<i>initially and specific to medication</i>	83%
	10.b.	<i>quarterly</i>	50%
	11.	<i>Lipid panel</i>	67%
	11.a.	<i>initially and specific to medication</i>	83%
	11.b.	<i>quarterly</i>	46%
	12.	<i>Electrolytes initially and specific to medication</i>	79%
	13.	<i>Prolactin level</i>	18%
	13.a.	<i>initially and specific to medication</i>	20%
	13.b.	<i>13b. annually</i>	25%
	14.	<i>Liver function test initially and specific to medication</i>	81%
	15.	<i>Amylase quarterly</i>	21%
	16.	<i>Lipase quarterly</i>	21%
	17.	<i>Vitals initially and specific to medication</i>	77%
	18.	<i>Weight/BMI</i>	76%
	18.a.	<i>initially and specific to medication</i>	79%
	18.b.	<i>monthly</i>	79%
	19.	<i>If there was a trigger for weight gain, was appropriate follow-up provided.</i>	34%
	<p>PSH conducted data analysis showing modest improvement in compliance for all monitoring indicators taken together, compared to the last reporting period.</p>		

		<p>Recommendation 4, November 2007: Provide ongoing feedback and mentoring by Senior Psychiatrists to improve compliance and correct the deficiencies outlined by this monitor above and in the previous report.</p> <p>Findings: Same as findings for Recommendation 4 in D.1.a. In addition, PSH reported the following:</p> <ol style="list-style-type: none"> 1. Monthly PPN training was conducted in late March and mid-April 2008 to address this requirement. 2. A template was piloted in April 2008 that includes a discussion of metabolic risk factors, including diabetes. 3. Training will be done on psychopharmacology and documentation during the next reporting period on both an individual and Department level <p>Other findings: This monitor reviewed the charts of nine individuals who were receiving new generation antipsychotic agents and suffering from a variety of metabolic disorders. The following table outlines the initials of the individuals, the medication(s) used and the metabolic disorder(s):</p> <table border="1" data-bbox="989 1078 1871 1419"> <thead> <tr> <th>Individual</th> <th>Medication(s)</th> <th>Diagnosis</th> </tr> </thead> <tbody> <tr> <td>AD</td> <td>Clozapine and quetiapine</td> <td>Diabetes Mellitus and Dyslipidemia</td> </tr> <tr> <td>ADT</td> <td>Clozapine</td> <td>Diabetes Mellitus, Dyslipidemia and Obesity</td> </tr> <tr> <td>AW</td> <td>Olanzapine</td> <td>Hyperlipidemia</td> </tr> <tr> <td>DRL</td> <td>Clozapine</td> <td>Diabetes Mellitus</td> </tr> <tr> <td>EG</td> <td>Olanzapine and risperidone</td> <td>Diabetes Mellitus</td> </tr> </tbody> </table>	Individual	Medication(s)	Diagnosis	AD	Clozapine and quetiapine	Diabetes Mellitus and Dyslipidemia	ADT	Clozapine	Diabetes Mellitus, Dyslipidemia and Obesity	AW	Olanzapine	Hyperlipidemia	DRL	Clozapine	Diabetes Mellitus	EG	Olanzapine and risperidone	Diabetes Mellitus
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		JIM	Risperidone	Borderline Diabetes Mellitus (based on medical problem list)
		PAB	Olanzapine	Diabetes Mellitus
		RAS	Quetiapine	Diabetes Mellitus and Hyperlipidemia
		TN	Risperidone	Diabetes Mellitus, Hyperlipidemia and Obesity
		<p>This review showed that, in general, the facility provided adequate laboratory monitoring of the metabolic indicators, blood counts and vital signs in individuals at risk. However, deficiencies still exist that must be corrected in order to achieve substantial compliance. The following is an outline of these deficiencies:</p> <ol style="list-style-type: none"> 1. There was inadequate laboratory monitoring of serum lipase and amylase in individuals currently receiving high-risk treatment with olanzapine (AW and EG), risperidone (JIM and TN) and quetiapine (AD and RAS). 2. There was inadequate laboratory monitoring of serum lipids in individuals diagnosed with diabetes mellitus and receiving high-risk treatment with olanzapine (EG) and risperidone (EG and JIM). 3. The WRPs did not address obesity in individuals who suffered from Diabetes Mellitus, significant obesity and received high-risk treatment with olanzapine (EG) and clozapine (DRL). 4. The WRP and corresponding psychiatric progress notes did not address hyperlipidemia in an individual diagnosed with Diabetes Mellitus who had significant elevation of serum lipids and was receiving high-risk treatment with olanzapine (PAB). 5. There was inadequate laboratory and clinical monitoring of endocrine status in female individuals who were receiving high-risk treatment with risperidone (JIM and TN). 6. There was no documentation of monthly psychiatric reassessments since January 2008 of an individual diagnosed with Borderline Diabetes Mellitus and receiving high-risk treatment with 		

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		<p>risperidone (JIM). There was inadequate monitoring of serum glucose levels in this individual.</p> <p>7. There was inadequate monitoring of serum lipids in an individual receiving high-risk treatment with clozapine who was diagnosed with Diabetes Mellitus and had recent significant elevation of serum triglycerides (DRL). The psychiatric progress notes did not document or address the individual's triglyceride level.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement corrective action to improve documentation of the rationale for prescribing high-risk antipsychotic treatment for individuals at risk of metabolic disorders, including Diabetes Mellitus. 2. Provide ongoing feedback and mentoring by Senior Psychiatrists to ensure correction of deficiencies noted by this monitor. 3. Monitor this requirement using the DMH standardized tool based on at least a 20% sample. 4. Identify patterns and trends regarding high-risk medication uses and implement corrective and educational actions.
F.1.e	<p>Each State hospital shall ensure regular monitoring, using a validated rating instrument (such as AIMS or DISCUS), of tardive dyskinesia (TD); a baseline assessment shall be performed for each individual at admission with subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication, and every 3 months if the test is positive, TD is present, or the individual has a history of TD.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Standardize TD monitoring tool and ensure that the indicators address the deficiencies identified by this monitor above and in the previous report.</p> <p>Findings: The facility has implemented this recommendation.</p>

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		<p>Recommendation 2, November 2007: Monitor this requirement in all individuals who are diagnosed with abnormal movement disorder or have history of this disorder and provide data analysis regarding low compliance with corrective actions.</p> <p>Findings: PSH used the DMH Tardive Dyskinesia Auditing Form (standardized) to assess compliance (April 2008). The sample varied from 11% to 38% depending on the indicator. The following outlines the data:</p> <table border="1" data-bbox="991 561 1890 1351"> <tr> <td data-bbox="991 561 1066 638">1.</td> <td data-bbox="1066 561 1774 638"><i>A baseline assessment shall be performed for each individual at admission</i></td> <td data-bbox="1774 561 1890 638">77%</td> </tr> <tr> <td data-bbox="991 638 1066 748">2.</td> <td data-bbox="1066 638 1774 748"><i>Subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication</i></td> <td data-bbox="1774 638 1890 748">85%</td> </tr> <tr> <td data-bbox="991 748 1066 860">3.</td> <td data-bbox="1066 748 1774 860"><i>Monitoring of the individual is conducted every 3 months if the test (AIMS or DISCUS) is positive, TD is present, or the individual has a history of TD</i></td> <td data-bbox="1774 748 1890 860">29%</td> </tr> <tr> <td data-bbox="991 860 1066 972">4.</td> <td data-bbox="1066 860 1774 972"><i>If an older generation antipsychotic is used there is evidence in monthly physician progress note of justification of using the older generation medication</i></td> <td data-bbox="1774 860 1890 972">50%</td> </tr> <tr> <td data-bbox="991 972 1066 1049">5.</td> <td data-bbox="1066 972 1774 1049"><i>A neurology consultation / TD Clinic evaluation was completed as indicated</i></td> <td data-bbox="1774 972 1890 1049">58%</td> </tr> <tr> <td data-bbox="991 1049 1066 1196">6.</td> <td data-bbox="1066 1049 1774 1196"><i>Monthly progress notes for the past 3 months indicate that antipsychotic treatment has been modified to reduce risk or there is documentation of rationale for continuation</i></td> <td data-bbox="1774 1049 1890 1196">50%</td> </tr> <tr> <td data-bbox="991 1196 1066 1237">7.</td> <td data-bbox="1066 1196 1774 1237"><i>Diagnosis of TD is listed on Axis I and/or Axis III</i></td> <td data-bbox="1774 1196 1890 1237">70%</td> </tr> <tr> <td data-bbox="991 1237 1066 1278">8.</td> <td data-bbox="1066 1237 1774 1278"><i>Tardive Dyskinesia is included in Focus 6 of the WRP</i></td> <td data-bbox="1774 1237 1890 1278">76%</td> </tr> <tr> <td data-bbox="991 1278 1066 1351">9.</td> <td data-bbox="1066 1278 1774 1351"><i>The WRP reflect objectives and interventions for Tardive Dyskinesia</i></td> <td data-bbox="1774 1278 1890 1351">70%</td> </tr> </table> <p>The facility's data analysis showed significant improvement since the</p>	1.	<i>A baseline assessment shall be performed for each individual at admission</i>	77%	2.	<i>Subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication</i>	85%	3.	<i>Monitoring of the individual is conducted every 3 months if the test (AIMS or DISCUS) is positive, TD is present, or the individual has a history of TD</i>	29%	4.	<i>If an older generation antipsychotic is used there is evidence in monthly physician progress note of justification of using the older generation medication</i>	50%	5.	<i>A neurology consultation / TD Clinic evaluation was completed as indicated</i>	58%	6.	<i>Monthly progress notes for the past 3 months indicate that antipsychotic treatment has been modified to reduce risk or there is documentation of rationale for continuation</i>	50%	7.	<i>Diagnosis of TD is listed on Axis I and/or Axis III</i>	70%	8.	<i>Tardive Dyskinesia is included in Focus 6 of the WRP</i>	76%	9.	<i>The WRP reflect objectives and interventions for Tardive Dyskinesia</i>	70%
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		<p>last reporting period in performing the AIMS exam at admission (from 42% to 79%). The other questions on the audit tools did not correlate with questions from the audit tools used in the last reporting period and therefore could not be compared. PSH found that psychiatrists were not aware that individuals with positive AIMS who did not have a diagnosis of TD required the same monitoring as individuals with a diagnosis or history of TD. The facility reported that a Department-wide instruction will occur in the next quarter to improve compliance. In addition, individualized feedback will be provided when units are fully staffed and an audit master plan will facilitate feedback and corrective actions.</p> <p>Recommendation 3, November 2007: Develop and implement a policy and procedure to ensure that:</p> <ol style="list-style-type: none"> a. The diagnoses listed on the WRP are aligned with those listed in psychiatric documentation, including TD; b. TD is recognized as one of the foci of hospitalization and that appropriate objectives and interventions are identified for treatment and/or rehabilitation; c. The individuals receive appropriate periodic screening; and d. The individuals receive care at a specialized TD clinic. <p>Findings: PSH did not address this recommendation. Instead, the facility reported that WRP mentors including senior psychiatrists have been instructed on this recommendation and are providing feedback to WRPT leaders to align the WRP with diagnosis, including TD. In addition, senior psychiatrists will provide individualized feedback to psychiatrists whom audits show as failing to comply with TD documentation requirements, including periodic screening. The facility reported that two neurologists who practice as Medical Surgical physicians at PSH have been recruited to start coverage for a movement disorders clinic.</p>
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		<p>Recommendation 4, November 2007: Update the staff psychiatrist manual to include the standards outlined in the policy/procedure.</p> <p>Findings: PSH has yet to implement this recommendation.</p> <p>Other findings: This monitor reviewed the charts of six individuals (ARB, CJ, EW, FS, HR and RS) who were identified in the facility's current database as having a diagnosis of TD. The database identified 62 individuals with diagnosis of TD, 64 individuals with history of TD and 140 individuals with positive AIMS results. This review indicated that PSH has made some progress as follows:</p> <ol style="list-style-type: none"> 1. The facility improved its tracking of individuals with diagnosis and/or history of TD and individuals with positive AIMS. 2. Admission AIMS tests were completed in most of the cases reviewed. 3. Some WRPs included tardive dyskinesia as a diagnosis with appropriate focus, objectives and interventions (e.g. EW). 4. In some charts, there was evidence of attempts to use safer antipsychotic medication alternatives (e.g. FS and HR). <p>However, this review also showed a pattern of deficiencies as follows:</p> <ol style="list-style-type: none"> 1. The WRP identified TD as a diagnosis but did not include corresponding focus, objectives or interventions (ARB, HR and RS). 2. Admission AIMS was not documented in the chart of FS. 3. Some WRPs include unattainable objectives for individuals suffering from TD (e.g. CJ and FS). 4. AIMS test was not conducted on a quarterly basis as required for
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		<p>several individuals (ARB, CJ, EW, HR and RS).</p> <p>5. There was evidence of regular treatment with anticholinergic medications without monitoring or documentation of the risks of this treatment (ARB).</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor this requirement using the DMH standardized tool based on at least a 20% sample. 2. Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period). 3. Develop and implement a policy and procedure to ensure that: <ol style="list-style-type: none"> a. The diagnoses listed on the WRP are aligned with those listed in psychiatric documentation, including TD; b. TD is recognized as one of the foci of hospitalization and that appropriate objectives and interventions are identified for treatment and/or rehabilitation; c. The individuals receive appropriate periodic screening; and d. The individuals receive care at a specialized TD clinic. 4. Update the staff psychiatrist manual to include the standards outlined in the policy/procedure.
F.1.f	Each State hospital shall ensure timely identification, reporting, data analyses, and follow up remedial action regarding all adverse drug reactions ("ADR").	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Increase reporting of ADRs.</p> <p>Findings: PSH did not increase reporting of ADRs during this review period. The facility reported that the new ADR policy and ADR reporting form were</p>

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		<p>not approved for use at PSH until April 9, 2008. After the printing of ADR reporting forms and training of nursing staff on ADR reporting, the policy was implemented on April 28, too late to have a significant impact on ADR reporting data for this reporting period. Of note is the fact that since the implementation of this form and policy, the reporting rate has increased fivefold from 6.8 to 37 ADRs per month.</p> <p>Recommendation 2, November 2007: Develop written instructions to all clinicians regarding significance and proper methods in reporting, investigating and analyzing ADRs.</p> <p>Findings: PSH has implemented this recommendation. In mid-April 2008, nursing staff were given written instructions, contained in the written nursing policy, regarding the proper method of completing the ADR reporting form. The P&T Manual describes the proper reporting and analysis of ADRs for pharmacists and physicians.</p> <p>Recommendation 3, November 2007: Implement recent revisions in the ADR reporting policy.</p> <p>Findings: Same as findings for Recommendation 1.</p> <p>Recommendation 4, November 2007: Continue review and analysis of ADRs and present summary of aggregated data to address the following:</p> <ol style="list-style-type: none">a. The number of ADRs reported each month during the review period compared with number reported during the previous period.b. Classification of probability and severity of ADRs.c. Any negative outcomes for individuals who were involved in serious reactions.d. Data analysis regarding patterns and trends of ADRs, including
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		<p>recommendations for corrective actions.</p> <p>e. Any Intensive Case Analysis done, including review of circumstances of the events, contributing factors, conclusions regarding preventability and any possible process deficiencies; and specific recommendations for corrective actions (full report).</p> <p>Findings: PSH reported ADR data that were gathered during this reporting period. The data showed the following:</p> <ol style="list-style-type: none">1. ADR reporting has decreased during this review period (41 ADRs were reported with an average of 6.8 per month. In the previous reporting period, 63 ADRs were reported with an average of 10.5 per month).2. No severe ADRs were reported this period and as a result, no intensive case analyses were done.3. A summary ADR report was generated for each month. These reports contain an analysis of aggregate ADR results for those ADRs listed as "moderate." <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Increase reporting of ADRs.2. Continue review and analysis of ADRs and present summary of aggregated data to address the following:<ol style="list-style-type: none">a. The number of ADRs reported during the review period compared with number reported during the previous period.b. Classification of probability and severity of ADRs.c. Any negative outcomes for individuals who were involved in serious reactions.d. Data analysis regarding patterns and trends of ADRs, including
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		<p>recommendations for corrective actions.</p> <p>e. Any Intensive Case Analysis done, including review of circumstances of the events, contributing factors, conclusions regarding preventability and any possible process deficiencies; and specific recommendations for corrective actions (full report).</p>
<p>F.1.g</p>	<p>Each State hospital shall ensure drug utilization evaluation ("DUE") occurs in accord with established, up-to-date medication guidelines that shall specify indications, contraindications, and screening and monitoring requirements for all psychotropic medications; the guidelines shall be in accord with current professional literature.</p> <p>A verifiably competent psychopharmacology consultant shall approve the guidelines and ensure adherence to the guidelines.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Ensure that the DUE policy clearly codifies the requirement that the DUE schedule gives priority to high-risk and high-volume medication uses.</p> <p>Findings: PSH has implemented this recommendation. The DUE policy is specified in the PSH Pharmacy and Therapeutics Manual and gives priority to high-risk psychotropic medications. The facility reported that six new generation antipsychotics are reviewed every six months to conduct DUEs.</p> <p>Recommendations 2 and 3, November 2007:</p> <ul style="list-style-type: none"> • Conduct DUEs that include review of the use, analysis of trends/patterns, conclusions regarding findings and recommendations for corrective actions/education activities based on the review. • Ensure proper aggregation and analysis of DUE data to determine practitioner and group patterns and trends. <p>Findings: During this reporting period, four focused DUEs were completed. These DUEs addressed the following issues:</p>

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		<ol style="list-style-type: none"> 1. Use of new generation antipsychotics (NGAs), including clozapine in individuals diagnosed with Diabetes Mellitus,; 2. Prescribing patterns for the NGA drug olanzapine, including its use in Individuals diagnosed with Diabetes Mellitus; 3. Metabolic risk Factors in individuals being prescribed NGAs, including clozapine; and 4. Effect of pharmacist interventions in the prescribing practices of physicians for the drug ziprasidone. <p>The above DUEs implemented adequate methods. The conclusions and recommendations for corrective actions were appropriate. The following is a summary for the most significant recommendations for corrective actions:</p> <ol style="list-style-type: none"> 1. Improve documentation of the rationale for prescribing high-risk NGAs for individuals at risk for metabolic conditions, including Diabetes Mellitus. 2. Revise the monitoring tool regarding management of Diabetes Mellitus to include information on the type of antipsychotic agent used. 3. Develop a set of New Generation Antipsychotic Laboratory Monitoring forms to improve compliance in the area of laboratory monitoring (this was accomplished during this review period). 4. Refer all individuals who meet criteria for the metabolic syndrome to Mall groups addressing medical risks. 5. Refine curriculum for Mall medical risk factors groups to include instruction about obesity, smoking, hypertension, hyperlipidemia, and Diabetes Mellitus. 6. Repeat DUE regarding metabolic risk factors in individuals being prescribed NGAs to assess effects of remedial interventions. 7. Improve the process of pharmacist feedback to physicians on new medication orders.
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		<p>Recommendation 4, November 2007: Ensure that the individualized medication guidelines are continually updated to reflect current literature, relevant clinical experience and current professional practice guidelines.</p> <p>Findings: Same as in F.1.a.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue DUEs that include review of use; analysis of trends/patterns; conclusions regarding findings; and recommendations for corrective actions/educational activities based on the review. 2. Provide a summary outline of corrective actions to address recommendations of the four DUEs completed during this reporting period.
F.1.h	Each State hospital shall ensure documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances ("MVR") consistent with generally accepted professional standards of care.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Consolidate the facility's policies and procedures that address reporting of medication variances.</p> <p>Findings: PSH has implemented this recommendation. AD #10.48 Medication Variances (November 12, 2007) provides the necessary integration.</p> <p>Recommendation 2, November 2007: Develop written instructions to all clinicians regarding significance and proper methods in reporting, investigating and analyzing MVRs.</p>

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		<p>Findings: PSH has implemented this recommendation. Written instructions are contained in AD #10.48 as well as PSH Nursing Policy for Reporting Medication Variances.</p> <p>Recommendation 3, November 2007: Continue review and analysis of medication variances and present summary of aggregated data to address the following:</p> <ul style="list-style-type: none">a. Total number of variances reported each month during the review period compared with numbers reported during the previous period;b. Classification of variances by category (e.g. prescription, administration, documentation, etc) and by potential vs. actual;c. Any negative outcomes for individuals who were involved in serious reactions;d. Data analysis regarding patterns and trends of variances, including recommendations for corrective actions; ande. Any Intensive Case Analysis done, including review of circumstances of the events, contributing factors, conclusions regarding preventability and any possible process deficiencies; and specific recommendations for corrective actions (full report). <p>Findings: PSH presented MVR data for this reporting period. The facility reported a downward trend in the number of variances compared to the last review period. However, this conclusion is not valid because not all data were entered for the February-April 2008 period and it appeared that not all the data were based on the written instructions regarding proper methods in reporting of variances. The data showed that only one variance reached a severity level that required an intensive case analysis. This analysis was done and the content was adequate.</p>
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		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that all MVRs are based on the written instructions regarding proper methods of reporting and investigating variances. 2. Continue review and analysis of medication variances and present summary of aggregated data to address the following: <ol style="list-style-type: none"> a. Total number of variances during the review period compared with numbers reported during the previous period; b. Classification of variances by category (e.g. prescription, administration, documentation, etc) and by potential vs. actual; c. Any negative outcomes for individuals who were involved in serious reactions; d. Data analysis regarding patterns and trends of variances, including recommendations for corrective actions; and e. Any Intensive Case Analysis done, including review of circumstances of the events, contributing factors, conclusions regarding preventability and any possible process deficiencies; and specific recommendations for corrective actions (full report).
F.1.i	<p>Each State hospital shall ensure tracking of individual and group practitioner trends, including data derived from monitoring of the use of PRNs, Stat medications, benzodiazepines, anticholinergics, and polypharmacy, and of ADRs, DUE, and MVR consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Same as in F.1.a through F.1.h.</p> <p>Findings: Same as in F.1.a through F.1.h.</p> <p>Recommendation 2, November 2007: Improve IT resources to the pharmacy to facilitate the development of databases regarding medication use.</p>

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		<p>Findings: PSH reported that it has identified current hospital IT databases that can be utilized to track individual and group practitioner trends, but this will require additional staffing. A master plan will be completed by the end of June to delineate staffing needs to accomplish these goals.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as in F.1.a through F.1.h.</p>
F.1.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>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Same as above.</p> <p>Findings: Same as above.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as in F.1.a through F.1.h.</p>
F.1.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>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Same as above.</p>

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		<p>Findings: Same as in F.1.b and F.1.f. to F.1.i</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as in F.1.b and F.1.f. to F.1.i.</p>
F.1.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>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Same as in D.1.b., D.1.c., D.1.f.viii and F.1.a through F.1.h.</p> <p>Findings: Same as in C.1.b., C.1.c., D.1.f.viii and F.1.a through F.1.h.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as in D.1.b., D.1.c., D.1.f.viii and F.1.a through F.1.h.</p>
F.1.m	Each State hospital shall review and ensure the appropriateness and safety of the medication treatment, consistent with generally accepted professional standards of care, for:	<p>Compliance: Partial.</p>
F.1.m.i	all individuals prescribed continuous anticholinergic treatment for more than two months;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Same as in F.1.c.</p>

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		<p>Findings: Same as in F.1.c.</p> <p>Recommendation 2, November 2007: Ensure that this practice is triggered for review by the appropriate clinical oversight mechanism, with corrective follow- up actions by the psychiatry department.</p> <p>Findings: Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h.</p> <p>Current recommendations: Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h.</p>
F.1.m.ii	all elderly individuals and individuals with cognitive disorders who are prescribed continuous anticholinergic treatment regardless of duration of treatment;	Same as above.
F.1.m.iii	all individuals prescribed benzodiazepines as a scheduled modality for more than two months;	Same as above.
F.1.m.iv	all individuals prescribed benzodiazepines with diagnoses of substance abuse or cognitive impairments, regardless of duration of treatment; and	Same as above.
F.1.m.v	all individuals with a diagnosis or evidencing symptoms of tardive dyskinesia.	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Same as F.1.e.</p> <p>Findings: Same as F.1.e.</p>

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		<p>Current recommendations: Same as F.1.e.</p>
F.1.m.vi	<p>all individuals diagnosed with dyslipidemia, and/or obesity, and/or diabetes mellitus who are prescribed new generation antipsychotic medications</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Same as in F.1.d and F.1.g.</p> <p>Findings: Same as in F.1.d and F.1.g.</p> <p>Current recommendations: Same as in F.1.d and F.1.g.</p>
F.1.n	<p>Each State hospital shall ensure that the medication management of individuals with substance abuse disorders is provided consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Same as in C.2.o and F.1.c.</p> <p>Findings: Same as in C.2.o and F.1.c.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as in C.2.o and F.1.c.</p>
F.1.o	<p>Metropolitan State Hospital shall provide a minimum of 16 hours per year of instruction, through conferences, seminars, lectures and /or videotapes concerning psychopharmacology. Such instruction may be provided either onsite or</p>	

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	through attendance at conferences elsewhere.	
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2. Psychological Services	
	<p>Each State hospital shall provide adequate and appropriate psychological supports and services that are derived from evidence-based practice or practice-based evidence and are consistent with generally accepted professional standards of care, to individuals who require such services; and:</p>
	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Individuals AM and JJB 2. Allison Pate, PhD, Senior Supervising Psychologist 3. Andrea Banks, PT 4. Anthony Coley, Acting Unit Supervisor 5. Chris Keierleber, RT 6. David Haimson, PhD, Chief of Psychology 7. Davis D'Assiss, Unit Supervisor 8. Dominique Kinney, PhD, Psychologist 9. Don Brown, RN, PBS 10. Emmanuel Neizer, (title) 11. Fred Wolfson, Program Director, Enhancement Services 12. Gari-Lyn Richardson, Director, Standards Compliance 13. George Christison, MD, Chief of Psychiatry 14. Georgiana Vinson, RN., Standards Compliance Auditor 15. Gregory Hargrave, Senior PT 16. Helga Thordarson, PhD, Senior Supervising Psychologist 17. Jacquelyn Williams, PH.D., Psychologist 18. Jana Larmer, PhD, Psychologist, WRP Master Trainer 19. Jeff Chambliss, PT, PBS 20. Jeffrey Weinstisn, PhD, Psychologist 21. Jonas Lunas, RN 22. Julia Fleming, RT, WRP Master Trainer 23. Kira Mellups, PhD, Psychologist 24. Light-Allende Kimberly, PsyD, Psychologist 25. Maria Castillo, RN, PBS 26. Melanie Bye, PhD, Mall Director 27. Sean Evans, PhD, Psychologist, PBS Chair 28. Steven Berman, PhD, Psychologist, BY CHOICE Coordinator 29. Susan Velasquez, PhD, Coordinator, Psychology Specialized Services

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		<p>30. Waheed Saeed, MD, Staff Psychiatrist</p> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Charts of the following 42 individuals: AB, AM, ATB, AV, BYB, CAZ, CF, CW, DJ, DM, DMK, EJH, FP, GB, GH, JA, JJB, JML, JP, JRP, KAM, KJ, KLK, LRL, MAC, MAE, MH, MHK, MLB, MMH, NMM, NWJ, PHL, RAG, RBC, RD, RJ, RT, SG, SV, TA, and WRP 2. Administrative Directive #15.09 (Positive Behavioral Support Program (October 22, 2007) 3. Behavioral Consultation Committee Attendance Sheets 4. Behavioral Consultation Meeting Minutes 5. Behavioral Guideline Monitoring Form 6. Behavioral Guidelines 7. BY CHOICE Staff Development Attendance Sheet 8. DMH Clinical Indicator List 9. DMH Psychology Services Monitoring Form 10. DMH Statewide Behavior Support Plan Monitoring Form 11. List of individuals referred to behavioral consultation committee 12. List of individuals who met trigger thresholds 13. List of individuals with BMI triggers 14. List of individuals with substance abuse diagnosis 15. List of PBS-BCC Checklist 16. Neuropsychology Assessment Referrals 17. Neuropsychology Focused Assessments 18. PBS Support Plan Fidelity Checks 19. PBS Team WRPC attendance Progress Notes 20. PSH "Psychology Bugle" Newsletters 21. PSH PBS Plan Integration and Outcomes Worksheet (March 2008) 22. Psychology Focused Assessments 23. Psychology Specialty Services Committee Minutes 24. Summary of Discipline-Facilitated Hours 25. Trigger Review Documentation 26. Weekly Group Activity Schedules
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		<p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPC for JJB (Program IV, unit 70) 2. WRPC for LBP (Program VI, Unit EB12) 3. Collaborative Recovery Mall Group 4. Relaxation Mall Group 5. Anti-Social—Face It and Pace It Mall Group 6. Mood Management Mall Group 7. Psychology Specialized Services Team Meeting
F.2.a	<p>Each State hospital shall ensure that it has positive behavior support teams (with 1 team for each 300 individuals, consisting of 1 clinical psychologist, 1 registered nurse, 2 psychiatric technicians (1 of whom may be a behavior specialist), and 1 data analyst (who may be a behavior specialist) that have a demonstrated competence, consistent with generally accepted professional standards of care, in the following areas:</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Implement the system-wide PBS plan.</p> <p>Findings: This monitor's documentation review (system-wide PBS program, PSH's progress report), observation of the Psychology Specialized Services Trigger (PSST), and interview of the Chief of Psychology, David Haimson, and the Senior Psychologist Supervisor, Susan Velasquez, found that PSH has implemented the system-wide PBS plan in January 2008. In conjunction with this, PSH has established the Psychology Specialized Services Team (PSST) meetings. The PSST meeting is held twice weekly to discuss high-risk cases and plan the most appropriate action for the individuals. This monitor had the opportunity to attend one of the PSST meetings. The team had a well-organized, coherent plan and process in place. However, this team needs the support of the psychiatry team for better case management of the cases being discussed, especially for individuals with PRN, Stat, and polypharmacy issues.</p> <p>Recommendation 2, November 2007: Ensure that PSH has the required number of PBS teams by recruiting additional staff to meet the 1:300 ratio as required by the EP.</p>

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		<p>Findings: This monitor's documentation review (PSH staffing documents and progress report) and interview with the Chief of Psychology found that PSH did not have the required number of PBS teams to meet the 1:300 PBS team-to-census ratio. The current ratio is 1:504. PSH currently has two full PBS teams and one partial PBS team. PSH is actively recruiting to fill the remaining vacancies in the PBS teams.</p> <p>Recommendation 3, November 2007: Continue training of all direct care staff in PBS principles.</p> <p>Findings: This monitor's review of PSH's training documentation and interview of the Chief of Psychology found that PSH had continued to train all new employees for eight hours during the New Employee Orientation program.</p> <p>The table below showing the number of staff in need of PBS training (N), the number of staff completing the training (T), and the percentage of staff trained (%C) is a summary of the facility's data.</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <thead> <tr> <th></th> <th>MDs</th> <th>PhDs</th> <th>SWs , RTs and Dieticians</th> <th>RNs</th> <th>LVNs</th> <th>PTs & PTAs</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>106</td> <td>67</td> <td>141</td> <td>390</td> <td>70</td> <td>904</td> <td></td> </tr> <tr> <td>T</td> <td>73</td> <td>52</td> <td>109</td> <td>305</td> <td>57</td> <td>703</td> <td></td> </tr> <tr> <td>%C</td> <td>69</td> <td>78</td> <td>74</td> <td>79</td> <td>82</td> <td>77</td> <td>77</td> </tr> </tbody> </table> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that PSH has the required number of PBS teams by recruiting additional staff to meet the 1:300 ratio as required by the EP. 2. Continue training of all direct care staff in PBS principles. 		MDs	PhDs	SWs , RTs and Dieticians	RNs	LVNs	PTs & PTAs	Mean	N	106	67	141	390	70	904		T	73	52	109	305	57	703		%C	69	78	74	79	82	77	77
	MDs	PhDs	SWs , RTs and Dieticians	RNs	LVNs	PTs & PTAs	Mean																											
N	106	67	141	390	70	904																												
T	73	52	109	305	57	703																												
%C	69	78	74	79	82	77	77																											

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<p>F.2.a.i</p>	<p>the development and use of positive behavior support plans, including methods of monitoring program interventions and the effectiveness of the interventions, providing staff training regarding program implementation, and, as appropriate, revising or terminating the program; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Ensure that PBS psychologists have the authority to write orders for the implementation of PBS plans.</p> <p>Findings: This monitor's review of AD#15.09 and interview of the Chief of Psychology found that the authority for PBS psychologists at PSH to write orders for implementation of PBS plans was approved with full support from PSH's Medical Executive Committee.</p> <p>Recommendation 2, November 2007: Ensure that all relevant staff receives systematic training in all aspects of the PBS plans.</p> <p>Findings: This monitor's training documentation review found that PBS team members have provided training to staff responsible for implementing the four active PBS plans (KK, LL ME and RJ).</p> <p>Recommendations 3 and 4, November 2007:</p> <ul style="list-style-type: none"> • Develop a systematic way of evaluating treatment outcomes and reporting those outcomes. • Revision of treatment plans should be directly related to the outcome data and reported at all scheduled WRPCs. <p>Findings: This monitor's review of PBS plans, outcome data, graphs, and interview of the Chief of Psychology and PBS staff found that PBS teams now use quantitative data to make decisions. According to the Chief of Psychology, a database has been set up to monitor and analyze outcome data. Furthermore, PBS team members attend WRPCs to assist WRPTs</p>
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		<p>with understanding and documenting the outcome data.</p> <p>Compliance: Substantial.</p> <p>Current recommendations: Continue to train all relevant staff on all aspects of PBS training.</p>
F.2.a.ii	<p>the development and implementation of a facility-wide behavioral incentive system, referred to as "By CHOICE" that encompasses self-determination and choice by the individuals served.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Train all staff in correctly implementing the BY CHOICE program.</p> <p>Findings: This monitor's review of PSH's BY CHOICE training documentation and interview of the BY CHOICE Coordinator, Steve Berman, found that PSH has continued to provide BY CHOICE training to its staff during the New Employee Orientation. As of April 2008, 86% of PSH staff completed the BY CHOICE General Training, 45% of staff completed the BY CHOICE Data Entry Training, and 74% of staff completed the Point Allocation Training. The BY CHOICE Coordinator has developed and distributed to WRPT members handouts on BY CHOICE documentation in the individuals' WRPs ("Items to Include in BY CHOICE Write-Up Section of WRP", and "BY CHOICE Guidelines for WRP Write-ups"). Social Workers underwent training in the Supplemental Clinical Training at their February service meeting (2/27/08). The rehabilitation therapists and psychologists had their training at their March service meetings (3/5/08, 3/12/08). According to the documentation presented, 100% of social workers, 81% of rehabilitation therapists, and 58% of psychologists received the Supplemental Clinical Training.</p> <p>Recommendation 2, November 2007: Ensure that the program receives adequate resources.</p>

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		<p>Findings: According to the BY CHOICE Coordinator, the BY CHOICE program still needs funding for computers for BY CHOICE staff and inventory control, and development of a BY CHOICE shopping catalog on unit computers.</p> <p>Recommendation 3, November 2007: Report BY CHOICE point allocation in the present status section of the individual's case formation and update at every scheduled WRPC.</p> <p>Findings: This monitor's interview of the BY CHOICE Coordinator found that the BY CHOICE Coordinator has been reviewing WRPs with regards to BY CHOICE documentation and sending monthly written feedback to psychologists detailing the results of each psychologist's BY CHOICE clinical audit. In addition, the BY CHOICE coordinator has been contacting units that were noncompliant with BY CHOICE procedures (for example, setting up of individuals with BY CHOICE cards and/or recording and reporting points for ongoing quantitative analysis) to improve compliance.</p> <p>According to the BY CHOICE Coordinator, the WRP documentation was seldom individualized, often over-generalized, and the same statements were repeated across WRPs. The BY CHOICE Coordinator also stated that some of the deficits in proper documentation were due in part to system changes and insufficient psychology staffing.</p> <p>PSH used item #16 from the DMH Psychology Services Monitoring Form (<i>The BY CHOICE point allocation is updated monthly in the individual's WRP</i>) to address this recommendation, reporting 13% compliance. The table below showing the census at PSH each month (N), the number WRPs audited (n), and percentage of compliance obtained (%C) is a summary of the facility's data.</p>
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	11/07	12/07	1/08	2/08	3/08	4/08	Mean
N	1500	1500	1501	1494	1501	1499	
n	96	97	150	150	150	150	
%S	6	6	10	10	10	10	
%C #16	14	12	8	9	17	15	13
<p>This monitor reviewed 16 charts (AM, ATB, DM, EJH, GH, JJB, JP, JRP, KJ, MAC, MH, MHK, MMH, NMM, NWJ and PHL). BY CHOICE point allocation in six of the WRPs in the charts (AM, KJ, MAC, MH, MMH and NWJ) was acceptable. The point allocation in the remaining ten WRPs (ATB, DM, EJH, GH, JJB, JP, JRP, MHK, NMM and PHL) failed to satisfy the documentation requirements. For example, documentation for BY CHOICE in NMM's WRP read, "Ms. M stated in today's WRP, 4/10/2008, that, "I just leave the points as it is." ATB's documentation stated "explained the BY CHOICE graph;" however, the data was not reported in the Present Status section.</p> <p>Recommendation 4, November 2007: Ensure that individuals know their performance requirements to earn full points.</p> <p>Findings: PSH used item #B4 from the BY CHOICE Competency and Fidelity Survey (<i>The individuals can discuss to the best of their ability what the expectations are for them to earn FP, MP, and NP for the current cycle</i>) to address this recommendation, reporting 92% compliance. The table below showing the census at PSH each month (N), the number of individuals surveyed by Standards Compliance (n), and percentage of compliance obtained (%C) is a summary of the facility's data.</p>							
	11/07	12/07	1/08	2/08	3/08	4/08	Mean
N	1500	1500	1501	1494	1501	1499	

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		n	31	66	67	65	37	60	
		%S	2	4	4	4	2	4	
		%C	100	88	91	85	95	98	92
		#B4							
		<p>This monitor interviewed two individuals (AM and JJB), and both of them stated that they were aware of what they had to do in their Mall groups to earn various levels of points (FP, MP and NP).</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Report BY CHOICE point allocation in the present status section of the individual's case formation and update at every scheduled WRPC. 2. Ensure that the program receives adequate resources. 3. Train all staff in correctly implementing the BY CHOICE program. 4. Ensure that individuals know their performance requirements to earn full points. 							
F.2.b	Each State Hospital shall ensure that the Chief of Psychology has the clinical and administrative responsibility for the Positive Behavior Supports Team and the By CHOICE incentive program.	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Continue current practice.</p> <p>Findings: This monitor's interview of the Chief of Psychology found that the Chief of Psychology continues to have all clinical and administrative responsibility of the PBS teams and the BY CHOICE incentive program.</p> <p>Compliance: Substantial.</p>							

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		<p>Current recommendations: Continue current practice.</p>
F.2.c	Each State Hospital shall ensure that:	<p>Compliance: Partial.</p>
F.2.c.i	behavioral assessments include structural and functional assessments and, as necessary, functional analysis;	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Continue current practice of staff training on PBS principles and practices.</p> <p>Findings: This monitor's interview of the Chief of Psychology found that PBS staff has continued to learn from seminars provided to the PBS staff over the year.</p> <p>This monitor's interview of PBS found that the PBS staff would like in-depth information on matters pertaining to protocol and intervention development, and data analysis and interpretation. All four state facilities may wish to have their DMH consultant provide this training.</p> <p>Current recommendations: Continue current practice of staff training on PBS principles and practices.</p>
F.2.c.ii	hypotheses of the maladaptive behavior are based on structural and functional assessments;	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, November 2007:</p> <ul style="list-style-type: none"> • Ensure that proper assessments are conducted prior to developing and implementing intervention plans. • Ensure that hypotheses of the maladaptive behaviors are based on structural and functional assessments and clearly stated in the PBS

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		<p>documentation.</p> <p>Findings: PSH used item #5 from the DMH Psychology Services Monitoring Form (<i>PBS assessments include structural and functional assessments, and as necessary, functional analysis</i>) to address this recommendation, reporting 95% compliance. The table below showing the number of PBS plans developed and implemented each month (N), the number of PBS plans reviewed (n), and percentage of compliance obtained (%C) is a summary of the facility's data.</p> <table border="1" data-bbox="991 597 1451 789"> <thead> <tr> <th></th> <th>12/07</th> <th>1/08</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>1</td> <td>2</td> <td></td> </tr> <tr> <td>n</td> <td>1</td> <td>2</td> <td></td> </tr> <tr> <td>%S</td> <td>100</td> <td>100</td> <td></td> </tr> <tr> <td>%C #5</td> <td>100</td> <td>90</td> <td>95</td> </tr> </tbody> </table> <p>PSH also used items #5 to #9 (see below) from the DMH PBS Plan Monitoring Form to address this recommendation, reporting 100% compliance for items #5, 6, 7, and 9, and 75% for item #8. The table below with its monitoring indicators showing the number of structural/functional assessments conducted each month (N), the number of assessments reviewed (n), and percentage of compliance obtained (%C) is a summary of the facility's data.</p> <p><i>Pertinent records were reviewed (e.g., individual's chart/record, meeting notes, anecdotal records, evaluations, previous interventions, etc) (#5).</i></p> <p><i>Structural assessments (e.g., ecological, sleep, medication effects, mall attendance, etc) were conducted, as needed, to determine broader variables affecting the individual's behavior (#6).</i></p> <p><i>Functional assessment interviews were conducted with people (e.g.,</i></p>		12/07	1/08	Mean	N	1	2		n	1	2		%S	100	100		%C #5	100	90	95
	12/07	1/08	Mean																			
N	1	2																				
n	1	2																				
%S	100	100																				
%C #5	100	90	95																			

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individual, parents and family members, therapists and care staff, teachers, etc) who often interact with the individual within different settings and activities (#7).

Direct observations were conducted across relevant circumstances (e.g., multiple settings, over time) and by more than one observer, as appropriate (#8).

Other assessment tools (e.g., rating scales, checklists) were used to produce objective information regarding events preceding and following the behavior of concern, as well as ecological and motivational variables that may be affecting the individual's behavior (#9).

	12/07	1/08	Mean
N	1	2	
n	1	2	
%S	100	100	
%C #5	100	100	100
%C #6	100	100	100
%C #7	100	100	100
%C #8	100	50	75
%C #9	100	100	100

This monitor's review of the PBS plans (KK, LL, ME and RJ) and structural and functional assessments (AV, KK, LL and LMR) and their data used to derive hypothesis for developing the intervention plans is in agreement with the facility's data.

Current recommendations:

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

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		documentation.
F.2.c.iii	There is documentation of previous behavioral interventions and their effects;	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Continue current practice.</p> <p>Findings: This monitor's review of all active structural and functional assessments found that PBS teams had documented previous behavioral interventions and their effects as part of their sources of information for a comprehensive assessment. This finding is in agreement with the facility's data.</p> <p>Current recommendation: Continue current practice.</p>
F.2.c.iv	behavioral interventions, which shall include positive behavior support plans, are based on a positive behavior supports model and do not include the use of aversive or punishment contingencies;	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Ensure that all behavioral interventions are based on a PBS model without any use of aversive or punishment contingencies.</p> <p>Findings: This monitor's interview of the Chief of Psychology and the Senior Supervising Psychologists found that PSH has established a system of monitoring by PBS Chairs of all behavior guidelines to ensure that interventions developed and implemented in PSH are based on a PBS model without any use of aversive or punishment contingencies.</p> <p>PSH used items #H.2.c and #8 (see below) from the DMH Psychology Services Monitoring Form to address this recommendation, reporting 100% and 99% compliance respectively. The table below with its</p>

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		<p>monitoring indicators showing the number of PBS plans developed and implemented each month (N), the number of PBS plans reviewed (n), and percentage of compliance obtained (%C) is a summary of the facility's data.</p> <p><i>Restraints and seclusion are not used as part of a behavioral intervention (#H.2.c).</i></p> <p><i>Behavioral interventions, which include positive behavior support plans, are based on a positive behavior supports model and do not include the use of aversive or punishment contingencies (#8).</i></p> <table border="1" data-bbox="991 634 1900 865"> <thead> <tr> <th></th> <th>11/07</th> <th>12/07</th> <th>1/08</th> <th>2/08</th> <th>3/08</th> <th>4/08</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>24</td> <td>11</td> <td>14</td> <td>9</td> <td>13</td> <td>6</td> <td>13</td> </tr> <tr> <td>n</td> <td>24</td> <td>11</td> <td>14</td> <td>9</td> <td>13</td> <td>6</td> <td>13</td> </tr> <tr> <td>%S</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> </tr> <tr> <td>%C #H.2c</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> </tr> <tr> <td>%C #8</td> <td>100</td> <td>100</td> <td>100</td> <td>89</td> <td>100</td> <td>100</td> <td>99</td> </tr> </tbody> </table> <p>The findings from this monitor's review of PBS plans and behavior guidelines are in agreement with the facility's data. All PBS plans and behavioral guidelines, except for one, were based on a positive behavior supports model. The Senior Supervising Psychologists tracked and monitored the one behavioral guideline that had included a punishing contingency and provided corrective feedback on the plan. The facility's system of reviewing all behavioral guidelines has been effective in this case. However, the reviewers should also look into the quality of the behavioral guidelines. The prevention and intervention strategies outlined in a number of behavioral guidelines are not a match to the target behaviors, are incomplete, are misplaced, or are of poor quality. Examples include:</p> <ol style="list-style-type: none"> 1. GB's prevention strategy was that "Mr. B not attend Mall groups." 		11/07	12/07	1/08	2/08	3/08	4/08	Mean	N	24	11	14	9	13	6	13	n	24	11	14	9	13	6	13	%S	100	100	100	100	100	100	100	%C #H.2c	100	100	100	100	100	100	100	%C #8	100	100	100	89	100	100	99
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		<p>This strategy may be good for the group, but it does nothing for Mr. B and therefore cannot be considered a prevention strategy for GB's target behaviors.</p> <ol style="list-style-type: none"> 2. As part of the intervention when AV's behaviors escalate, staff is asked to escort AV to the side room but there are no intervention strategies for staff to use in the side room. 3. Information under prevention strategies for DMK highlighted the risk factors and behaviors "to educate staff" but there were no antecedent/ environmental management strategies that staff should follow to eliminate the potential for the target behaviors. 4. In one case, the intervention for self harm/aggression was for staff to place individual on a 1:1 or offer medication to reduce agitation. In contrast to another behavior guideline, that offered a more appropriate strategy of separation of the individual from others and allowing positive interaction with staff and discussion of the individual's thoughts and feelings. <p>Current recommendation: Ensure that all behavioral interventions are based on a PBS model without any use of aversive or punishment contingencies.</p>
F.2.c.v	behavioral interventions are consistently implemented across all settings, including school settings;	<p>Current findings on previous recommendations:</p> <p>Recommendations 1-3, November 2007:</p> <ul style="list-style-type: none"> • Ensure that staff across settings is aware of individuals' behavioral plans and that they receive written plans and training. • Monitor the implementation of PBS plans to ensure that all behavioral interventions are consistently implemented across all settings, including the PSR Mall and vocational and education settings. • 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.

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		<p>Findings: PSH used items #20 and #9 (see below) from the DMH PBS Plan Monitoring Form to address these recommendations, reporting 100% compliance for both items. The table below with its monitoring indicators showing the number of PBS plans developed and implemented in each month (N), the number of assessments reviewed (n), and percentage of compliance obtained (%C) is a summary of the facility's data.</p> <p><i>Everyone working with the individual on a regular basis is familiar with the PBS plan and implements its strategies with high degree of fidelity (#20).</i></p> <p><i>Behavioral interventions are consistently implemented across all settings including school settings (#9).</i></p> <table border="1" data-bbox="991 743 1476 976"> <thead> <tr> <th></th> <th>2/08</th> <th>4/08</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>1</td> <td>1</td> <td></td> </tr> <tr> <td>n</td> <td>1</td> <td>1</td> <td></td> </tr> <tr> <td>%S</td> <td>100</td> <td>100</td> <td></td> </tr> <tr> <td>%C #9</td> <td>100</td> <td>100</td> <td>100</td> </tr> <tr> <td>%C #20</td> <td>100</td> <td>100</td> <td>100</td> </tr> </tbody> </table> <p>This monitor's review of the training data for KK, LL, ME and RJ is in agreement with the facility's findings.</p> <p>Recommendation 4, November 2007: Conduct regular fidelity checks.</p> <p>Findings: This monitor's documentation review (fidelity checks, PBS plans, and Graphs) found that PBS teams conduct fidelity checks. However, except for ME, the rest of the plans had fidelity checks primarily at the first treatment implementation phase (KK, LL and RJ). Review of ME's fidelity</p>		2/08	4/08	Mean	N	1	1		n	1	1		%S	100	100		%C #9	100	100	100	%C #20	100	100	100
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		<p>check data found that treatment implementation was poor (mostly below 50%). PBS teams should strive to conduct regular fidelity checks and use the data to retrain staff and/or make changes to the PBS plan.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. 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. 2. Monitor the implementation of PBS plans through fidelity checks to ensure that all behavioral interventions are consistently implemented across all settings, including the PSR Mall and vocational and education settings.
F.2.c.vi	<p>triggers for instituting individualized behavioral interventions are specified and utilized, and that these triggers include excessive use of seclusion, restraint, or psychiatric PRN and Stat medication for behavior control;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, November 2007:</p> <ul style="list-style-type: none"> • Refine the implementation of the trigger system. • Ensure proper documentation. <p>Findings:</p> <p>This monitor's documentation review (PSH's trigger data and chart reviews) and interview of the Chief of Psychology, Senior Supervising Psychologists, and the Coordinator of the Psychology Specialty Services Team found that PSH has refined the response to triggers and put in place new committees and meetings to address this recommendation.</p> <p>According to the PBS chairs, they receive and analyze the facility-wide trigger data and share the information with the unit psychologist. If a behavioral guideline is deemed necessary, the PBS team members work with the unit psychologist to develop and implement the behavioral guideline. Trigger data is also reviewed at the newly established Psychology Specialized Services Trigger (PSST) meetings. The Coordinator of the PSST tracks and monitors implementation of the</p>

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		<p>decisions and recommendations made. The PSST and PBS teams have decided that a second trigger would move the case to a PBS plan level even if a behavioral guideline is in place.</p> <p>PSH had developed and implemented 77 behavioral interventions over the last six months. According to the Chief of Psychology and WRPT members, PBS team members attend WRPT meetings to work with the teams on data analysis and explanation, and assist the team with proper documentation. PSH should also include review of the PRN and Stat med data to this process.</p> <p>This monitor reviewed the charts of 10 individuals with triggers (DMK, FP, KAM, MLB, RAG, RBC, RD, RT, SG and SV). Except for RBC's WRP, there was documentation in the remaining nine WRPs regarding the review of and decisions made pertaining to the status of the individuals' triggers/maladaptive behaviors. For example, individual therapy was provided for FP; the PSST reviewed RT's status and placed on the list for follow-up; behavior guideline outcome data was presented for MLB; and the psychologist was communicating with the psychiatrist regarding RAG while a behavior guideline was in place.</p> <p>Current recommendations: Ensure proper documentation.</p>
F.2.c.vii	positive behavior support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy;	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Ensure that treatment modalities are integrated to better serve individuals, as indicated.</p> <p>Findings: This monitor's documentation reviews (PBS plans, behavior guidelines, charts, and PSH's progress report) found that psychologists generally do</p>

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		<p>not formally integrate other treatment modalities in their assessments and treatment plans. There is evidence that some integration is being done at an information level. For example, as documented in RAG's WRP, the psychologist has been in communication with the psychiatrist regarding RAG's medication and mental illness, and there is some documentation of integration in the psychology note for KLK (January 24, 2008). This process should be formalized to ensure a comprehensive assessment and multimodal therapy to address all domains of the individual's needs.</p> <p>Current recommendation: Ensure that treatment modalities are integrated to better serve individuals, as indicated.</p>																																
F.2.c.viii	<p>all positive behavior support plans are specified in the objectives and interventions sections of the individual's Wellness and Recovery Plan;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Specify PBS plans in the objectives and interventions sections of the individual's WRP, as outlined in the DMH WRP Manual.</p> <p>Findings: PSH also used item #12 from the DMH Psychology Services Monitoring Form (<i>The PBS plan is clearly specified in the objectives and interventions sections of the individual's Wellness and Recovery Plan</i>) to address this recommendation, reporting 46% compliance. The table below showing the number of active PBS plans (N), the number of PBS plans reviewed (n), and percentage of compliance obtained (%C) is a summary of the facility's data.</p> <table border="1" data-bbox="991 1263 1906 1416"> <thead> <tr> <th></th> <th>11/07</th> <th>12/07</th> <th>1/08</th> <th>2/08</th> <th>3/08</th> <th>4/08</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>2</td> <td>2</td> <td>2</td> <td>3</td> <td>3</td> <td>4</td> <td></td> </tr> <tr> <td>n</td> <td>2</td> <td>2</td> <td>2</td> <td>3</td> <td>3</td> <td>4</td> <td></td> </tr> <tr> <td>%S</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td></td> </tr> </tbody> </table>		11/07	12/07	1/08	2/08	3/08	4/08	Mean	N	2	2	2	3	3	4		n	2	2	2	3	3	4		%S	100	100	100	100	100	100	
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		%C #12	50	50	50	33	33	50	46
		<p>According to the Senior Psychologists, there were instances in which the PBS team members did not attend the WRPCs because the scheduled meeting times were changed without notification. In addition, there were units without psychologists to help the WRPTs with the documentation.</p> <p>This monitor's findings from review of the WRPs of individuals with PBS plans (FJ, KK, LL, ME, RJ and WRP) is in agreement with the facility's data. In addition, documentation of PBS plans/behavior guidelines in the Present Status sections of the individuals' WRPs needs attention. For example, documentation of JP's behavior guideline in the Present Status section of his WRP (dated 6/12/2008) stated that the behavior guideline was updated on 5/19/08, targeting Mall group attendance, and the attendance rate given was 52.86%. But, in the same paragraph it was stated that "Mr. P has engaged in no behaviors that would warrant a referral to PBS or need for behavior guidelines."</p> <p>Current recommendation: Specify PBS plans in the objectives and interventions sections of the individual's WRP, as outlined in the DMH WRP Manual.</p>							
F.2.c.ix	all positive behavior support plans are updated as indicated by outcome data and reported at least quarterly in the Present Status section of the case formulation in the individual's Wellness and Recovery Plan	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, November 2007:</p> <ul style="list-style-type: none"> • Collect objective information to evaluate the effectiveness of the PBS plans, including change in behaviors, stability of behavior change, changes in co-varying behaviors, achievement of broader goals and durability of behavior change. • Continue to track and monitor that PBS plans are updated using outcome data in the individual's present status section of the WRP. 							

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		<p>Findings: This monitor's review of PSH's recent PBS plans (FJ, KK, LL and ME) found that data is being collected on the individual's maladaptive behaviors. However, none of the plans collected data on the individual's co-varying behaviors, alternate behaviors, and achievement and broader goals and durability of behavior change. In most cases, strengthening alternate and/or incompatible behaviors with broader goals of application in the individual's routine will not only help reduce the maladaptive behaviors but also improve the quality of the individual's life.</p> <p>Graphical data presented on "Staff Compliance on PBS plans" (for example, plans for ME) show poor treatment implementation, with most points below 50% integrity. Unit Supervisors should work with staff and PBS teams to increase treatment integrity. Poor treatment implementation was also noted in ME's WRP.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Collect objective information to evaluate the effectiveness of the PBS plans, including change in behaviors, stability of behavior change, changes in co-varying behaviors, achievement of broader goals and durability of behavior change. 2. Continue to track and monitor that PBS plans are updated using outcome data in the Present Status section of the individual's WRP.
F.2.c.x	<p>all staff has received competency-based training on implementing the specific behavioral interventions for which they are responsible, and performance improvement measures are in place for monitoring the implementation of such interventions.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, November 2007:</p> <ul style="list-style-type: none"> • Provide competency-based PBS training to all staff. • 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. <p>Findings: This monitor's interview with the PBS staff and documentation review</p>

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		<p>(staff training/certification data, and fidelity check data) found that it is the standard practice for PBS teams to test the protocol with the individual in the setting in which the plan is to be implemented, following which staff responsible for implementing the plan are trained before implementing the plan. Fidelity checks are conducted on an ongoing basis to ensure that the plan is being implemented with integrity. According to the PBS staff, staff retraining is conducted if fidelity scores are below 90%.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Provide competency-based PBS training to all staff. 2. 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.
F.2.c.xi	<p>all positive behavior support team members shall have as their primary responsibility the provision of behavioral interventions;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Ensure required number of PBS teams to meet the 1:300 ratio.</p> <p>Findings: This monitor's documentation review (staffing census and progress report) and interview of the Chief of Psychology found that PSH does not have a sufficient number of PBS teams to meet the 1:300 ratio. The currently staffed PBS teams place the ratio at 1:504. PSH is actively recruiting to fill the vacant positions.</p> <p>Current recommendation: Ensure required number of PBS teams to meet the 1:300 ratio.</p>
F.2.c.xii	<p>the By CHOICE point allocation is updated monthly in the individual's Wellness and Recovery Plan.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Ensure that BY CHOICE point allocation is updated monthly in the</p>

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		<p>individual's WRP.</p> <p>Findings: PSH used item #16 from the DMH Psychology Services Monitoring Form (<i>The BY CHOICE point allocation is updated monthly in the individual's WRP</i>) to address this recommendation, reporting 13% compliance. The table showing the census at PSH each month (N), the number WRPs audited (n), and percentage of compliance obtained (%C) is a summary of the facility's data.</p> <table border="1" data-bbox="991 561 1906 753"> <thead> <tr> <th></th> <th>11/07</th> <th>12/07</th> <th>1/08</th> <th>2/08</th> <th>3/08</th> <th>4/08</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>1500</td> <td>1500</td> <td>1501</td> <td>1494</td> <td>1501</td> <td>1499</td> <td></td> </tr> <tr> <td>n</td> <td>96</td> <td>97</td> <td>150</td> <td>150</td> <td>150</td> <td>150</td> <td></td> </tr> <tr> <td>%S</td> <td>6</td> <td>6</td> <td>10</td> <td>10</td> <td>10</td> <td>10</td> <td></td> </tr> <tr> <td>%C 16</td> <td>14</td> <td>12</td> <td>8</td> <td>9</td> <td>17</td> <td>15</td> <td>13</td> </tr> </tbody> </table> <p>This monitor reviewed 11 charts (AM, ATB, DM, EJH, GH, JML, JRP, KJ, MAC, MH and MMH). Three of the WRPs in the charts (MAC, MH and MMH) had acceptable BY CHOICE documentation, and the remaining eight (AM, ATB, DM, EJH, GH, JML, JRP and KJ) did not.</p> <p>Current recommendation: Ensure that BY CHOICE point allocation is updated monthly in the individual's WRP.</p>		11/07	12/07	1/08	2/08	3/08	4/08	Mean	N	1500	1500	1501	1494	1501	1499		n	96	97	150	150	150	150		%S	6	6	10	10	10	10		%C 16	14	12	8	9	17	15	13
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F.2.d	<p>Each State hospital shall ensure that it has at least one developmental and cognitive abilities team (DCAT; consisting of 1 clinical psychologist, 1 registered nurse, 1 social worker, 1 psychiatric technician, and 1 data analyst (who may be a behavior specialist) who have a demonstrated competence, consistent with generally accepted professional standards of care, in assessing</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1-5, November 2007:</p> <ul style="list-style-type: none"> • Develop and implement a full DCAT, consisting of a clinical psychologist, registered nurse, social worker, psychiatric technician, and data analyst. • Ensure that all individuals with cognitive challenges are assessed by the DCAT. 																																								

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	<p>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>	<ul style="list-style-type: none"> • Ensure that all DCAT members are available for consultation to other staff to assist with planning therapeutic activities at the individual's cognitive functioning level. • Ensure that DCAT members' primary responsibility is consistent with the EP. • Ensure that DCAT members receive appropriate training. <p>Findings: PSH does not have a DCAT team at this time. According to the Chief of Psychology, PSH is actively recruiting to fill these vacant positions. The Psychology staff has taken on some of the DCAT responsibilities. For example, cognitive screening is done during the Integrated Assessment: Psychology section; DCAT/PBS referrals are handled by the existing PBS teams; and cognitive assessments are conducted by the Neuropsychology Consultation Service.</p> <p>Compliance: Partial.</p> <p>Current 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. 3. Ensure that all DCAT members are available for consultation to other staff to assist with planning therapeutic activities at the individual's cognitive functioning level. 4. Ensure that DCAT members' primary responsibility is consistent with the EP. 5. Ensure that DCAT members receive appropriate training.
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<p>F.2.e</p>	<p>Each State Hospital shall develop and implement a Behavioral Consultation Committee (BCC), chaired by the Chief of Psychology, and co-chaired by the Chief of Psychiatry, to review the Wellness and Recovery Plan and maladaptive behavior(s) of the individuals who have not made timely progress on positive behavior support plans. The Chief of Psychology is responsible for the functions of this committee, together with members of the positive behavior support team (in functions of the committee that relate to individuals under the care of those team members). The committee membership shall include all clinical discipline heads, including the medical director, as well as the clinical administrator of the facility.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Schedule regular meetings and ensure that all standing members of the BCC attend the meetings regularly.</p> <p>Findings: This monitor's documentation review (BCC meeting minutes, BCC meeting attendance roster) and interview of the Chief of Psychology and BCC chair found that the Committee holds meetings fairly regularly. Five meetings were scheduled and held in the last six months. Attendance at these meetings from PBS team members and WRPT members is high. However, standing member attendance is inconsistent. On average, only six standing member signatures were in the signature pages from the five BCC meetings held in the past six months. The purpose and meaning of the BCC would not be fully realized without strong participation on a regular basis by all the team members, especially the standing members.</p> <p>Recommendation 2, November 2007: Set up a system of accountability to ensure that BCC recommendations are implemented.</p> <p>Findings: This monitor's interview with the Chief of Psychology and BCC chair found that the PBS team members were to monitor the implementation of all BCC recommendations.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Schedule regular meetings and ensure that all standing members of the BCC attend the meetings regularly.</p>
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<p>F.2.f</p>	<p>Each State Hospital shall ensure that it has sufficient neuropsychological services for the provision of adequate neuropsychological assessment of individuals with persistent mental illness.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Ensure that WRPT members, especially psychiatrists and psychologists, make referrals, when appropriate, for neuropsychological assessments.</p> <p>Findings: This monitor's documentation review (progress notes and training documentation) and interview of the Senior Psychologists found that the Neuropsychological Consultation Service (NCS) at PSH has conducted many training sessions to over the last six months for all new psychologists and other staff at PSH on understanding neuropsychological assessment needs and referral criteria. The NCS has been assisting unit psychologists in completing the cognitive screening sections of the Integrated Assessment: Psychology Section and identifying individuals who might require neuropsychological assessments. Referral for neuropsychological assessments had increased from 48 in the previous review period to 78 in this review period.</p> <p>Recommendation 2, November 2007: Increase the number of neuropsychologists to meet the anticipated demand for neuropsychological services.</p> <p>Findings: This monitor's interview of the Chief of Psychology found that PSH had hired one neuropsychologist. PSH now has four neuropsychologists. As it stands, the current staff is unable to complete all assessments in a timely manner and provide other services required of the neuropsychologists. Additional neuropsychologists are required to conduct all necessary assessments and needed services at PSH.</p> <p>Recommendation 3, November 2007: Ensure that retesting and follow-up neuropsychological evaluations are</p>
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		<p>conducted in a timely fashion.</p> <p>Findings: This monitor's documentation review (referrals, assessments completed) and interview of the staff found that neuropsychological assessments are not being completed in a timely manner (within 60 days of receiving the referral). The neuropsychologists were able to complete only 47% of the referrals in a timely fashion. A number of factors were identified as reasons for the poor rate of completion, including an increase in the number of referrals received and the effort expended by the neuropsychologists on assisting with the cognitive screening of the Integrated Assessment: Psychology Section,</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that WRPT members, especially psychiatrists and psychologists, make referrals when appropriate for neuropsychological assessments. 2. Increase the number of neuropsychologists to meet the anticipated demand for neuropsychological services. 3. Ensure that retesting and follow-up neuropsychological evaluations are conducted in a timely fashion.
F.2.g	<p>All clinical psychologists with privileges at any State Hospital shall have the authority to write orders for the implementation of positive behavior support plans, consultation for educational or other testing, and positive behavior support plan updates.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Ensure that this authority is fully approved and implemented.</p> <p>Findings: This monitor's review of AD#15.09 (9/12/07) and interview of the Chief of Psychology found that all psychologists at PSH have the authority to</p>

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		<p>write orders for the implementation of positive behavior support plans, consultation for educational or other testing, and positive behavior support plan updates.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
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3. Nursing Services		
	<p>Each State hospital shall provide adequate and appropriate nursing care and services consistent with generally accepted professional standards of care to individuals who require such services.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Angie Broehl, Psychiatric Technician 2. Charles Allen, Nursing Coordinator, Program 6 3. Diane Farelas, Assistant Coordinator of Nursing Services 4. Joellyn Arce, Nursing Coordinator (MSH) 5. Lidia Lau, Assistant Coordinator of Nursing Services 6. Regina Olender, Nurse Administrator <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. PSH's progress report and data 2. Charts of the following 72 individuals: AAR, AHM, AJG, AV, BKP, CES, CMB, DAR, DEW, DIR, DL, EHS, FA, FS, GH, GJ, HDM, HRB, HST, ICM, JAP, JBD, JBP, JC, JDD, JEM, JG, JGM, JP, JPL, JRS, JTF, JTJ, KCS, KLK, KLS, KN, LL, LS, MA, MAA, MAG, MFA, MLB, MMV, MO, MSG, NM, NPC, NSB, PHR, PJD, RB, RF, RFE, RS, RSR, RT, RTH, RWC, SDC SEC, SH, SHW, SLK, TDR, TMA, VM, VMC, WDN, WHG and WTS 3. RN Competency Evaluation data 4. Stat and PRN Medication Enhancement Plan Requirements inservice course outline 5. Training records for PRN/Stat Medication Requirements 6. Behavioral Charting instructions using Positive Behavior Support (PBS) 7. Training records for Medication Variance Training 8. NP 511, Medication Variances; NP 400, Change of Physical/Behavioral Condition/Status; NP 303, Recovery Focused Documentation; NP draft, Medication Reconciliation; NP vii, Change of Shift Procedure 9. Memo dated 1/10/08 regarding Clinical Supervision Restructure for Nursing Services (nursing seniors)

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		<p>10. Memo dated 3/14/08 regarding Evaluation of Staffing Patterns for Attendance at the WRPC</p> <p>11. Training records for Principles of Medications</p> <p>12. Training records for PBS</p> <p>13. Training records for WRP Level I</p> <p>14. MTRs and Controlled Signature sheets for Units EB09, EB10, EB12, 4, 11, 34, 35, 36, and 37</p> <p><u>Observed:</u></p> <p>1. Shift report on Unit 71</p> <p>2. 8 am medication pass on Unit EB 09</p>
F.3.a	<p>Each State hospital shall develop and implement policies and protocols regarding the administration of medication, including pro re nata ("PRN") and "Stat" medication (i.e., emergency use of psychoactive medication), consistent with generally accepted professional standards of care, to ensure:</p>	<p>Compliance: Partial.</p>
F.3.a.i	<p>safe administration of PRN medications and Stat medications;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Report compliance with competency for Stat medications.</p> <p>Findings: PSH's progress report indicated that efforts to use the HSSs for competency evaluations for Stat medication audits did not produce accurate data and will be taken over by Standards Compliance auditors in June 2008.</p> <p>Recommendation 2, November 2007: Increase sample size audited for PRN medications.</p>

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		<p>Findings: At the time of this review, PSH reported that sample size remained below 20% due to auditor availability and workload. The Standards Compliance Director reported that the facility is working to increase the sample size.</p> <p>Recommendation 3, November 2007: Continue to monitor this requirement.</p> <p>Findings Since the new monitoring tool for this requirement was initiated in January 2008, PSH's data reflects the January-April 2008 period.</p> <p>PSH data from the Nursing Administration of PRN Medication Monitoring audit, based on a 6% mean sample of PRNs given each month, indicated the following compliance rate for each item listed below:</p> <table border="1" data-bbox="991 857 1887 1390"> <tr> <td><i>Safe administration of PRN medications</i></td> <td>97%</td> </tr> <tr> <td><i>PRN medication administered based on a complete physician's order</i></td> <td>99%</td> </tr> <tr> <td><i>Nurse administered correct med, dose, form, route, on the correct date, and for correct indication to the correct individual</i></td> <td>97%</td> </tr> <tr> <td><i>Correct medication</i></td> <td>99%</td> </tr> <tr> <td><i>Correct dose</i></td> <td>99%</td> </tr> <tr> <td><i>Correct form</i></td> <td>99%</td> </tr> <tr> <td><i>Correct route</i></td> <td>98%</td> </tr> <tr> <td><i>Correct time</i></td> <td>98%</td> </tr> <tr> <td><i>Correct date</i></td> <td>99%</td> </tr> <tr> <td><i>Correct indication</i></td> <td>98%</td> </tr> <tr> <td><i>Correct individual</i></td> <td>99%</td> </tr> </table>	<i>Safe administration of PRN medications</i>	97%	<i>PRN medication administered based on a complete physician's order</i>	99%	<i>Nurse administered correct med, dose, form, route, on the correct date, and for correct indication to the correct individual</i>	97%	<i>Correct medication</i>	99%	<i>Correct dose</i>	99%	<i>Correct form</i>	99%	<i>Correct route</i>	98%	<i>Correct time</i>	98%	<i>Correct date</i>	99%	<i>Correct indication</i>	98%	<i>Correct individual</i>	99%
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		<p>PSH data from the Nursing Administration of Stat Medication Monitoring audit, based on a 12% mean sample of Stats given each month, indicated the following compliance rates for each item listed below:</p> <table border="1" data-bbox="991 375 1885 834"> <tr> <td><i>Safe administration of Stat medications</i></td> <td>92%</td> </tr> <tr> <td><i>Stat medication administered based on a complete physician's order</i></td> <td>99%</td> </tr> <tr> <td><i>Stat medication administered within one hour of order</i></td> <td>96%</td> </tr> <tr> <td><i>Correct medication</i></td> <td>98%</td> </tr> <tr> <td><i>Correct dose</i></td> <td>98%</td> </tr> <tr> <td><i>Correct form</i></td> <td>98%</td> </tr> <tr> <td><i>Correct route</i></td> <td>96%</td> </tr> <tr> <td><i>Correct time</i></td> <td>96%</td> </tr> <tr> <td><i>Correct date</i></td> <td>98%</td> </tr> <tr> <td><i>Correct indication</i></td> <td>98%</td> </tr> <tr> <td><i>Correct individual</i></td> <td>98%</td> </tr> </table> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Increase sample size for PRN and Stat data. 2. Ensure reliability of PRN/Stat data. 3. Continue to monitor this requirement. 	<i>Safe administration of Stat medications</i>	92%	<i>Stat medication administered based on a complete physician's order</i>	99%	<i>Stat medication administered within one hour of order</i>	96%	<i>Correct medication</i>	98%	<i>Correct dose</i>	98%	<i>Correct form</i>	98%	<i>Correct route</i>	96%	<i>Correct time</i>	96%	<i>Correct date</i>	98%	<i>Correct indication</i>	98%	<i>Correct individual</i>	98%
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F.3.a.ii	documentation of the circumstances requiring PRN and Stat administration of medications;	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Continue to monitor this requirement.</p> <p>Findings: PSH data from the Nursing Administration of PRN Medication Monitoring audit, based on a 6% mean sample PRNs given each month, indicated the following compliance rates for each item listed below:</p>																						

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		<i>Nursing staff document the circumstances requiring PRN medications</i>	55%
		<i>In the MTR there is a brief description of the circumstances and behavior requiring PRN medication</i>	69%
		<i>In the IDN there is a comprehensive assessment of the individual prior to the PRN medication administration, which describes the circumstances and behavior requiring the medication.</i>	78%
		<p>PSH data from the Nursing Administration of Stat Medication Monitoring audit, based on a 12% mean sample of Stats given each month, indicated the following compliance rates for each item listed below:</p>	
		<i>Nursing staff document the circumstances requiring Stat medications</i>	55%
		<i>In the MTR there is a brief description of the circumstances and behavior requiring Stat medication</i>	60%
		<i>In the IDN there is a comprehensive assessment of the individual prior to the Stat medication administration, which describes the circumstances and behavior requiring the medication.</i>	86%
		<p>Other findings: PSH's progress report indicated that although the PRN and Stat Medication Training Compliance for November 2007 was 85%, problematic issues regarding the documentation of the PRN and Stat medications continued. In December 2007, Nursing disallowed the "Read & Sign" method of training, which was followed by training conducted by the Nursing Supervisors of each building. Only slight improvements in compliance have resulted thus far.</p>	

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		<p>Current recommendations: See F.3.a.i.</p>												
F.3.a.iii	documentation of the individual's response to PRN and Stat medication.	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Continue to monitor this requirement.</p> <p>Findings: PSH data from the Nursing Administration of PRN Medication Monitoring audit, based on a 6% mean sample PRNs given each month, indicated the following compliance rates for each item listed below:</p> <table border="1" data-bbox="993 673 1887 974"> <tr> <td><i>Nursing staff documents the individual's response to PRN medication</i></td> <td>3%</td> </tr> <tr> <td><i>In the MTR is a brief description of the individual's response to the administered PRN medication, which is documented within one hour of administration</i></td> <td>7%</td> </tr> <tr> <td><i>In the IDN there is a comprehensive assessment of the individual's response to the PRN medication, which was completed within one hour of administration</i></td> <td>54%</td> </tr> </table> <p>PSH data from the Nursing Administration of Stat Medication Monitoring audit, based on a 21% mean sample of Stats given each month, indicated the following compliance rates for each item listed below:</p> <table border="1" data-bbox="993 1198 1887 1421"> <tr> <td><i>In the MTR there is a brief description of the individual's response to the administered Stat medication</i></td> <td>30%</td> </tr> <tr> <td><i>The brief description was documented within one hour of administration</i></td> <td>20%</td> </tr> <tr> <td><i>In the IDN there is a comprehensive assessment of the individual's response to the administered Stat medication,</i></td> <td>71%</td> </tr> </table>	<i>Nursing staff documents the individual's response to PRN medication</i>	3%	<i>In the MTR is a brief description of the individual's response to the administered PRN medication, which is documented within one hour of administration</i>	7%	<i>In the IDN there is a comprehensive assessment of the individual's response to the PRN medication, which was completed within one hour of administration</i>	54%	<i>In the MTR there is a brief description of the individual's response to the administered Stat medication</i>	30%	<i>The brief description was documented within one hour of administration</i>	20%	<i>In the IDN there is a comprehensive assessment of the individual's response to the administered Stat medication,</i>	71%
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		<p><i>The comprehensive assessment was completed within one hour of administration</i></p>	<p>56%</p>
<p>F.3.b</p>	<p>Each State hospital shall ensure that all failures to properly sign the Medication Treatment Record (MTR) or the controlled medication log are treated as medication variances, and that appropriate follow-up occurs to prevent recurrence of such variances.</p>	<p>A review of 100 incidents of PRNs from 13 individuals' medical records (AV, CES, DAR, DIR, DL, FS, KKK, MLB, RS, RTH, SH, SLK and VMC), found that 12 had adequate documentation regarding the reason for the medication and the response to the medication. Most of the incidents reviewed displayed the same deficits as from the last review regarding the time the PRN was given, the route, and the location if given by injection and who actually gave the medications. In addition, only four incidents had alternative methods documented.</p> <p>A review of 63 incidents of Stats from seven individuals' medical records (AV, HDM, KKK, LL, NM, SDC and WTS) found that 21 had adequate documentation regarding the circumstances and response to the Stat medication. A number of Stat medications had been documented in the IDNs as "PRN" medications. Similar to the above findings for PRN medications, the exact time, route, and location, if an injection, was not documented in the IDNs.</p> <p>Current recommendation: Continue to monitor this requirement.</p> <p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Present data as described above.</p> <p>Findings: See data below.</p> <p>Recommendation 2, November 2007: Continue to provide training to staff regarding this requirement.</p>	

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		<p>Findings: Although PSH's training records indicated that 73% of staff has been trained regarding NP #511 Medication Variance Report, the data noted below indicated that it has not changed practice.</p> <p>Recommendation 3, November 2007: Continue to monitor this requirement.</p> <p>Findings: PSH's progress report indicated that from November 2007 to April 2008, there were 231 missing initials found on the Medication Treatment Records and only 34 Medication Variance Reports completed. In addition, for 200 incidents of missing signatures on the Control Sheets, there was only one Medication Variance Report completed.</p> <p>Below are the findings from this monitor's review of the following units' MTRs and Control Sheet signature pages:</p> <table border="1" data-bbox="991 894 1879 1416"> <tr> <td data-bbox="991 894 1157 1008">Unit 4</td> <td data-bbox="1157 894 1879 1008"> <ul style="list-style-type: none"> Missing initials on MTRs 6/9, 6/10 and 6/11/08 for 10 individuals (AD, BA, CR, LM, PR, RB, RS, SP, TM and TT). </td> </tr> <tr> <td data-bbox="991 1008 1157 1045">Unit 11</td> <td data-bbox="1157 1008 1879 1045"> <ul style="list-style-type: none"> Missing initials on MTRs 6/7/08 for JD and MO. </td> </tr> <tr> <td data-bbox="991 1045 1157 1230">Unit EB09</td> <td data-bbox="1157 1045 1879 1230"> <ul style="list-style-type: none"> Missing initials on MTRs 5/16, 5/18, 5/21, 5/24, 5/31, 6/1, 6/2, 6/3, 6/4, 6/5, 6/6, 6/8, 6/9 and 6/10/08 for 28 individuals (AW, BW, CD, CL, DM, DO, GM, GO, GP, GW, HL, HM, JA, LD, LV, MM, MS, RIK, RK, RV, RW, SC, SG, TA, TG, TM, VR and VT). </td> </tr> <tr> <td data-bbox="991 1230 1157 1344">Unit EB12</td> <td data-bbox="1157 1230 1879 1344"> <ul style="list-style-type: none"> Missing initials on MTRs on 6/3, 6/4, 6/5, 6/10 and 6/11/08 for six individuals (CS, KN, LP, PL, RF and VP). </td> </tr> <tr> <td data-bbox="991 1344 1157 1416">Unit EB10</td> <td data-bbox="1157 1344 1879 1416"> <ul style="list-style-type: none"> Missing initials on MTRs on 6/11/08 for CM. Missing signature on Control Sheet for 6/10/08 and </td> </tr> </table>	Unit 4	<ul style="list-style-type: none"> Missing initials on MTRs 6/9, 6/10 and 6/11/08 for 10 individuals (AD, BA, CR, LM, PR, RB, RS, SP, TM and TT). 	Unit 11	<ul style="list-style-type: none"> Missing initials on MTRs 6/7/08 for JD and MO. 	Unit EB09	<ul style="list-style-type: none"> Missing initials on MTRs 5/16, 5/18, 5/21, 5/24, 5/31, 6/1, 6/2, 6/3, 6/4, 6/5, 6/6, 6/8, 6/9 and 6/10/08 for 28 individuals (AW, BW, CD, CL, DM, DO, GM, GO, GP, GW, HL, HM, JA, LD, LV, MM, MS, RIK, RK, RV, RW, SC, SG, TA, TG, TM, VR and VT). 	Unit EB12	<ul style="list-style-type: none"> Missing initials on MTRs on 6/3, 6/4, 6/5, 6/10 and 6/11/08 for six individuals (CS, KN, LP, PL, RF and VP). 	Unit EB10	<ul style="list-style-type: none"> Missing initials on MTRs on 6/11/08 for CM. Missing signature on Control Sheet for 6/10/08 and
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Unit EB10	<ul style="list-style-type: none"> Missing initials on MTRs on 6/11/08 for CM. Missing signature on Control Sheet for 6/10/08 and 											

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			pre-signed signature on 6/11/08.
		Unit 34	<ul style="list-style-type: none"> • Missing initials on MTRs on 5/28, 6/1, 6/2 and 6/3/08 for five individuals (CM, DP, DW, JG and TW). • Medications pre-signed for noon on 6/11/08 for five individuals (DL, IL, JG, LH and SM). • Missing signature on Control Sheet for 6/3/08
		Unit 35	<ul style="list-style-type: none"> • Missing initials on MTRs on 5/28, 5/29, 5/31, 6/5, 6/10 and 6/11/08 for 14 individuals (AJM, AP, AW, DS, EP, EW, JP, MDC, MR, RR, RT, RW, SO and SRC). • Medications pre-signed for noon on 6/11/08 for nine individuals (ACC, DM, JPD, KS, MR, RIR, RR, RT and SO). • Control Sheet pre-signed for 6/10/08.
		Unit 36	<ul style="list-style-type: none"> • Missing initials on MTRs on 6/6, 6/7, 6/9 and 6/10/08 for AF, CDC and LQ. • Missing signature on Control Sheet for 6/7, 6/9 and 6/11/08.
		Unit 37	<ul style="list-style-type: none"> • Medications pre-signed for noon on 6/11/08 for five individuals (DJ, DLP, JA, JLZ and LC).
		<p>At the time of this review, there were no Medication Variance Reports completed for any of the above deficiencies.</p> <p>Compliance: Noncompliance.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a system to ensure that all failures to properly sign the Medication Treatment Record (MTR) or the controlled medication log are treated as medication variances, and that appropriate follow-up occurs to prevent recurrence of such 	

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		<p>variances.</p> <p>2. Continue to monitor this requirement.</p>
<p>F.3.c</p>	<p>Each State hospital shall ensure that all nursing interventions are fully integrated into the therapeutic and rehabilitation service plan and that nursing interventions are written in a manner aligned with the rest of the interventions in the therapeutic and rehabilitation service plan, in particular, in observable, behavioral, and/or measurable terms. No nursing care plans other than the nursing interventions integrated in the therapeutic and rehabilitation service plan are required. No nursing diagnoses other than as specified in the therapeutic and rehabilitation service plan, in terms of the current DSM criteria, are required.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1-4, November 2007:</p> <ul style="list-style-type: none"> • Develop and implement proactive interventions related to the individual's needs and risks. • Present data in a manner that is able to be interpreted. • Same as C.1.a, Recommendation 3. • Continue to monitor this requirement. <p>Findings:</p> <p>In its progress report and this monitor's interviews with Nursing, PSH indicated that Nursing is continuing to have significant deficits regarding writing plans of care that are specific to the individual, measurable, and realistic. The facility indicated that to address this issue, a focused training for the development of plans of care is being developed for the high-risk medical issues that are monitored by the public health nurse. This issue is also on the Nursing Services Statewide Agenda. In addition, NP 302 Nursing Applications of the Wellness & Recovery Plan, which also addresses interventions in the WRP, has been revised. Also, the Nurse Administrator indicated that there are no Nursing Seniors to use as mentors for the WRPTs as other disciplines have. Nursing indicated that the HSSs and Assistant Coordinator of Nursing Services (ACNS) have been out of the clinical mainstream and the nurses from the training center are basically distant from the EP process, leaving a deficit for filling the clinical senior role. This issue regarding the lack of clinical expertise in the nursing supervisor role has been related to a number of problems such as the reliability of auditing data and understanding of the compliance criteria. As PSH's progress report indicated, "The current nursing supervision structure is obsolete" and thus is a barrier to reaching</p>

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		<p>substantial compliance in nursing.</p> <p>PSH's training data indicated that at the time of this review, 92% of RNs, 92% of PTs, and 94% of LVNs had received and passed the WRP Level I training.</p> <p>PSH's data from the Nursing Interventions monitoring audit, based on a 36 % mean sample of audited WRPs, indicated the following compliance rates for each item listed below:</p> <table border="1" data-bbox="989 561 1885 1391"> <tr> <td><i>If DMH WRP Attachment developed, it was filed with the previous WRP</i></td> <td>12%</td> </tr> <tr> <td><i>If a DMH WRP Attachment was developed, it has been reviewed and integrated into the current WRP.</i></td> <td>24%</td> </tr> <tr> <td><i>There are interventions specific to how nursing is going to assist the individual in meeting his or her goals for each open foci</i></td> <td>12%</td> </tr> <tr> <td><i>Focus 1: Psychiatric & Psychological</i></td> <td>30%</td> </tr> <tr> <td><i>Focus 2: Social Skills</i></td> <td>39%</td> </tr> <tr> <td><i>Focus 3: Dangerousness and Impulsivity</i></td> <td>45%</td> </tr> <tr> <td><i>Focus 4: Hope and Spirituality</i></td> <td>34%</td> </tr> <tr> <td><i>Focus 5: Substance Abuse</i></td> <td>40%</td> </tr> <tr> <td><i>Focus 6: Medical, Health & Wellness</i></td> <td>38%</td> </tr> <tr> <td><i>Focus 7: Legal.</i></td> <td>28%</td> </tr> <tr> <td><i>Focus 8: School and Education</i></td> <td>17%</td> </tr> <tr> <td><i>Focus 9: Occupational Skills</i></td> <td>10%</td> </tr> <tr> <td><i>Focus 10: Leisure & Recreation</i></td> <td>18%</td> </tr> <tr> <td><i>Focus 11: Community Integration</i></td> <td>33%</td> </tr> <tr> <td><i>Nursing intervention include specific strategies to assist the individual in meeting his or her objectives.</i></td> <td>12%</td> </tr> <tr> <td><i>Nursing interventions align and complement other interventions in the WRP to assist the individual 24 hours a day</i></td> <td>5%</td> </tr> </table>	<i>If DMH WRP Attachment developed, it was filed with the previous WRP</i>	12%	<i>If a DMH WRP Attachment was developed, it has been reviewed and integrated into the current WRP.</i>	24%	<i>There are interventions specific to how nursing is going to assist the individual in meeting his or her goals for each open foci</i>	12%	<i>Focus 1: Psychiatric & Psychological</i>	30%	<i>Focus 2: Social Skills</i>	39%	<i>Focus 3: Dangerousness and Impulsivity</i>	45%	<i>Focus 4: Hope and Spirituality</i>	34%	<i>Focus 5: Substance Abuse</i>	40%	<i>Focus 6: Medical, Health & Wellness</i>	38%	<i>Focus 7: Legal.</i>	28%	<i>Focus 8: School and Education</i>	17%	<i>Focus 9: Occupational Skills</i>	10%	<i>Focus 10: Leisure & Recreation</i>	18%	<i>Focus 11: Community Integration</i>	33%	<i>Nursing intervention include specific strategies to assist the individual in meeting his or her objectives.</i>	12%	<i>Nursing interventions align and complement other interventions in the WRP to assist the individual 24 hours a day</i>	5%
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<i>Nursing intervention include specific strategies to assist the individual in meeting his or her objectives.</i>	12%																																	
<i>Nursing interventions align and complement other interventions in the WRP to assist the individual 24 hours a day</i>	5%																																	

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		<i>Nursing interventions are written in observable behavioral and measurable terms</i>	1%
		<i>Nursing interventions are written in observable terms</i>	15%
		<i>Nursing interventions are written in behavioral and/or measurable terms</i>	2%
		<i>Only the approved DMH forms are used</i>	74%
	<p>A review of 44 individuals' WRPs (AAR, AHM, AJG, BKP, CMB, DEW, EHS, FA, GJ, HST, JAP, JBD, JBP, JDD, JEM, JG, JGM, JRS, JTF, JTJ, KCS, KLS, KN, LS, MA, MAA, MAG, MFA, MMV, MO, NSB, PHR, PJD, RB, RF, RFE, RT, RWC, SEC, SHW, TDR, VM, WDN and WHG) found that there had been basically no improvement in this area since the last review. Most of the nursing objectives/interventions were generic or inappropriate for the individual's cognitive status. Information contained in the nursing admission/integrated assessments regarding an individual's interests, past issues, coping strategies or stress relievers were usually not included in the WRPs. When individual education was included in the WRP for specific issues, there was no documentation that it was actually taking place as often as the WRP indicated. There was also no documentation that contained an assessment of the individual's response to the education. This monitor's discussions with unit staff during the review indicated that they knew a great deal about the individuals but this knowledge was not reflected in the WRPs. These findings are similar to those of PSH regarding this requirement.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement additional training as scheduled to address this requirement. 2. Develop a system to identify and implement the use of nursing 		

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		<p>"seniors." 3. Continue to monitor this requirement.</p>
<p>F.3.d</p>	<p>All nursing staff working with an individual shall be familiar with the goals, objectives and interventions for that individual.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Evaluate staffing patterns to ensure consistent and appropriate nursing staff attendance at the WRPCs.</p> <p>Findings: See D.3.d.iii.</p> <p>Recommendation 2, November 2007: See F.3.c, Current Recommendation #3.</p> <p>Findings: See F.3.c.</p> <p>Recommendations 3 and 4, November 2007:</p> <ul style="list-style-type: none"> • Identify target population for data (N). • Continue to monitor this requirement. <p>Findings: PSH's data from the Nursing Interventions monitoring audit for February-April 2008, based on a 44% mean sample of staff interviewed, indicated 45% mean compliance with the requirement that all Nursing staff working with an individual shall be familiar with the goals, objectives and interventions for that individual; 88% mean compliance with the requirement that Nursing staff working with the individual are able to discuss an individual's goals (focus of hospitalization); 65% mean compliance with the requirement that Nursing staff working with the individual are able to discuss an individual's objectives, and; 54% mean compliance with the requirement</p>

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		<p>that Nursing staff working with the individual are able to discuss an individual's interventions.</p> <p>A review of 44 WRPs (see F.3.c), observations at two WRPCs (see D.3.d.iii) and conversations with unit staff revealed that the WRPs were least representative of the individuals' goals and that staff in the WRPCs saw the WRP as a task to complete rather than as a blueprint for guiding treatment. Conversations with unit staff indicated that much of their knowledge about the individuals was not included in the WRP and consequently, was not ever addressed by the team. Increasing the quality of the WRPs will increase the degree of compliance with this requirement.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
F.3.e	<p>Each State hospital shall ensure that nursing staff timely monitor, document and report the status of symptoms, target variables, health, and mental health status, of individuals in a manner that enables interdisciplinary teams to assess each individual's status, and response to interventions, and to modify, as appropriate, individuals' therapeutic and rehabilitation service plans. Each State Hospital shall ensure that all nursing shift changes include a review of changes in status of individuals on the unit.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Evaluate staffing patterns to ensure consistent and appropriate staff attendance at the WRPCs.</p> <p>Findings: See D.3.d.iii.</p> <p>Recommendation 2, November 2007: See F.3.c, Current Recommendation #3.</p> <p>Findings: See F.3.c.</p>

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		<p>Recommendation 3, November 2007: Review documentation guidelines for acute illness and injuries to ensure that they meet generally accepted professional standards of nursing practice.</p> <p>Findings: In response to this recommendation, PSH has completed NP 400, Change of Condition using the DMH Special order draft and working in conjunction with the Med/Surg physicians' workgroup and the Statewide Nursing Services group. In addition, NP 303, Recovery Oriented Documentation, which outlines documentation requirements, was completed. Both the Statewide Nursing and Physician Workgroups are continuing to meet to standardize the Change of Condition process.</p> <p>Recommendation 4, November 2007: Develop and implement a structure for shift report.</p> <p>Findings: PSH's progress report indicated that the Units are piloting person-centered assignments and that Unit EB 12 PM shift has been consistently giving shift report of the key issues occurring on that shift. In addition, the Statewide Nursing Services Group will be working on this issue after the Change of Condition project is completed.</p> <p>Recommendation 5, November 2007: Develop/revise policies and procedures to reflect changes in process for shift report.</p> <p>Findings: Although PSH has updated the Change of Shift Procedure, it will need to be further revised in conjunction with changes made by the Statewide Nursing Services Group.</p>
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		<p>Recommendation 6, November 2007: Continue to monitor this requirement.</p> <p>Findings: PSH has developed a shift report monitoring tool for individuals with acute medical changes including illness and injury treated at PSH; those sent to the emergency room and then returned to PSH; and those sent to a hospital for accident, illness, or medical emergency and admitted. An auditor observes shift report when a medical condition trigger is activated to observe if the trigger event is discussed at the change of shift report.</p> <p>PSH's data from the Nursing Shift Change Monitoring audit from February-April 2008, based on a 20% mean sample of units monitored, indicated the following compliance rate for each item listed below:</p> <table border="1" data-bbox="991 782 1885 1421"> <tr> <td><i>If the individual reported symptoms, there is documentation in IDN of timely notification by the nurse to the physician</i></td> <td>88%</td> </tr> <tr> <td><i>If individual reported emergent symptoms, there is documentation in the IDN of immediate notification by the nurse to the physician</i></td> <td>94%</td> </tr> <tr> <td><i>If individual reported non-emergent symptoms there is documentation in the IDN of notification within one hour by the nurse to the physician</i></td> <td>88%</td> </tr> <tr> <td><i>If the individual had changes in their condition, there is documentation in the IDN of the changes.</i></td> <td>95%</td> </tr> <tr> <td><i>If the individual had changes in status, there is documentation in the IDN of the changes.</i></td> <td>94%</td> </tr> <tr> <td><i>If the individual's physician required notification, there is documentation in the IDN of when the physician was notified</i></td> <td>94%</td> </tr> <tr> <td><i>If the individual was transferred from the DMH hospital to an acute facility, there is documentation in the IDN of the</i></td> <td>83%</td> </tr> </table>	<i>If the individual reported symptoms, there is documentation in IDN of timely notification by the nurse to the physician</i>	88%	<i>If individual reported emergent symptoms, there is documentation in the IDN of immediate notification by the nurse to the physician</i>	94%	<i>If individual reported non-emergent symptoms there is documentation in the IDN of notification within one hour by the nurse to the physician</i>	88%	<i>If the individual had changes in their condition, there is documentation in the IDN of the changes.</i>	95%	<i>If the individual had changes in status, there is documentation in the IDN of the changes.</i>	94%	<i>If the individual's physician required notification, there is documentation in the IDN of when the physician was notified</i>	94%	<i>If the individual was transferred from the DMH hospital to an acute facility, there is documentation in the IDN of the</i>	83%
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		<i>transfer which includes:</i>	
		<i>Reason for the transfer</i>	100%
		<i>Name of facility to which the individual was transferred</i>	83%
		<i>Date and time of transfer</i>	100%
		<i>If the individual exhibited any target variables, the nursing staff reports the occurrence to the oncoming shift</i>	91%
		<i>If the individual exhibited any target variables, his/her interventions are discussed at shift change, including appropriate continuum of care across shifts</i>	86%
		<p>In the observed shift report on Unit 71, there was no oncoming nurse present for nearly half of the report due to staffing issues. The report was frequently interrupted by the telephone or staff walking in and out of the office. Although some of the information presented was more clinically relevant than seen during previous reviews, there continues to be a significant disconnect between clinical issues such as signs and symptoms of Axis I, II, and III and the information that is passed on the oncoming shift. For example, individuals who need to have blood sugars monitored throughout the day do not have the readings from the previous shift reported. For individuals who have mood disorders or cognitive problems related to dementia, there is no status reported regarding their mood or mental status. The shift reports observed at PSH have basically been more focused on tasks than on clinical issues. In addition, the Unit had two new admissions. However, there was no information regarding diagnoses, treatment regimens or signs and symptoms to evaluate reported to the oncoming shift.</p>	
		<p>Other findings: This monitor reviewed the charts of 10 individuals (CM, GH, HRB, JC, JP, JPL, MSG, NPC, RSR and TMA) who required emergency medical care. Below is a summary of the findings:</p>	

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		<ol style="list-style-type: none"> 1. An individual was admitted to the community hospital for pneumonia rule out pulmonary edema. Issues included: <ol style="list-style-type: none"> a. Good documentation of status and assessment at the time individual became ill and upon return from the hospital. b. No status documented at the time of transfer to hospital. c. IDNs out of order in medical record. 2. An individual was seen at the community hospital for altered level of consciousness. Issues included: <ol style="list-style-type: none"> a. Good documentation of description and assessment when noted to be unresponsive. b. No summary of hospitalization and treatment provided documented upon his return to PSH. c. IDNs out of order in medical record. 3. An individual was seen at the community hospital for a fractured knee. Issues included: <ol style="list-style-type: none"> a. No status documented at the time of transfer to hospital. b. No description or assessment of affected leg found in the IDNs. c. No documentation upon return from hospital and summary of hospital findings. d. IDNs out of order in medical record. 4. An individual was seen at the community hospital for fever and dehydration. Issues included: <ol style="list-style-type: none"> a. No documentation or assessment regarding transfer to unit EB01 on 2/14/08. b. No IDNs found from 2/11 to 2/14/08. c. IDN dated 2/15/08 indicated that vital signs were "WNL" (within normal limits) but did not include actual values for baseline. d. No lung sounds assessed for respiratory issues. e. No summary of hospital findings upon return to PSH. 5. An individual was seen at the community hospital for status epilepticus. Issues included that IDNs for 12/31/07 not provided
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		<p>for review of the event.</p> <ol style="list-style-type: none">6. An individual was seen at the community hospital for altered mental status. Issues included:<ol style="list-style-type: none">a. No neuro checks documented for an individual with a significant change in mental status.b. No IDN upon return from hospital.c. IDN dated 4/26/08 difficult to read but indicates an issue with a physician order.7. An individual was seen at the community hospital for altered mental status. Issues included:<ol style="list-style-type: none">a. Good assessment prior to transfer for change in mental status. However, the correct acronym is PERRLA (pupils equal, round, reactive to light and accommodation), not PERL as found in the IDNs.b. No documentation found upon return from the hospital.8. An individual was seen at the community hospital for abdominal pain. Issues included:<ol style="list-style-type: none">a. Incomplete assessment prior to being transfer to the hospital.b. IDNs upon return were illegible.9. An individual was seen at the community hospital for impaction. Issues included an incomplete assessment prior to being transfer to the hospital; no bowel sounds and abdomen not assessed.10. An individual was seen at the community hospital for abdominal pain. Issues included:<ol style="list-style-type: none">a. No assessment or vital signs prior to transfer to hospital.b. No IDN upon return from hospital. <p>Overall, significant issues continue regarding complete and adequate assessments of symptoms, assessments prior to transfer to off-site medical centers, and adequate documentation upon return to PSH, including an initial assessment and summary of the hospital findings.</p>
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		<p>Compliance: Partial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>				
F.3.f	Each State hospital shall develop and implement a system to monitor nursing staff while administering medication to ensure that:	<p>Compliance: Partial.</p>				
F.3.f.i	nursing staff are knowledgeable regarding each individual's prescribed medications;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Provide data indicating that every nurse that passes medications has been observed every quarter.</p> <p>Findings: PSH's training data indicated that out of 1053 staff, 967 staff have taken the Principles of Medication class, passed the mock med pass competency and are eligible to pass meds</p> <p>Recommendation 2, November 2007: Continue to monitor this requirement.</p> <p>Findings: PSH's data from the Statewide Medication Administration Monitoring audit from November 2007-April 2008, based on a 7% mean sample of medication pass observations, indicated the following compliance rate for each item below:</p> <table border="1"> <tr> <td><i>Verbalizes generic and trade names of medications administered</i></td> <td>85%</td> </tr> <tr> <td><i>Describes therapeutic effects, usual doses, and routes of</i></td> <td>88%</td> </tr> </table>	<i>Verbalizes generic and trade names of medications administered</i>	85%	<i>Describes therapeutic effects, usual doses, and routes of</i>	88%
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		<table border="1"> <tr> <td><i>medications administered</i></td> <td></td> </tr> <tr> <td><i>Differentiates expected side effects from adverse reactions</i></td> <td>80%</td> </tr> <tr> <td><i>Explains "sliding scale" for regular insulin</i></td> <td>73%</td> </tr> <tr> <td><i>Verbalizes symptoms and appropriate interventions of hypo/hyperglycemia</i></td> <td>80%</td> </tr> </table> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Increase sample size to 20%. 2. Continue to monitor this requirement. 	<i>medications administered</i>		<i>Differentiates expected side effects from adverse reactions</i>	80%	<i>Explains "sliding scale" for regular insulin</i>	73%	<i>Verbalizes symptoms and appropriate interventions of hypo/hyperglycemia</i>	80%
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<i>Explains "sliding scale" for regular insulin</i>	73%									
<i>Verbalizes symptoms and appropriate interventions of hypo/hyperglycemia</i>	80%									
F.3.f.ii	education is provided to individuals during medication administration;	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Continue to monitor this requirement.</p> <p>Findings: PSH's data indicated 20% mean compliance with this requirement.</p> <p>Current recommendation: See F.3.f.i.</p>								
F.3.f.iii	nursing staff are following the appropriate medication administration protocol; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Continue to monitor this requirement.</p> <p>Findings: PSH's data from the Statewide Medication Administration Monitoring audit for November 2007-April 2008, based on a 7% mean sample of observed medication passes, indicated the following compliance rate for each item below:</p>								

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		<table border="1"> <tr> <td><i>Correct medication</i></td> <td>99%</td> </tr> <tr> <td><i>Correct dose</i></td> <td>100%</td> </tr> <tr> <td><i>Correct individual</i></td> <td>100%</td> </tr> <tr> <td><i>Correct route</i></td> <td>100%</td> </tr> <tr> <td><i>Correct time/date</i></td> <td>100%</td> </tr> <tr> <td><i>Applies principles of asepsis to medication administration</i></td> <td>64%</td> </tr> <tr> <td><i>Prepares/organizes medications no more than one hour before administration</i></td> <td>97%</td> </tr> <tr> <td><i>Identifies individual by name and photograph to ensure correct identification</i></td> <td>89%</td> </tr> <tr> <td><i>Checks for allergies</i></td> <td>61%</td> </tr> <tr> <td><i>Measures, interprets and records BP and pulse before administering cardiac and antihypertensive medication. Withholds meds as indicated</i></td> <td>76%</td> </tr> <tr> <td><i>Opens/pours medication in front of individual</i></td> <td>95%</td> </tr> <tr> <td><i>Checks medication with MTR three times</i></td> <td>62%</td> </tr> <tr> <td><i>Ensures individual swallowed all medications</i></td> <td>90%</td> </tr> <tr> <td><i>Applies proper technique with use of safety syringes</i></td> <td>64%</td> </tr> <tr> <td><i>Ensures individuals privacy and confidentiality</i></td> <td>99%</td> </tr> </table> <p>Current recommendation: See F.3.f.i.</p>	<i>Correct medication</i>	99%	<i>Correct dose</i>	100%	<i>Correct individual</i>	100%	<i>Correct route</i>	100%	<i>Correct time/date</i>	100%	<i>Applies principles of asepsis to medication administration</i>	64%	<i>Prepares/organizes medications no more than one hour before administration</i>	97%	<i>Identifies individual by name and photograph to ensure correct identification</i>	89%	<i>Checks for allergies</i>	61%	<i>Measures, interprets and records BP and pulse before administering cardiac and antihypertensive medication. Withholds meds as indicated</i>	76%	<i>Opens/pours medication in front of individual</i>	95%	<i>Checks medication with MTR three times</i>	62%	<i>Ensures individual swallowed all medications</i>	90%	<i>Applies proper technique with use of safety syringes</i>	64%	<i>Ensures individuals privacy and confidentiality</i>	99%
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F.3.f.iv	medication administration is documented in accordance with the appropriate medication administration protocol.	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Continue to monitor this requirement.</p> <p>Findings: PSH's data from the Statewide Medication Administration Monitoring audit for November 2007-April 2008, based on a 7% mean sample of observed medication passes, indicated the following compliance rate for</p>																														

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		<p>each item below:</p> <table border="1" data-bbox="991 264 1885 456"> <tr> <td><i>Documents and signs out controlled medications correctly</i></td> <td>100%</td> </tr> <tr> <td><i>Documents medication that is given on MTR immediately after administering</i></td> <td>92%</td> </tr> <tr> <td><i>Documents telephone order, read back, noting, and transcribing orders</i></td> <td>100%</td> </tr> </table> <p>In the 8am medication pass observed on Unit EB 09, there were a number of individuals who had not had their blood pressure or pulse taken in order for the staff to be able to administer their morning medications. Thus, a number of individuals did not receive all of their AM medications during the observation. In addition, the Psychiatric Technician did not check the MTRs three times as required. Although she had a good rapport with the individuals receiving medications, she misidentified the use of some of the medications when asked by the individuals the purpose of the medications. In addition, she was not able to log into the computer to gain access to controlled medications that were to be given. However, another staff member was successful at logging in and allowing her to access the medications. By 8:30am when this monitor left the Unit, most of the individuals who were to receive morning medications had not yet received them due to some of the delays mentioned above. Clearly, the PT would not be able to complete administration of the morning medications within the accepted timeframe of one hour.</p> <p>Other findings: In this monitor's judgment, derived from observations of medication administration and from review of the MTRs and Controlled Sheets (see F.3.b), the medication administration practices significantly deviate from the data presented from the Statewide Medication Administration Monitoring audit. The differences between actual practice and data need to be reconciled.</p>	<i>Documents and signs out controlled medications correctly</i>	100%	<i>Documents medication that is given on MTR immediately after administering</i>	92%	<i>Documents telephone order, read back, noting, and transcribing orders</i>	100%
<i>Documents and signs out controlled medications correctly</i>	100%							
<i>Documents medication that is given on MTR immediately after administering</i>	92%							
<i>Documents telephone order, read back, noting, and transcribing orders</i>	100%							

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		<p>Current recommendation: See F.3.f.i.</p>
F.3.g	Each State hospital shall ensure that individuals remain in a "bed-bound" status only for clinically justified reasons.	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, November 2007:</p> <ul style="list-style-type: none"> • Develop a monitoring tool to address this requirement. • Continue to monitor this requirement. <p>Findings: Although PSH has the Statewide tool for this requirement, PSH does not have individuals who are bed-bound.</p> <p>Compliance: Not applicable.</p> <p>Current recommendation: None.</p>
F.3.h	Each State hospital shall ensure that, before they work directly with individuals, all nursing and psychiatric technicians have successfully completed competency-based training regarding:	<p>Compliance: Partial.</p>
F.3.h.i	mental health diagnoses, related symptoms, psychotropic medications and their side effects, monitoring of symptoms and target variables, and documenting and reporting of the individual's status;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Provide data for existing nursing staff for this requirement.</p> <p>Findings: No data was provided for existing PSH RNs, LVNs, and PTs.</p>

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		<p>Recommendation 2, November 2007: Continue to monitor this requirement.</p> <p>Findings: PSH's training data from November 2007 to April 2008 indicated that all new employees have met this requirement.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Provide data for existing staff. 2. Continue to monitor this requirement.
F.3.h.ii	the provision of a therapeutic milieu on the units and proactive, positive interventions to prevent and de-escalate crises; and	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, November 2007:</p> <ul style="list-style-type: none"> • Continue training to address this requirement. • Provide data regarding this requirement. <p>Findings: PSH's progress report indicated that Statewide PMAB Task Force is revising the PMAB training to include more emphasis on therapeutic intervention and conflict management. As of April 2008, out of 1238 nursing staff required to take PMAB training, 1002 have completed the training.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
F.3.h.iii	positive behavior support principles.	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Continue to monitor this requirement.</p>

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		<p>Findings: PSH's training data indicated that of the 48 new employees hired since November 2007 to April 2008, 45 completed and passed the PBS training. Hospital-wide, the training records indicated that as of May 2008, 79% of existing staff have completed and passed the training.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
F.3.i	<p>Each State hospital shall ensure that, prior to assuming their duties and on a regular basis thereafter, all staff responsible for the administration of medication has successfully completed competency-based training on the completion of the MTR and the controlled medication log.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Continue to monitor this requirement.</p> <p>Findings: See F.3.f.i.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>

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4. Rehabilitation Therapy Services		
	<p>Each State hospital shall provide adequate, appropriate and timely rehabilitation therapy services to each individual in need of such services, consistent with generally accepted professional standards of care.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Alejandro Fernandez, Supervising Rehabilitation Therapist 2. Allison Rembulat, Recreation Therapist 3. Amanda Cavicchi, Music Therapist 4. Billy Mange, Senior Vocational Rehabilitation Counselor 5. Burta Booze, Recreation Therapist 6. Curtis Peters, Supervising Rehabilitation Therapist 7. Debra Taylor-Tatum, Supervising Rehabilitation Therapist 8. Denise Byerly, RN, POST Team Coordinator 9. G. Michelle Reid-Proctor, MD, Physical Medicine and Rehabilitation 10. Greg Siples, Chief of Rehabilitation Services 11. Jacqueline Doss-Haynes, Supervising Rehabilitation Therapist 12. Janet Richards, Occupational Therapist 13. Jerry Marquez, Physical Therapist Assistant 14. Karen Strain, Recreation Therapist 15. Louis F. Lacouette, Physical Therapist 16. Mark Camero, Supervising Rehabilitation Therapist 17. Michael Gomes, Recreation Therapist 18. Stan Hydinger, Supervising Rehabilitation Therapist 19. Victor G. Ruiz, Speech Pathologist <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. AD #10.21 Enrichment/Supplemental Activity program revised 2. DMH Rehabilitation Therapy Service Manual 3. DMH Rehabilitation Therapy F.4 Audit Tool and instructions (final draft) 4. Proposed POST daily and monthly progress note templates 5. Audit data related to WRP integration of Physical, Occupational and Speech Therapy services for April 2008 6. 24-Hour Rehabilitation Support Plan (draft)

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		<ol style="list-style-type: none"> 7. Criteria for 24-Hour Support Plan (draft) 8. Training regarding Rehabilitation Therapist's Role in the Vocational Screening and Assessment Process 9. PSH Mall Course Schedule for week of review 10. List of individuals with adaptive equipment 11. Proposed Adaptive Equipment database 12. California Labor Market and Economic Analysis 13. Occupational Employment Statistics 14. Records for the following 23 individuals participating or enrolled in observed Mall groups: AP, AW, BR, CL, CT, CT, DH, EM, GC, GH, IC, KAM, LLQ, MB, MD, MFA, MO, MT, PAL, TK, TME, WL and WPC 15. Records for the following 19 individuals to compare Integrated Assessments-Rehabilitation Therapy Section with WRP documents: AHM, BR, BTH, GSG, HPV, JGM, KEM, KLA, MS, MT, ND, PL, RBS, SJ, SR, TC, VJW, VM and WAO 16. List of individuals who received direct Physical Therapy services from November 2007-April 2008 17. Records for the following two individuals with Physical Therapy assessment in April 2008 to compare assessments and corresponding WRP's: EM, NPC 18. Records for the following four individuals who received direct Physical Therapy services between November 2007-April 2008: JN, MEB, TC and VB 19. List of individuals who received direct Speech Therapy services from November 2007-April 2008 20. Records for the following six individuals with Speech Therapy assessments in April 2008 to compare assessments and corresponding WRP's: JGP, KLS, LM, NSC, REF and WHG 21. Records for the following five individuals who received direct Speech Therapy services between November 2007-April 2008: JAC, PC, PH, RAR and RWT 22. List of individuals who received direct Occupational Therapy services from November 2007-April 2008
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		<p>23. Records for the following individual with Occupational Therapy assessment in April 2008 to compare assessment and corresponding WRP: DFV</p> <p>24. Records for the following five individuals who received direct Occupational Therapy services between November 2007-April 2008: AO, BAJ, JH, JR and LF</p> <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPC for SZ on Program 1, Unit EB-11 2. Stress Reduction through Karaoke PSR Mall group 3. Exercise Sports for Stress Management PSR Mall group 4. Healthy Living PSR Mall group 5. DBT Interpersonal Effectiveness PSR Mall group 6. Conflict Management PSR Mall group 7. Sounding the Deep Self PSR Mall group 8. Social Skills through Drumming PSR Mall group 9. Songwriting for Self Discovery PSR Mall group
F.4.a	Each State hospital shall develop and implement policies and procedures, consistent with generally accepted professional standards of care, related to the provision of rehabilitation therapy services that address, at a minimum:	<p>Compliance: Partial.</p>
F.4.a.i	the provision of direct services by rehabilitation therapy services staff; and	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Develop and implement a procedure that specifies criteria for the need for and implementation of a 24-hour support plan (Individual Rehabilitation Support Plan) related to physical and nutritional rehabilitation supports.</p>

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		<p>Findings: A draft of a 24-hour support plan template and instructions was developed and implemented 4/1/08. According to facility report, no 24-hour support plans were required during the month of April. The draft template and instructions appear to meet generally accepted standards of practice.</p> <p>Recommendation 2, November 2007: Develop and implement a system by which assessment/consultation findings, recommended supports/objectives and progress toward these objectives can be reported to the WRPT by all Rehabilitation Therapy Services disciplines.</p> <p>Findings: According to facility report and review of procedures, the Psychosocial Rehabilitation Therapist reports findings regarding monthly progress toward direct Occupational, Physical, and/or Speech therapy treatment objectives to the WRPT. However, a format for progress note documentation by OT, PT and SLP that is consistent across the state facilities and that meets practice act requirements has not yet been developed and implemented. In addition, upon record review of individuals receiving direct OT/PT/SLP treatment, it is noted that foci, objectives and interventions and progress towards objectives are not being integrated into the WRP.</p> <p>Recommendation 3, November 2007: Provide competency-based training to Rehabilitation Therapy staff regarding Recommendation #2.</p> <p>Findings: According to facility report, 74 out of 76 Rehabilitation Therapists have been trained to competency regarding the POST process. This was verified by review of training rosters and post-tests.</p>
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		<p>Recommendation 4, November 2007: Ensure that all Rehabilitation Therapy staff is provided competency-based training on all procedures related to the EP, Wellness and Recovery model and Psychosocial Rehabilitation Mall, including Mall Facilitator Monthly Progress notes and writing of lesson plans/curricula.</p> <p>Findings: According to facility report, 47 out of 76 Rehabilitation Therapists have been trained to competency on the EP overview provided by Staff Development; training rosters were reviewed but no post-tests were available as raw data. WRP competency-based training was provided to 64 out of 76 Rehabilitation Therapists; this was verified by review of training rosters and post-tests. The facility reports that 64 out of 74 therapists received Focus 10 training to competency. However, a review of the training curriculum found that the content was not in line with the requirements of the EP and PSR Mall philosophy and requires revision, particularly with regard to writing and modifying Focus 10 objectives.</p> <p>Recommendation 5, November 2007: Develop and implement an audit tool to ensure the adequate and timely provision and implementation of Rehabilitation Services, including direct treatment (1:1 and group) and indirect supports (e.g., Individual Rehabilitation Support, adaptive equipment). Implementation findings should include recommendations regarding foci, objectives and interventions made by Rehabilitation Therapy Services, quality of these objectives regarding Wellness and Recovery criteria, documentation of progress towards objectives, modification of objectives/ interventions as needed and WRP inclusion.</p>
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		<p>Findings: This recommendation has been partially met; an F.4 Monitoring tool draft has been developed and is pending finalization and implementation.</p> <p>Recommendation 6, November 2007: Establish inter-rater reliability among staff performing audit prior to implementation.</p> <p>Findings: This recommendation has not been addressed.</p> <p>Other findings: According to a review of records for individuals in direct Physical, Occupational and Speech Therapy, 67% had assessment findings that were aligned with treatment objectives and activities. The reason for poor alignment appeared to be the lack of re-assessment of individuals who had been in direct treatment for an extended period of time (over one year).</p> <p>Upon review of a Physical Therapy assessment that included recommendations for direct treatment, as well as review of records of individuals in direct Physical Therapy treatment, it was noted that two of five assessments included recommendation for focus and interventions, one of five contained adequate objectives and none showed WRP inclusion.</p> <p>Upon review of Speech Therapy assessments that included recommendations for direct treatment, as well as review of records of individuals in direct Speech Therapy treatment, it was noted that seven of eight assessments included recommendation for focus, four of eight contained adequate objectives, six of eight showed documentation of interventions and none showed WRP inclusion.</p>
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		<p>Upon review of an Occupational Therapy assessment that included recommendations for direct treatment, as well as records of individuals in direct Occupational Therapy treatment, it was noted that two of seven assessments included recommendation for focus and interventions, one of seven contained adequate objectives and none showed WRP inclusion.</p> <p>Upon review of the current appointment database for direct OT, PT and SLP therapy services, it was difficult to determine how many individuals received direct treatment during the November-April review period. The current database should be revised to list assessments, consultations and therapy sessions separately.</p> <p>Record review of individuals receiving direct Physical Therapy treatment found that four of four records contained IDN documentation of progress and none contained documentation of progress in the WRP.</p> <p>Record review of individuals receiving direct Speech Therapy treatment found that five of five records contained IDN documentation of progress and none contained documentation of progress in the WRP.</p> <p>Record review of individuals receiving Occupational Therapy treatment found that five of five contained IDN documentation of progress and none contained documentation of progress in the WRP.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Develop and implement formats for progress notes for Occupational, Physical and Speech Therapy direct treatment that are consistent with those at the other state facilities as well as with individual discipline practice act requirements.
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		<ol style="list-style-type: none"> 2. Provide training to all Rehabilitation Therapy staff (Rehabilitation Therapists, Vocational Rehabilitation staff and POST team members) regarding the role of the RT as WRPT liaison. 3. Finalize and implement the F.4 audit tool draft to ensure the adequate and timely provision and implementation of Rehabilitation Services, including direct treatment (1:1 and PSR Mall group) and indirect supports (e.g., 24-hour plan, adaptive equipment). 4. Establish inter-rater agreement among staff performing audit prior to implementation.
F.4.a.ii	<p>the oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Develop and implement a plan to ensure that in vivo monitoring of Physical Therapy programs implemented by nursing staff or individuals themselves occurs as needed.</p> <p>Findings: Currently, individualized Physical Therapy plans are not implemented by nursing staff. All plans are carried out as direct Physical and Occupational Therapy treatment by the Physical Therapy Assistant and Occupational Therapists. There is no program in place to ensure that individuals who require assistance by direct care staff to ensure implementation of Physical Therapy home exercise programs occurs as clinically indicated. It appears that such a program would be beneficial secondary to low staffing ratios for Physical and Occupational Therapists and Physical Therapy Assistants.</p> <p>There is not currently a database that tracks individuals who require indirect Physical or Occupational therapy programs, that lists when staff has received competency-based training/return demonstration and notes how often the individual should be re-assessed by the Physical or Occupational Therapist to determine the continued</p>

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		<p>appropriateness of the program. There is not currently a system in place to provide oversight of program implementation.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a procedure for nursing staff provision of indirect Physical and Occupational Therapy programs. 2. Develop and implement a database to track individuals receiving these services, as well as when staff has completed competency-based training/return demonstration and how often the individual should be re-assessed by the Physical or Occupational Therapist to determine the continued appropriateness of the program.
F.4.b	<p>Each State hospital shall provide competency-based training to nursing staff, as appropriate, on the use and care of adaptive equipment, transferring and positioning, as well as the need to promote individuals' independence.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Develop and implement a plan to ensure that competency-based training on the use and care of adaptive equipment, transferring and positioning, and the need to promote individuals' independence occurs as needed.</p> <p>Findings: This recommendation has not been addressed.</p> <p>While the facility has recognized this need and has developed an informal plan to address it, there is no formal system in place to ensure that staff requiring training in these areas is trained to competency. According to facility report, POST team therapists have provided no competency-based training to nursing staff regarding Rehabilitation Therapy supports.</p> <p>Compliance: Partial.</p>

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		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a plan to ensure that competency-based training on the use and care of adaptive equipment, transferring and positioning and the need to promote individuals' independence occurs as needed. 2. Ensure that databases for Physical and Occupational Therapy programs implemented by nursing staff, adaptive equipment and 24-hour plans track the need for and provision of competency-based training for individuals and/or staff.
F.4.c	<p>Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Develop and implement a plan to track Rehabilitation Therapy staff attendance at WRPCs.</p> <p>Findings: Record review of IA-RTS assessments from January-April 2008 found that RT attendance was noted at 78% of WRPCs as evidenced by attendance rosters reviewed. Upon in-vivo observation of one WRPC, it was noted that the Rehabilitation Therapist was present and contributed to the meeting.</p> <p>Recommendation 2, November 2007: Ensure WRP inclusion of recommendations regarding foci, objectives and interventions made by Rehabilitation Therapy Services, quality of these objectives regarding Wellness and Recovery criteria and progress towards objectives.</p> <p>Findings: According to record review of individuals participating in Rehabilitation Therapist-led PSR Mall groups, 17% had WRP inclusion of appropriate focus, none had inclusion of adequate objectives and 48% showed</p>

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		<p>inclusion of interventions. From the same record sample, 22% had evidence of Monthly Facilitator Mall Progress Notes, but only 4% contained progress notes that were completed according to procedure.</p> <p>Recommendation 3, November 2007: Ensure that all Mall groups facilitated by Rehabilitation Therapists have requisite lesson plans and curricula per PSR Mall standards.</p> <p>Findings: According to facility report, 68 Lesson Plans have been completed for RT-provided Mall groups. During observation of six PSR Mall groups led by Rehabilitation Therapists, it was noted that five of seven had lesson plans and five of seven lesson plans were in use. However, many lesson plans reviewed were written to apply to more than one focus, were too general and lacked adequate detail.</p> <p>Recommendation 4, November 2007: Track the number of hours provided per week by therapist according to facility requirements, as well as the number of hours scheduled versus provided and calculate averages per therapist, discipline and department for performance improvement purposes.</p> <p>Findings: The facility collects data regarding PSR Mall hours scheduled versus provided by program for Rehabilitation Therapists and for Vocational Rehabilitation providers. Reported data for percentage of hours provided/scheduled (weighted mean for November-April) are as follows:</p> <table border="1" data-bbox="989 1263 1478 1417"> <tr> <td>Program I</td> <td>86%</td> </tr> <tr> <td>Program III</td> <td>76%</td> </tr> <tr> <td>Program IV</td> <td>87%</td> </tr> <tr> <td>Program V</td> <td>81%</td> </tr> </table>	Program I	86%	Program III	76%	Program IV	87%	Program V	81%
Program I	86%									
Program III	76%									
Program IV	87%									
Program V	81%									

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		<table border="1"> <tr> <td>Program VI</td> <td>78%</td> </tr> <tr> <td>Program VII</td> <td>86%</td> </tr> <tr> <td>Program VIII</td> <td>84%</td> </tr> <tr> <td>Vocational Rehabilitation</td> <td>77%</td> </tr> </table>	Program VI	78%	Program VII	86%	Program VIII	84%	Vocational Rehabilitation	77%	<p>Recommendation 5, November 2007: Develop and implement Vocational Rehabilitation (V.I.C.T.O.R.Y) program and ensure that it reflects Wellness and Recovery language and philosophy.</p> <p>Findings: A literature review was done prior to initiating the V.I.C.T.O.R.Y proposal revisions to ensure that the program would reflect best practices. A supportive curriculum and lesson plans for Vocational Services 1 and 2 were developed and are being piloted in the current Mall cycle. Participating individuals will give feedback on the curriculum to help further develop it according to the individuals' desires and needs.</p> <p>According to facility report, 330 individuals currently have a work assignment. The number and type of industrial therapy assignments is being evaluated, as well as the need for additional staff positions to increase the number of employment opportunities available. Currently, many of the Vocational Instructor positions that fall in areas of interest to the individuals served fall under the Department of Corrections. Unfilled Education positions will be converted to various Vocational positions to further develop the V.I.C.T.O.R.Y Proposal. A Peer-to-Peer Training Program work group has been initiated to develop a plan to provide this service.</p> <p>Other findings: Upon review of a sample of IA-RTS assessments completed from January-April 2008, it was noted that 100% included recommendations</p>
Program VI	78%										
Program VII	86%										
Program VIII	84%										
Vocational Rehabilitation	77%										

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		<p>for focus, none contained adequate objectives and 53% included interventions.</p> <p>No audit data was available regarding individuals with 24-hour Rehabilitation Support plans, as this process has not been implemented. No 24-hour Rehabilitation Support plans were reviewed as none were developed during the November 2007-April 2008 review period.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that for all individuals receiving direct treatment by Rehabilitation Therapists, progress towards objectives is documented in the WRP and focus, objectives and interventions are modified as needed. 2. Develop and implement a database to track individuals with 24-hour plans, as well as when staff has completed competency-based training/return demonstration and how often the individual should be re-assessed by the POST team member(s) to determine the continued appropriateness of the plan. 3. Ensure that all 12-week lesson plans developed by Rehabilitation Therapists are written for only one focus.
F.4.d	<p>Each State hospital, consistent with generally accepted professional standards of care, shall ensure that each individual who requires adaptive equipment is provided with equipment that meets his/her assessed needs and promotes his/her independence and shall provide individuals with training and support to use such equipment.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Develop and implement a plan to ensure that in vivo monitoring of adaptive equipment occurs as needed on an individualized basis by a professional with clinical expertise to determine compliance with both implementation and continued appropriateness of supports.</p>

		<p>Findings: This recommendation has not been addressed.</p> <p>Recommendation 2, November 2007: Develop and implement an adaptive equipment database to track when a piece of equipment is ordered, the date of implementation, level of assistance to the individual with device, whether training/monitoring is necessary and when training/monitoring is provided, if appropriate.</p> <p>Findings: A proposed database was developed to meet this recommendation. The database appears to be sufficient but does not yet track the following: date of assessment, level of assistance needed for device, re-assessment frequency and re-assessment dates and date of training if indicated. According to facility report, 71 individuals currently require the use of adaptive equipment.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a database to track all individuals with adaptive equipment, including when a piece of equipment is ordered compared to the date of implementation, level of assistance of individual with device, whether training was necessary, when training was provided if appropriate and if/how often the individual should be re-assessed by the POST team member(s) to determine the continued appropriateness of the equipment. 2. Ensure that each individual who requires adaptive equipment is provided with equipment that meets his/her assessed needs and promotes his/her independence and provide individuals with training and support to use such equipment.
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5. Nutrition Services		
	<p>Each State hospital shall provide the individuals it serves, particularly those experiencing weight-related problems, adequate and appropriate dietary services consistent with generally accepted professional standards of care.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Dolores Otto-Moreno, Assistant Director of Nutrition Services 2. Grace Ferris, Assistant Director of Nutrition Services 3. Kitchie Miana, Assistant Director of Nutrition Services 4. Tai Kim, Director of Nutrition Services <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Lists of individuals with Nutrition Care Assessments due from November 2007-April 2008 for each assessment type 2. Records for the following 81 individuals with type a-j.ii. assessment from November 2007-April 2008: AB, ABT, ADY, AM, AMC, BK, BLB, BS, CCH, CMG, CP, CS, DAR, DCG, DGA, DIT, DQ, DRH, ECF, EFM, EJH, EMN, EW, GB, GP, GR, HJL, HP, JB, JC, JDC, JDM, JIM, JJD, JJK, JJP, JJS, JSC, KEM, KJ, LB, LCB, LGH, LJS, LMB, LP, LS, MAT, MJO, MLB, MMS, MS, NMM, OWV, PAB, PC, PLA, PSP, RAR, RCP, RE, RF, RLG, RLP, RP, RWT, RYM, RZ, SEL, SH, SJP, SM, SRB, TCS, TCW, VEB, VM, WK, WPW, WSD and ZCJ 3. Meal Accuracy Report audit data from November 2007-April 2008 4. Nutrition Care Monitoring Tool audit data from November 2007-April 2008 regarding Nutrition Education Training and response to MNT (weighted mean across assessment sub-types) 5. Audit data for November 2007-April 2008 regarding WRP integration of Nutrition Services recommendations 6. Records for the following three individuals from observed Nutrition PSR Mall group: CCN, PH and TS 7. Facilitator hour summary data for Dietitians for January- February 2008 8. Diabetes Management 24-Week Lesson Plan 9. DMH Nutrition Care Monitoring Instructions (revised and approved 11/07)

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		<p>10. DMH Statewide Dietetics Department Policy: Dysphagia and Aspiration Management 11. Nutrition PSR Mall group schedule for the week of review 12. DMH Statewide Dietetics Department Policy for Tube Feeding 13. Facility training data and competency scores for RN's and Dietitians, as well as raw data binders</p> <p><u>Observed:</u> Nutrition and Diabetes PSR Mall group</p>
F.5.a	<p>Each State hospital shall modify policies and procedures to require that the therapeutic and rehabilitation service plans of individuals who experience weight problems and/or related health concerns include adequate strategies and methodologies to address the identified problems and that such strategies and methodologies are implemented in a timely manner, monitored appropriately and revised, as warranted, consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Track Mall Facilitator hours by Dietitians.</p> <p>Findings: According to facility report, a total of 202 facilitator hours were scheduled and 157 were provided (78%) from November 2007-April 2008.</p> <p>Recommendation 2, November 2007: Continue current practice.</p> <p>Findings: Current procedures for Nutrition services appear to meet generally accepted standards of practice.</p> <p>According to review of Meal Accuracy Report data, trays (regular and modified diets) audited from November 2007-April 2008 (total of 4452 out of 8995, for a 49% sample) were 98% accurate.</p> <p>Upon observation of the Nutrition and Diabetes PSR Mall group, it was noted that a lesson plan had been written and was being followed, and</p>

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		<p>all individuals were engaged. According to record review of three individuals participating/enrolled in the Diabetes Management group, progress notes were completed for none of the three individuals and completed per procedure for none of the three individuals. Three out of three records showed evidence of alignment between assessment findings and group recommendation. Two out of three had documentation of focus, none had documentation of adequate objectives and two of the three had adequate documentation of intervention in the WRP.</p> <p>Nutrition Education/Training is a direct service provided by Dietitians to individuals and is based on objective assessment findings.</p> <p>Record review of a sample of Nutrition assessments across assessment sub-types found that a weighted mean of 94% of Nutrition Care Assessments had evidence of Nutrition Training/Education if clinically indicated and 94% of Nutrition Care Assessments had evidence of individual response to MNT (Medical Nutrition Training).</p> <p>The facility database for all assessment types per month for November 2007-April 2008 was reviewed and revealed that 90% (weighted mean) of assessments audited from November 2007-April 2008 had evidence of Nutrition Education/Training and 96% had evidence of individual response to NMT.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Continue current practice.</p>
F.5.b	Each State hospital shall ensure that one or more treatment team members demonstrate competence	Current findings on previous recommendation:

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	<p>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>Recommendation, November 2007: Continue current practice.</p> <p>Findings: According to facility report and review of data, Dietitians initiated monitoring of inclusion of Nutrition recommendations into the WRP in November 2007, with the NCMT revised November 2007. However, the assessment and monitoring instructions currently do not include directions for writing recommendations in WRP language in the format of focus, objective and intervention, with monitoring to ensure that recommendations are written in this format for efficient WRP inclusion. According to facility report, the instructions for the NCMT have been revised to include monitoring of Nutrition recommendations in the WRP format and monitoring of compliance will be initiated in May 2008.</p> <p>Review of facility data for WRP inclusion of Nutrition Care recommendations from November 2007-April 2008 shows that 61% of recommendations were incorporated into the WRP.</p> <p>Upon record review of a sample of Nutrition Care assessments completed across assessment sub-types, it was noted that 39% of corresponding WRP documents contained Nutrition Care recommendations.</p> <p>The process by which the Nurse reports findings regarding Nutrition Services recommendations to the WRPT continues; however, the process does not appear to be adequately implemented, as the data for WRP integration reveals less than substantial compliance. Review of facility RN training data shows that nine newly hired RNs and 55 current RNs were trained between November 2007 and April 2008. As of 5/1/08, 135 RNs have been trained out of 228 RNs in need of training (59% compliance) regarding the reporting of Nutrition</p>
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		<p>recommendations to the WRPT.</p> <p>In addition, ten out of ten (100%) full-time RDs were trained regarding writing goals and recommendations the form of focus, objective and intervention. According to facility report, RNs have been responsible for entering Nutrition data into the WRP, but the Dietitians will begin to do their own WRP input starting in May 2008. According to report, all 10 RDs have access to and have received training on how to utilize WaRMSS.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement new process changes regarding WRP integration of Nutrition assessment findings and recommendations. 2. Continue current practice.
F.5.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>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Continue current practice.</p> <p>Findings: The DMH Statewide Dietetics Department Policy: Dysphagia and Aspiration Management was revised and implemented in November 2007. This procedure addresses the dietitian's role in the team process regarding dysphagia and aspiration prevention and management and appears to meet generally accepted standards of practice.</p> <p>Compliance: Substantial.</p>

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		<p>Current recommendation: Continue current practice.</p>
F.5.d	<p>Each State hospital shall ensure that staff with responsibilities for assessments and interventions regarding aspiration and dysphagia has successfully completed competency-based training commensurate with their responsibilities.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Continue current practice.</p> <p>Findings: According to facility report, one new employee has been hired and has been trained to competency (at least 90%) regarding Dysphagia course content. At the time of the last review, it was noted that 100% of dietitians had received Dysphagia Training to competency.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.5.e	<p>Each State hospital shall develop and implement policies and procedures requiring treatment of the underlying causes for tube feeding placement and ongoing assessment of the individuals for whom these treatment options are utilized, to determine the feasibility of returning them to oral intake status.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, November 2007:</p> <ul style="list-style-type: none"> • Continue current practice. • Collaborate with relevant disciplines (e.g., SLP, Nurses, Physicians) to develop and implement a plan/procedure to ensure ongoing assessment of the individuals receiving enteral nutrition, to determine the feasibility of returning them to oral intake status or justification of continued NPO status. <p>Findings: The DMH Statewide Dietetics Department Policy for Tube Feeding (10/07) was implemented to describe the role of the Dietician with</p>

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		<p>regard to enteral nutrition. Current procedure was reviewed and appears to meet accepted standards of practice.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
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6. Pharmacy Services		
	<p>Each State hospital shall provide adequate and appropriate pharmacy services consistent with generally accepted professional standards of care. Each State hospital shall develop and implement policies and procedures that require:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Laura Yao, Business Manager II 2. Phung Chau, BS, Pharmacy Director 3. Richard Plon, PharmD, Pharmacist II <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Recommendations made by pharmacists regarding new psychotropic medication orders in eight individuals (BA, ER, JM, LC, LM, LR, VC and WG) 2. Charts of the following two individuals: CAL and CW 3. PSH's data regarding recommendations made by the pharmacists and physicians' responses (November 2007 to April 2008)
F.6.a	<p>Upon the prescription of a new medication, pharmacists to conduct reviews of each individual's medication regimen and, as appropriate, make recommendations to the prescribing physician about possible drug-to-drug interactions, side effects, and need for laboratory work and testing; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Ensure that pharmacists provide recommendations, when appropriate, and intensify recruitment efforts to improve compliance.</p> <p>Findings: PSH's Pharmacy has recruited one pharmacist during this reporting period and currently has 13 out of 14 Pharmacist I positions filled, with one planning to retire in June 2008. There is one candidate in the process of being hired. The Pharmacy currently has all 10 Pharmacy Technician positions filled. In addition, four limited-term positions are in the process of hiring.</p> <p>In an effort to enhance pharmacists' recommendations to the physicians, the Pharmacy has been providing in-service training by the facility's psychopharmacology consultant, Dr. Cummings twice a month.</p>

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		<p>The training has been provided to all pharmacists on recognizing potential adverse drug reactions, drug-to-drug interactions, and other topics relevant to pharmacists' recommendations.</p> <p>Recommendation 2, November 2007: Continue to monitor this requirement.</p> <p>Findings: The facility has monitoring data (November 2007 to April 2008) based on a review of a 100% sample of new medication orders, including changes to existing orders. The number of recommendations made remains below what is expected. The following table summarizes the data regarding the average number of recommendations per month made by the pharmacists in each category:</p> <table border="1" data-bbox="991 743 1585 1239"> <thead> <tr> <th></th> <th>Mean#</th> </tr> </thead> <tbody> <tr> <td><i>Drug-to-drug interactions</i></td> <td>2</td> </tr> <tr> <td><i>Side-effects</i></td> <td>0</td> </tr> <tr> <td><i>Need for lab work and testing</i></td> <td>4</td> </tr> <tr> <td><i>Contra-indications</i></td> <td>0</td> </tr> <tr> <td><i>Drug allergy</i></td> <td>1</td> </tr> <tr> <td><i>Dose range</i></td> <td>6</td> </tr> <tr> <td><i>Indication for medication</i></td> <td>1</td> </tr> <tr> <td><i>Drug-to-food interactions</i></td> <td>0</td> </tr> <tr> <td><i>Others</i></td> <td>1</td> </tr> <tr> <td>Total recommendations</td> <td>15</td> </tr> </tbody> </table> <p>The facility recognized that the number of recommendations is insufficient.</p>		Mean#	<i>Drug-to-drug interactions</i>	2	<i>Side-effects</i>	0	<i>Need for lab work and testing</i>	4	<i>Contra-indications</i>	0	<i>Drug allergy</i>	1	<i>Dose range</i>	6	<i>Indication for medication</i>	1	<i>Drug-to-food interactions</i>	0	<i>Others</i>	1	Total recommendations	15
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		<p>Recommendations 3 and 4, November 2007:</p> <ul style="list-style-type: none"> • Develop and implement an electronic system to ensure consistent documentation. • Provide IT assistance to pharmacy regarding electronic database and data collection systems. <p>Findings: PSH reported that its IT Director has acquired a copy of MSH's database and has been in the process of making necessary changes to meet the Pharmacy's needs. The facility acknowledged that progress in this area has been slow due to insufficient manpower within the IT Department.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that pharmacists provide recommendations, when appropriate, and resolve implementation barriers. 2. Continue to monitor this requirement and provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period). 3. Develop and implement an electronic system to ensure consistent documentation. 4. Provide IT assistance to pharmacy regarding electronic database and data collection systems.
F.6.b	Physicians to consider pharmacists' recommendations, and for any recommendations not followed, document in the individual's medical record an adequate clinical justification.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Continue to monitor this requirement.</p>

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		<p>Findings: PSH reported that on average each month during this reporting period, nine recommendations were followed, one was not followed but rationale was documented and six were not followed with no documentation of rationale.</p> <p>Other findings: This monitor reviewed the charts of two individuals (CAL and CW) to assess the type of recommendation(s) made by the pharmacist and physician's follow-up. In the case of CW, the recommendation was to institute vital signs checks upon restarting clozapine treatment. In the case of CAL, the pharmacist recommended precautions regarding drug-drug interactions involving beta and alpha blocker medications. In both cases, the review showed that the recommendations were followed in a timely manner.</p> <p>Recommendation 2, November 2007: Provide follow-up regarding situations in which the physician did not respond to the pharmacist's recommendation and/or disagreed with the recommendation without documented acceptable rationale. Assign responsibility and accountability to medical/psychiatry for plans of corrections for problems identified.</p> <p>Findings: PSH reported that the Pharmacy has been forwarding cases of Clinical Pharmacy Review that received inadequate responses to Senior Psychiatrists for follow-up as recommended by the P&T Committee. No further information was provided regarding the outcome of this process.</p> <p>Compliance: Partial.</p>
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		<p>Current recommendations:</p> <ol style="list-style-type: none">1. Continue to monitor this requirement and provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).2. Provide information about the outcome of follow-up in situations in which the physician did not respond to the pharmacist's recommendation and/or disagreed with the recommendation without documented acceptable rationale.
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7. General Medical Services		
		<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Alan Ta, MD, Physician and Surgeon 2. Arporn Sungkakitkorane, MD, Physician and Surgeon 3. Bong Doan, MD, Staff Psychiatrist 4. Christopher Sangdahl, MD, Staff Psychiatrist 5. Chris Elder, Nursing Coordinator, Medical Services 6. Darryl Brown, Medical Services Administrator 7. Dien Mach, MD, Physician and Surgeon 8. Dominique Tran, MD, Physician and Surgeon 9. Faye Owen, MD, Staff Psychiatrist 10. Khue Nguyen, MD, Physician and Surgeon 11. Mohamed Hafez, MD, Physician and Surgeon 12. Nibonth Viravathana, MD, Physician and Surgeon 13. Philip Martin, MD, Staff Psychiatrist 14. Tim Alder, MD, Staff Psychiatrist <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. The charts of 10 individuals who were transferred to an outside medical facility or the Infirmary (at unit 1) during this reporting period (DK, GH, HRB, JHP, JP, JPL, MG, NPC, RSP and TMA) 2. AD #10.47, Medical Services, revised 3. AD #10.25, Medical Emergencies, revised 4. Medical Services Policies and Procedures #01.11 and 01.12 regarding consultation services 5. Medical Services Policy and Procedure P #01.10, History and Physical Examination 6. DMH Medical Surgical Progress Notes Auditing Form 7. DMH Medical Surgical Progress Notes Auditing Form Instructions 8. DMH Integration of Medical Conditions into the WRP Auditing Form

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		<ol style="list-style-type: none"> 9. PSH Medical Surgical Progress Notes Auditing summary data (February to April 2008) 10. DMH Integration of Medical Conditions into the WRP Auditing Form Instructions 11. PSH Integration of Medical Conditions into the WRP Auditing summary data (February to April 2008) 12. DMH Medical Transfer Auditing Form 13. DMH Medical Transfer Auditing Form Instructions. 14. PSH Medical Transfer Auditing summary data (February to April 2008) 15. DMH Diabetes Mellitus Auditing Form 16. DMH Diabetes Mellitus Auditing Form Instructions 17. PSH Diabetes Mellitus Auditing summary data (February to April 2008) 18. DMH Hypertension Auditing Form 19. DMH Hypertension Auditing Form Instructions 20. PSH Hypertension Auditing summary data (February to April 2008) 21. DMH Dyslipidemia Auditing Form 22. DMH Dyslipidemia Auditing Form Instructions 23. PSH Dyslipidemia Auditing summary data (February to April 2008) 24. DMH Asthma/COPD Auditing Form 25. DMH Asthma/COPD Auditing Form Instructions 26. PSH Asthma/COPD Auditing summary data (February to April 2008) 27. PSH summary data regarding Radiology and EKG testing (November 2007 to April 2008)
F.7.a	<p>Each State hospital shall provide adequate, appropriate, and timely preventive, routine, specialized, and emergency medical care to all individuals in need of such services, consistent with generally accepted professional standards of care. Each State hospital shall ensure that individuals</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Revise and implement policies and procedures regarding Medical Attention to Individuals and Medical Emergency Response to correct all of the process deficiencies listed in the previous reports. The</p>

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	<p>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>standards in these policies and procedures should be implemented across all facilities.</p> <p>Findings: PSH participated in three statewide meetings of the Medical Services Chiefs. Subsequently, the facility revised its existing ADs/policies/procedures. The facility provided an outline of the revisions as they related to each of the areas of deficiency. The outline was overinclusive but the revisions adequately addressed the deficiencies cited by this monitor as follows:</p> <ol style="list-style-type: none"> 1. Requirements regarding completeness of all sections of initial assessments: <ol style="list-style-type: none"> a. AD #10.47 (page 2) indicates that the initial physical assessment including medical history, review of systems and physical examination must be completed within 24 hours of admission . Section 60 (page 8) requires monitoring of compliance by auditing 100% of records of newly admitted individuals. b. Medical Services Policy and Procedure #01.10 History and Physical Examinations (Section 8.1, pages 2-3) indicates that the medical provider shall document the initial refusal in the admission record's designated area with date and signature. The unit RN or the RN case manager shall ask the individual weekly for three weeks to reconsider his/her refusal. Should the individual continue to refuse, the RN case manager shall document these persistent refusals on the last page of the Admission H&P Assessment form. Should the individual agree to an Admission H&P within 30 days of admission, the individual shall be scheduled for such to be completed as soon as possible. 2. Timeliness and documentation requirements regarding medical attention to changes in the status of individuals:
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		<ul style="list-style-type: none"> a. AD 10.47 (page 3) indicates that nursing staff will chart acute changes in the medical condition, including vital signs, and document findings and effectiveness of nursing interventions in the IDN section of the medical record. Section 18 (page 4) addresses documentation of significant changes from the baseline in a summary update note by the medical physician at least every quarter. Sections 20-22 (page 4) indicate the timeliness of medical responses and critical notifications. Sections 33-38 (page 6) address physician-to-physician communication regarding changes in the individual's physical status. b. AD #10.47, Section 10.1.5 (page 2) outlines the requirements for risk assessment for medical problems as part of the admission medical history, review of systems and physical examination c. Nursing Policy and Procedure #400 (April 2008) outlines the duties, responsibilities, and requirements of the RN, Shift Lead, HSS and level of care staff when there is a change of condition/status. <ol style="list-style-type: none"> 3. Requirements for preventive health screening of individuals: AD #10.47 addresses this issue in sections 10.3 (admission lab testing that screens for syphilis, hepatitis B and C, chickenpox, measles, rubella and sickle cell, if applicable), 11.6 (TB skin test) and 11.10 (mammograms). 4. Proper physician-nurse communications and physician response within time frames that reflect the urgency of the condition: AD #10.47 (page 3) indicates that any acute change in condition with nursing assessment shall be reported to the physician as soon as possible during the current shift. Section 20-22 (page 4) contains relevant information that was listed in #2 above. 5. Emergency medical response system, including drill practice: <ul style="list-style-type: none"> a. AD #10.25 provides instructions for responding to medical emergencies and plans for conducting regularly scheduled
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		<p>drills. The AD indicates that the Central Nursing Service office, including the Health Services Specialists (HHS), shall develop an ongoing series of Medical Emergency Drills including "Mock Codes" (Section 64, page 7). Finding from such drills shall be summarized at least quarterly and submitted for review by the Emergency Care Committee.</p> <ul style="list-style-type: none"> b. AD #10.47 (page 8) outlines the scope of emergency medical services at PSH, activation of the EMS, type and location of emergency medical equipment and emergency drugs and staff training requirements. c. PSH developed the following tools: Medical Emergency Response or Drill Evaluation Sheet, Medical Emergency Flow Sheet, Medical Emergency Response or Drill Monitoring Form, Medical Emergency Call Log and Medical Emergency Drill Improvement Plan. Approval of these tools is pending. d. PSH received approval for an extra four hours of MOD time for coverage during mock codes. Drills are expected to commence in July 2008. <p>6. Communication of needed data to consultants:</p> <ul style="list-style-type: none"> a. AD #10.47, Sections 27-31(pages 4-6) addresses both in-house and off-site specialty medical clinics' procedures. This AD covers requirements for consultation request forms. b. Medical Services Policy and Procedures #01.12 outlines the process of providing the pertinent data to off-site consultants. <p>7. Timely review and filing of consultation and laboratory reports:</p> <ul style="list-style-type: none"> a. AD #10.47, Section 17 (page 4) requires that all results of consultations be reviewed and initialed by unit medical physician, psychiatrist, and the registered nurse case manager. Reports are to be filed in the medical record within seven days of receipt on the unit. Sections 23-26 (page 4) outline timeliness and the requirements for notification and filing of Stat x-rays and Stat, call-back and critical values of
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		<p>laboratory work-ups.</p> <p>b. Nursing Policy #502 provides guidelines to insure that the results of all diagnostic procedures are appropriately recorded, reviewed and followed-up.</p> <p>8. Follow-up on consultation recommendations: AD #10.47 (page 6) requires that the medical physician has to either to follow the consultant's recommendation on the day the consult/report is reviewed or to write a note to justify the decision not to follow the recommendation.</p> <p>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: AD #10.47, Section 48 (page 7-8) indicates that the medical physician should evaluate the possibility of any risk factors for medical complications and take a proactive role in providing guidance to other disciplines to improve individual care.</p> <p>10. Parameters for physician participation in the WRP process to improve integration of medical and mental health care: AD #10.47, Section 49 (page 8) addresses the process of including medical conditions into the individual's WRP by the unit WRPT (focus 6).</p> <p>Recommendation 2, November 2007: Standardize all monitoring instruments regarding this section for use across facilities. The standardized tools must include indicators and operational instructions.</p> <p>Findings: The DMH recently standardized monitoring instruments, indicators and operational instructions for this section of the EP. The following is an outline of these instruments:</p>
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		<ol style="list-style-type: none"> 1. DMH Medical Surgical Progress Notes Audit Form 2. DMH Integration of Medical Conditions into the WRP Audit Form 3. DMH Medical Transfer Audit Form 4. DMH Diabetes Mellitus Audit Form 5. DMH Hypertension Audit Form 6. DMH Dyslipidemia Audit Form 7. DMH Asthma/COPD Audit Form <p>The implementation of these tools should facilitate more meaningful, streamlined and standardized data. The DMH has yet to standardize the monitoring forms regarding the initial admission medical assessment and the emergency medical response system.</p> <p>Recommendation 3, November 2007: Ensure easy access by physicians to the laboratory information system, radiology data/reports, chart notes and consultation reports.</p> <p>Findings: Since the last review, the facility's contract laboratory at Community Hospital of San Bernardino (CHSB) has further developed its data system (NFuse Lab Data System) to enable online availability to designated Patton practitioners. Approved PSH physicians will be able to access laboratory results remotely on a trial basis starting in June 2008.</p> <p>Recommendation 4, November 2007: Monitor medical care using standardized tools and provide data analysis and corrective actions regarding low compliance. To standardize the process of data presentation by all facilities, results of monitoring data should be presented for each corresponding cell as follows:</p> <ol style="list-style-type: none"> a. F.7.b.ii: Admission medical assessment, medical surgical progress notes, emergent medical care, medical transfers to outside facilities, integration of medical conditions into the WRP, and other
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		<p>processes related to laboratory testing, consultations and clinic referrals.</p> <p>b. F.7.c: Quality of care monitoring regarding specific conditions (e.g. hypertension, diabetes mellitus, asthma/COPD, hepatitis, etc).</p> <p>Findings: See F.7.b.ii and F.7.c.</p> <p>Other findings: This monitor reviewed the charts of 10 individuals (DK, GH, HRB, JHP, JP, JPL, MG, NPC, RSR and TMA) who were transferred to an outside medical facility or the infirmary (at unit 1) during this reporting period. The following table outlines the date/time of physician evaluation at the time of transfer and the reason for the transfer:</p> <table border="1" data-bbox="991 743 1871 1352"> <thead> <tr> <th>Individual</th> <th>Date and time of MD evaluation</th> <th>Reason for transfer</th> </tr> </thead> <tbody> <tr> <td>1.</td> <td>Not documented</td> <td>Unsteady gait and elevated temperature</td> </tr> <tr> <td>2.</td> <td>04/11/08 10:30</td> <td>Cellulitis of both legs</td> </tr> <tr> <td>3.</td> <td>3/27/08 10:25</td> <td>Chest pain</td> </tr> <tr> <td>4.</td> <td>11/02/07 15:15</td> <td>Coffee-ground emesis</td> </tr> <tr> <td>5.</td> <td>1/10/08 21:45</td> <td>Altered mental status (confusion, unsteady gait and disorientation)</td> </tr> <tr> <td>6.</td> <td>2/17/08 11:00</td> <td>Fever and decreased white cell counts</td> </tr> <tr> <td>7.</td> <td>12/23/07 15:00</td> <td>Status epilepticus</td> </tr> <tr> <td>8.</td> <td>12/14/07 09:00</td> <td>Probable ileus</td> </tr> <tr> <td>9.</td> <td>3/09/08 12:10</td> <td>Unresponsiveness to verbal stimuli</td> </tr> <tr> <td>10.</td> <td>1/17/08 20:20</td> <td>Abdominal pain</td> </tr> </tbody> </table> <p>The review found evidence of timely and appropriate care in most</p>	Individual	Date and time of MD evaluation	Reason for transfer	1.	Not documented	Unsteady gait and elevated temperature	2.	04/11/08 10:30	Cellulitis of both legs	3.	3/27/08 10:25	Chest pain	4.	11/02/07 15:15	Coffee-ground emesis	5.	1/10/08 21:45	Altered mental status (confusion, unsteady gait and disorientation)	6.	2/17/08 11:00	Fever and decreased white cell counts	7.	12/23/07 15:00	Status epilepticus	8.	12/14/07 09:00	Probable ileus	9.	3/09/08 12:10	Unresponsiveness to verbal stimuli	10.	1/17/08 20:20	Abdominal pain
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		<p>charts. However, a persisting pattern of deficiencies was found as follows:</p> <ol style="list-style-type: none">1. An individual was transferred to an outside facility for evaluation of unsteady gait and elevated temperature, but the chart did not include any documentation of physician evaluation prior to the transfer or upon return from the transfer. During hospitalization, the individual was diagnosed with pneumonia, sepsis and dehydration, and received adequate treatment for these conditions. The facility indicated that parts of the chart were missing due to HIMD error.2. There was no documentation by the regular physician and surgeon of an assessment of possible contributing factors regarding the occurrence of status epilepticus in an individual who had been seizure-free for almost 10 years. No neurology consultation was obtained by PSH for this individual following the incident.3. An individual suffered from progressive abdominal pain and bowel obstruction, which was later found to be a result of fecal impaction. However, after return from hospitalization, no treatment was provided to decrease the risk of recurrence for this individual.4. There was evidence of incomplete workup to evaluate causes of metabolic factors that appear to have contributed to the occurrence of delirium in an individual.5. The physician evaluation of an individual who returned from hospitalization due to a syncopal episode did not provide conclusions regarding the need for any interventions to decrease the risk of recurrences.6. The nurse's assessment of an individual who complained of abdominal pain did not document if and when a physician was notified. (The individual was later evaluated by the physician.)7. An individual was transferred to an outside facility because of gastrointestinal bleeding that was witnessed by a nurse. During the hospital stay, the individual was found to have a second problem for
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		<p>which he was treated. However, after acute hospitalization, PSH did not address the status of the gastrointestinal bleeding or obtain specialty consultations to provide needed follow-up.</p> <p>8. There was no consistent system of documentation of the physician's evaluation upon transfer to the general facility (Progress Notes or Urgent Care Room Record).</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure easy access by physicians to the laboratory information system, radiology data/reports, chart notes and consultation reports. 2. Implement the revised ADs and Medical Policies and Procedures. 3. Consolidate the ADs and Policies and Procedures that address consultation services. 4. Finalize standardized tools to audit the initial medical assessment and the medical emergency response system. 5. Ensure proper oversight of medical services to correct this monitor's clinical findings of deficiencies (listed in Other findings above).
F.7.b	Each State hospital shall develop and implement protocols and procedures, consistent with generally accepted professional standards of care, that:	Please see sub-cells for compliance findings.
F.7.b.i	require the timely provision of initial and ongoing assessments relating to medical care, including but not limited to, vision care, dental care, and laboratory and consultation services;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Same as in F.7.a.</p>

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		<p>Findings: Same as in F.7.a.</p> <p>Recommendation 2, November 2007: Same as in D.1.c.i.</p> <p>Findings: Same as in D.1.c.i.</p> <p>Other findings: PSH used the DMH Medical-Surgical Progress Note Auditing Form to assess compliance (February to April 2008). This tool evaluates compliance with the quarterly medical reassessments. The average sample was 20% of the individuals with Axis III diagnoses. The following outlines the data:</p> <table border="1" data-bbox="991 781 1887 1122"> <tr> <td data-bbox="991 781 1066 857">1.</td> <td data-bbox="1066 781 1774 857"><i>There is a quarterly note that documents reassessment of the individual medical status.</i></td> <td data-bbox="1774 781 1887 857">32%</td> </tr> <tr> <td data-bbox="991 857 1066 933">2.</td> <td data-bbox="1066 857 1774 933"><i>Significant conditions for which the individual is at risk for complications are identified.</i></td> <td data-bbox="1774 857 1887 933">37%</td> </tr> <tr> <td data-bbox="991 933 1066 1122">3.</td> <td data-bbox="1066 933 1774 1122"><i>If applicable, the on call (after hours) physician documents in the PPN necessary communication between the regular medical physician and the on-call (after hours) physician regarding changes in the individual's physical condition.</i></td> <td data-bbox="1774 933 1887 1122">12%</td> </tr> </table> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Same as in F.7.a. 2. Same as in D.1.c.i. 3. Monitor this requirement using the DMH Medical-Surgical Progress 	1.	<i>There is a quarterly note that documents reassessment of the individual medical status.</i>	32%	2.	<i>Significant conditions for which the individual is at risk for complications are identified.</i>	37%	3.	<i>If applicable, the on call (after hours) physician documents in the PPN necessary communication between the regular medical physician and the on-call (after hours) physician regarding changes in the individual's physical condition.</i>	12%
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		<p>Note Auditing Form based on at least a 20% sample.</p> <p>4. Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).</p>								
<p>F.7.b.ii</p>	<p>require the timely provision of medical care, including but not limited to, vision care, dental care, and laboratory and consultation services; timely and appropriate communication between nursing staff and physicians regarding changes in an individual's physical status; and the integration of each individual's mental health and medical care;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Same as F.7.a.</p> <p>Findings: Same as F.7.a.</p> <p>Recommendation 2, November 2007: Continue to monitor laboratory services.</p> <p>Findings: The following is a summary of the facility's data (November 2007 to April 2008):</p> <p>Radiology Monitor-Accuracy of Target (%S=100):</p> <table border="1" data-bbox="991 1008 1887 1157"> <tr> <td data-bbox="991 1008 1066 1081">1.</td> <td data-bbox="1066 1008 1774 1081"><i>Percentage of exams where right individual was X-rayed</i></td> <td data-bbox="1774 1008 1887 1081">100%</td> </tr> <tr> <td data-bbox="991 1081 1066 1157">2.</td> <td data-bbox="1066 1081 1774 1157"><i>Percentage of exams where right body part was X-rayed</i></td> <td data-bbox="1774 1081 1887 1157">100%</td> </tr> </table> <p>Radiology Monitor-Reporting of Abnormal Results (%S=100):</p> <table border="1" data-bbox="991 1271 1887 1344"> <tr> <td data-bbox="991 1271 1774 1344"><i>Percentage of abnormal X-rays when the physician and the unit were notified on the day the exam was read</i></td> <td data-bbox="1774 1271 1887 1344">100%</td> </tr> </table>	1.	<i>Percentage of exams where right individual was X-rayed</i>	100%	2.	<i>Percentage of exams where right body part was X-rayed</i>	100%	<i>Percentage of abnormal X-rays when the physician and the unit were notified on the day the exam was read</i>	100%
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<i>Percentage of abnormal X-rays when the physician and the unit were notified on the day the exam was read</i>	100%									

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		<p>Radiology Monitor-Teleradiology Readings (%S=100):</p> <table border="1"> <tr> <td data-bbox="991 264 1066 375">1.</td> <td data-bbox="1066 264 1774 375"><i>Percentage of films sent by teleradiology that were verified by radiologist during on-site visit/ primary reading</i></td> <td data-bbox="1774 264 1890 375">100%</td> </tr> <tr> <td data-bbox="991 375 1066 488">2.</td> <td data-bbox="1066 375 1774 488"><i>Percentage of agreements between primary reading and reading by radiologist via teleradiography/secondary reading</i></td> <td data-bbox="1774 375 1890 488">98%</td> </tr> </table> <p>Radiology Monitor-Stat Results (%S=100):</p> <table border="1"> <tr> <td data-bbox="991 602 1774 678"><i>Percentage of Stat results provided to ordering physician before the end of the day exam was ordered</i></td> <td data-bbox="1774 602 1890 678">100%</td> </tr> </table> <p>EKG Monitor-Primary Reading vs. Computer Reading (%S=99%):</p> <table border="1"> <tr> <td data-bbox="991 792 1774 868"><i>Percentage of 12-lead charts where physician's reading substantially agrees with computer reading</i></td> <td data-bbox="1774 792 1890 868">98%</td> </tr> </table> <p>EKG Monitor-Overreading of Defibrillator Tracings (%S=100):</p> <table border="1"> <tr> <td data-bbox="991 982 1774 1091"><i>Percentage of overread (reading by a second qualified physician as a quality measure) that agreed with primary reading (regular reading by a qualified physician)</i></td> <td data-bbox="1774 982 1890 1091">100%</td> </tr> </table> <p>Laboratory Monitor-Stat Orders (%S=100):</p> <table border="1"> <tr> <td data-bbox="991 1205 1066 1315">1.</td> <td data-bbox="1066 1205 1774 1315"><i>Percentage of Stat results that were received in the in-house lab within four hours of pick up by the contract lab</i></td> <td data-bbox="1774 1205 1890 1315">100%</td> </tr> <tr> <td data-bbox="991 1315 1066 1391">2.</td> <td data-bbox="1066 1315 1774 1391"><i>Percentage of Stat results provided to the ordering physician within six hours of the time of the order</i></td> <td data-bbox="1774 1315 1890 1391">100%</td> </tr> </table>	1.	<i>Percentage of films sent by teleradiology that were verified by radiologist during on-site visit/ primary reading</i>	100%	2.	<i>Percentage of agreements between primary reading and reading by radiologist via teleradiography/secondary reading</i>	98%	<i>Percentage of Stat results provided to ordering physician before the end of the day exam was ordered</i>	100%	<i>Percentage of 12-lead charts where physician's reading substantially agrees with computer reading</i>	98%	<i>Percentage of overread (reading by a second qualified physician as a quality measure) that agreed with primary reading (regular reading by a qualified physician)</i>	100%	1.	<i>Percentage of Stat results that were received in the in-house lab within four hours of pick up by the contract lab</i>	100%	2.	<i>Percentage of Stat results provided to the ordering physician within six hours of the time of the order</i>	100%
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		<p>Laboratory Monitor Critical Values (%S=100%):</p> <table border="1" data-bbox="993 266 1887 342"> <tr> <td data-bbox="993 266 1774 342"><i>Percentage of critical laboratory values (panic values) called to the unit within 15 minutes of notification by contract lab</i></td> <td data-bbox="1774 266 1887 342">100%</td> </tr> </table> <p>Recommendation 3, November 2007: Develop and implement a system to assess timeliness and appropriateness of consultation services.</p> <p>Findings: PSH presented information derived from two ADs (#10.47 and #10.01) and two Policies and Procedures (01.11 and 01.12) that contain various types of data relevant to the processes of consultations (in-house and external). However, the facility did not address this recommendation.</p> <p>Recommendation 4, November 2007: Standardize monitoring tools regarding admission medical assessments, ongoing medical care, emergency medical response and the integration of medical conditions into the WRP. The tools must include indicators and corresponding operational instructions for use across facilities.</p> <p>Findings: Same as findings for Recommendation 2 in F.7.a.</p> <p>Recommendation 5, November 2007: Develop and implement standardized tool, including indicators and operational instructions, to assess medical surgical progress notes.</p> <p>Findings: PSH has implemented this recommendation.</p> <p>Recommendation 6, November 2007: Provide data analysis and corrective actions regarding areas of low</p>	<i>Percentage of critical laboratory values (panic values) called to the unit within 15 minutes of notification by contract lab</i>	100%
<i>Percentage of critical laboratory values (panic values) called to the unit within 15 minutes of notification by contract lab</i>	100%			

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		<p>compliance.</p> <p>Findings: PSH used the DMH Medical Transfer Auditing Form to assess compliance (February to April 2008). The average sample was 100% of individuals who had ER visits or acute medical care hospitalization in the given month. The following is a summary of the data:</p> <table border="1" data-bbox="991 488 1887 1385"> <tr> <td data-bbox="991 488 1066 597">1.</td> <td data-bbox="1066 488 1774 597"><i>There is appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i></td> <td data-bbox="1774 488 1887 597">66%</td> </tr> <tr> <td data-bbox="991 597 1066 748">2.</td> <td data-bbox="1066 597 1774 748"><i>There is appropriate and timely response and documentation from the transferring physician meeting the standards of care for the condition being transferred.</i></td> <td data-bbox="1774 597 1887 748">59%</td> </tr> <tr> <td data-bbox="991 748 1066 824">3.</td> <td data-bbox="1066 748 1774 824"><i>Sufficient information is provided to the accepting facility in order to ensure continuity of care.</i></td> <td data-bbox="1774 748 1887 824">14%</td> </tr> <tr> <td data-bbox="991 824 1066 976">4.</td> <td data-bbox="1066 824 1774 976"><i>Sufficient information is provided by the external facility (acute medical care facility/emergency department) at the time of discharge in order to ensure the continuity of care.</i></td> <td data-bbox="1774 824 1887 976">50%</td> </tr> <tr> <td data-bbox="991 976 1066 1127">5.</td> <td data-bbox="1066 976 1774 1127"><i>Upon return from acute medical treatment, the accepting physician provides an appropriate note describe the course of treatment provided at the acute medical facility.</i></td> <td data-bbox="1774 976 1887 1127">69%</td> </tr> <tr> <td data-bbox="991 1127 1066 1278">6.</td> <td data-bbox="1066 1127 1774 1278"><i>Timely written progress notes by the regular medical physician shall address the treatment provided at the acute medical facility and follow-up treatment provided at the DMH hospital.</i></td> <td data-bbox="1774 1127 1887 1278">78%</td> </tr> <tr> <td data-bbox="991 1278 1066 1385">7.</td> <td data-bbox="1066 1278 1774 1385"><i>The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.</i></td> <td data-bbox="1774 1278 1887 1385">20%</td> </tr> </table>	1.	<i>There is appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i>	66%	2.	<i>There is appropriate and timely response and documentation from the transferring physician meeting the standards of care for the condition being transferred.</i>	59%	3.	<i>Sufficient information is provided to the accepting facility in order to ensure continuity of care.</i>	14%	4.	<i>Sufficient information is provided by the external facility (acute medical care facility/emergency department) at the time of discharge in order to ensure the continuity of care.</i>	50%	5.	<i>Upon return from acute medical treatment, the accepting physician provides an appropriate note describe the course of treatment provided at the acute medical facility.</i>	69%	6.	<i>Timely written progress notes by the regular medical physician shall address the treatment provided at the acute medical facility and follow-up treatment provided at the DMH hospital.</i>	78%	7.	<i>The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.</i>	20%
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		<p>PSH analyzed its data and developed the following plan to improve compliance:</p> <ol style="list-style-type: none"> 1. Use of pre-printed PSH Physician's Order Sheet; 2. Implementation of a nursing checklist to capture data on items provided to the transferring facility; 3. Training to nursing staff and physicians on the requirement; 4. Feedback of data to individual practitioner; and 5. Ongoing joint meetings between PSH and off site-facilities to facilitate exchange of information. <p>The facility also used the DMH Integration of Medical Conditions into WRP Auditing Form. The average sample was 21% of WRPCs due in the month (February to April 2008). The following outlines the data:</p> <table border="1" data-bbox="991 743 1881 1122"> <tr> <td data-bbox="991 743 1066 821">1.</td> <td data-bbox="1066 743 1774 821"><i>All medical conditions listed in Axis III are included on the Medical Conditions Form.</i></td> <td data-bbox="1774 743 1881 821">48%</td> </tr> <tr> <td data-bbox="991 821 1066 899">2.</td> <td data-bbox="1066 821 1774 899"><i>The WRP includes each medical condition listed on the medical conditions form.</i></td> <td data-bbox="1774 821 1881 899">43%</td> </tr> <tr> <td data-bbox="991 899 1066 977">3.</td> <td data-bbox="1066 899 1774 977"><i>There is an appropriate focus statement for each medical condition or diagnosis.</i></td> <td data-bbox="1774 899 1881 977">7%</td> </tr> <tr> <td data-bbox="991 977 1066 1055">4.</td> <td data-bbox="1066 977 1774 1055"><i>There is an appropriate objective for each medical condition or diagnosis.</i></td> <td data-bbox="1774 977 1881 1055">8%</td> </tr> <tr> <td data-bbox="991 1055 1066 1122">5.</td> <td data-bbox="1066 1055 1774 1122"><i>There are appropriate intervention(s) for each objective.</i></td> <td data-bbox="1774 1055 1881 1122">1%</td> </tr> </table> <p>PSH indicated that the low compliance on the last three indicators was related to the following:</p> <ol style="list-style-type: none"> 1. The focus statement did not meet the WRP Manual requirements. The medical condition was not listed in many cases and there was no specific information about the disease process including historical or current data. 	1.	<i>All medical conditions listed in Axis III are included on the Medical Conditions Form.</i>	48%	2.	<i>The WRP includes each medical condition listed on the medical conditions form.</i>	43%	3.	<i>There is an appropriate focus statement for each medical condition or diagnosis.</i>	7%	4.	<i>There is an appropriate objective for each medical condition or diagnosis.</i>	8%	5.	<i>There are appropriate intervention(s) for each objective.</i>	1%
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		<p>2. Barriers to compliance included nursing staff not utilizing “as evidenced by” in the objective.</p> <p>3. Nursing staff did not write comprehensive interventions that would enable all nursing staff to follow the plan of care.</p> <p>As a corrective action, the facility reported that nursing staff will be required to take Foci and Objective and Interventions and Mail Integration training. These courses will be offered beginning in May, 2008.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a system to assess timeliness and appropriateness of consultation services. 2. Monitor this requirement using the DMH standardized tools regarding Medical Transfers and Integration of Medical Conditions into the WRP based on at least a 20% samples. 3. Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).
F.7.b.iii	define the duties and responsibilities of primary care (non-psychiatric) physicians;	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Ensure that the duty statement is aligned with the standardized tools and medical policies and procedures upon their completion.</p> <p>Findings: The facility reported that “most duty statements have been updated,” but did not specifically address the recommendation.</p>

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		<p>Compliance: Partial.</p> <p>Current recommendations: Ensure that the duty statement is aligned with the standardized tools and medical policies and procedures upon their completion. It will be sufficient if the duty statement makes reference to the revised ADs and Policies and Procedures.</p>
F.7.b.iv	ensure a system of after-hours coverage by primary care physicians with formal psychiatric training (i.e., privileging and proctorship) and psychiatric backup support after hours; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Continue current practice and ensure psychiatric input in all psychiatric emergencies that occur after-hours in all sections of the facility.</p> <p>Findings: PSH did not provide information regarding psychiatric input in all psychiatric emergencies that occur after-hours in all sections of the facility.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Continue current practice and ensure psychiatric input in all psychiatric emergencies that occur after-hours in all sections of the facility.</p>
F.7.b.v	endeavor to obtain, on a consistent and timely basis, an individual's medical records after the individual is treated in another medical facility.	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Continue efforts to improve receipt of records from regional medical centers.</p>

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		<p>Findings: PSH reported that meetings were held with the leadership of two main hospitals, at which return of records was emphasized. On May 22, 2008, a Patton delegation met with the leadership of Community Hospital of San Bernardino (CHSB), and on May 29, 2008 a similar meeting was held with the Medical Director and key Arrowhead Regional Medical Center(ARMC) clinic nursing administrators. The facility did not provide self-assessment data regarding this requirement.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue efforts to improve receipt of records from regional medical centers. 2. Provide self-assessment data regarding this requirement.
F.7.c	<p>Each State hospital shall ensure that physicians monitor each individual's health status indicators in accordance with generally accepted professional standards of care, and, whenever appropriate, modify their therapeutic and rehabilitation service plans to address any problematic changes in health status indicators.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Standardize all monitoring tools regarding Quality of Care for specific conditions (Diabetes Mellitus, Hypertension, Asthma/COPD, Hepatitis and others). All tools must include indicators and operational instructions for use across facilities.</p> <p>Findings: Same as findings for Recommendation 2 in F.7.a.</p> <p>Recommendation 2, November 2007: Monitor this requirement using standardized tools and provide data analysis and corrective actions regarding areas of low compliance.</p>

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		<p>Findings: PSH used the DMH standardized tools to assess compliance regarding the management of Diabetes Mellitus, hypertension, dyslipidemia and asthma/COPD (February to April 2008). The average samples ranged from 18% to 19% of individuals suffering from these disorders. The following is a summary of the data and data analysis:</p> <p>Diabetes Mellitus:</p> <table border="1"> <tr> <td>1.</td> <td><i>The individual has been evaluated and supporting documentation is completed at least quarterly.</i></td> <td>56%</td> </tr> <tr> <td>2.</td> <td><i>HgbA1C was ordered quarterly.</i></td> <td>50%</td> </tr> <tr> <td>3.</td> <td><i>The HgbA1C is equal to or less than 7%.</i></td> <td>79%</td> </tr> <tr> <td>4.</td> <td><i>Blood sugar is monitored regularly.</i></td> <td>82%</td> </tr> <tr> <td>5.</td> <td><i>Urinary micro albumin is monitored annually.</i></td> <td>56%</td> </tr> <tr> <td>6.</td> <td><i>If the urine micro albumin level is greater than 30, ACE or ARP is prescribed, if not otherwise contraindicated.</i></td> <td>64%</td> </tr> <tr> <td>7.</td> <td><i>The lipid profile is monitored on admission or time of diagnosis and at least annually.</i></td> <td>81%</td> </tr> <tr> <td>8.</td> <td><i>LDL is less than 100mg/dl or there is a plan of care in place to appropriate treat the LDL.</i></td> <td>75%</td> </tr> <tr> <td>9.</td> <td><i>Blood pressure is monitored weekly.</i></td> <td>55%</td> </tr> <tr> <td>10.</td> <td><i>If blood pressure is greater than 130/80, there is a plan of care in place to appropriately lower the blood pressure.</i></td> <td>75%</td> </tr> <tr> <td>11.</td> <td><i>An eye exam by an ophthalmologist/optometrist was completed at least annually.</i></td> <td>79%</td> </tr> <tr> <td>12.</td> <td><i>Podiatry care was provided by a podiatrist at least annually.</i></td> <td>54%</td> </tr> <tr> <td>13.</td> <td><i>A dietary consultation was considered and the recommendation followed, as applicable.</i></td> <td>72%</td> </tr> </table>	1.	<i>The individual has been evaluated and supporting documentation is completed at least quarterly.</i>	56%	2.	<i>HgbA1C was ordered quarterly.</i>	50%	3.	<i>The HgbA1C is equal to or less than 7%.</i>	79%	4.	<i>Blood sugar is monitored regularly.</i>	82%	5.	<i>Urinary micro albumin is monitored annually.</i>	56%	6.	<i>If the urine micro albumin level is greater than 30, ACE or ARP is prescribed, if not otherwise contraindicated.</i>	64%	7.	<i>The lipid profile is monitored on admission or time of diagnosis and at least annually.</i>	81%	8.	<i>LDL is less than 100mg/dl or there is a plan of care in place to appropriate treat the LDL.</i>	75%	9.	<i>Blood pressure is monitored weekly.</i>	55%	10.	<i>If blood pressure is greater than 130/80, there is a plan of care in place to appropriately lower the blood pressure.</i>	75%	11.	<i>An eye exam by an ophthalmologist/optometrist was completed at least annually.</i>	79%	12.	<i>Podiatry care was provided by a podiatrist at least annually.</i>	54%	13.	<i>A dietary consultation was considered and the recommendation followed, as applicable.</i>	72%
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		<table border="1"> <tr> <td data-bbox="989 233 1066 266">15.</td> <td data-bbox="1066 233 1774 305"><i>Focus 6 for Diabetes has appropriate objectives and interventions for this condition.</i></td> <td data-bbox="1774 233 1890 266">70%</td> </tr> </table> <p>The facility conducted data analysis, which highlighted the following:</p> <ol style="list-style-type: none"> 1. Although HgbA1C was ordered quarterly in about 50% of diabetic individuals, March and April data revealed that in about 90% of the individuals, diabetes was either well controlled with HgbA1C equal to or less than 7% or a plan of care was in place (when HgbA1C was greater than 7%). 2. Urinary microalbumin was monitored annually only in about 56% of diabetic individuals. 3. April data showed better treatment with ACE or ARP(if not contraindicated) in 91% of the diabetic individuals with elevated urinary microalbumin 4. Blood pressure was not monitored weekly in half of the diabetic individuals. 5. There was decline in appropriateness of objectives and interventions in focus 6 for diabetes from February to April, which reflects a change in auditors rather than in actual practice. <p>The facility presented the following plan to improve compliance:</p> <ol style="list-style-type: none"> 1. Encourage physicians to follow Diabetes practice guidelines. 2. Provide physicians with group and individual physician performance data analysis. 3. Senior Physicians to evaluate, monitor performance and ensure staff physicians' adherence to adopted practice guidelines and quality and appropriateness of medical care to individuals who suffer from Diabetes Mellitus. 	15.	<i>Focus 6 for Diabetes has appropriate objectives and interventions for this condition.</i>	70%
15.	<i>Focus 6 for Diabetes has appropriate objectives and interventions for this condition.</i>	70%			

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		<p>Hypertension:</p> <table border="1"> <tr> <td data-bbox="989 264 1066 337">1.</td> <td data-bbox="1066 264 1774 337"><i>The individual has been evaluated and supporting documentation completed at least quarterly.</i></td> <td data-bbox="1774 264 1885 337">60%</td> </tr> <tr> <td data-bbox="989 337 1066 375">2.</td> <td data-bbox="1066 337 1774 375"><i>Blood pressure is monitored weekly.</i></td> <td data-bbox="1774 337 1885 375">91%</td> </tr> <tr> <td data-bbox="989 375 1066 488">3.</td> <td data-bbox="1066 375 1774 488"><i>Blood pressure is less than 140/90 or there is an appropriate plan of care in place to reduce blood pressure.</i></td> <td data-bbox="1774 375 1885 488">92%</td> </tr> <tr> <td data-bbox="989 488 1066 561">4.</td> <td data-bbox="1066 488 1774 561"><i>If the individual is 40 or older, aspirin has been ordered unless contraindicated.</i></td> <td data-bbox="1774 488 1885 561">63%</td> </tr> <tr> <td data-bbox="989 561 1066 599">5.</td> <td data-bbox="1066 561 1774 599"><i>Hypertension is addressed in Focus 6 of the WRP.</i></td> <td data-bbox="1774 561 1885 599">91%</td> </tr> <tr> <td data-bbox="989 599 1066 672">6.</td> <td data-bbox="1066 599 1774 672"><i>Focus 6 for Hypertension has appropriate objectives and interventions.</i></td> <td data-bbox="1774 599 1885 672">75%</td> </tr> <tr> <td data-bbox="989 672 1066 745">7.</td> <td data-bbox="1066 672 1774 745"><i>A dietary consult was considered and the recommendation was followed, as applicable.</i></td> <td data-bbox="1774 672 1885 745">67%</td> </tr> <tr> <td data-bbox="989 745 1066 899">8.</td> <td data-bbox="1066 745 1774 899"><i>The BMI is less than or equal to 25 and the waist circumference is less than 40 for males and less than 35 for females or a weight management program has been initiated.</i></td> <td data-bbox="1774 745 1885 899">51%</td> </tr> <tr> <td data-bbox="989 899 1066 937">9.</td> <td data-bbox="1066 899 1774 937"><i>An exercise program has been initiated.</i></td> <td data-bbox="1774 899 1885 937">46%</td> </tr> <tr> <td data-bbox="989 937 1066 1010">10.</td> <td data-bbox="1066 937 1774 1010"><i>If the individual is currently a smoker, smoking cessation has been discussed and included in the WRP.</i></td> <td data-bbox="1774 937 1885 1010">36%</td> </tr> </table> <p>PSH's data analysis indicated that blood pressure was well controlled in the majority of individuals diagnosed with hypertension, but there was low compliance with exercise and smoke cessation programs. The plan of correction was the same as for Diabetes Mellitus. In addition, the facility reported that the physicians will be required to alert the WRPT for recommended exercise programs and smoke cessation classes</p> <p>Dyslipidemia:</p> <table border="1"> <tr> <td data-bbox="989 1386 1066 1425">1.</td> <td data-bbox="1066 1386 1774 1425"><i>The individual has been evaluated and supporting</i></td> <td data-bbox="1774 1386 1885 1425">50%</td> </tr> </table>	1.	<i>The individual has been evaluated and supporting documentation completed at least quarterly.</i>	60%	2.	<i>Blood pressure is monitored weekly.</i>	91%	3.	<i>Blood pressure is less than 140/90 or there is an appropriate plan of care in place to reduce blood pressure.</i>	92%	4.	<i>If the individual is 40 or older, aspirin has been ordered unless contraindicated.</i>	63%	5.	<i>Hypertension is addressed in Focus 6 of the WRP.</i>	91%	6.	<i>Focus 6 for Hypertension has appropriate objectives and interventions.</i>	75%	7.	<i>A dietary consult was considered and the recommendation was followed, as applicable.</i>	67%	8.	<i>The BMI is less than or equal to 25 and the waist circumference is less than 40 for males and less than 35 for females or a weight management program has been initiated.</i>	51%	9.	<i>An exercise program has been initiated.</i>	46%	10.	<i>If the individual is currently a smoker, smoking cessation has been discussed and included in the WRP.</i>	36%	1.	<i>The individual has been evaluated and supporting</i>	50%
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			<i>documentation completed at least quarterly.</i>	
		2.	<i>A lipid panel was ordered at least quarterly.</i>	60%
		3.	<i>The HDL level is >40(M) or >50(F) or a plan of care is in place.</i>	71%
		4.	<i>The LDL level is ≤ or a plan of care is in place.</i>	83%
		5.	<i>The Triglyceride level is ≤ 200 or a plan of care is in place.</i>	87%
		6.	<i>Dyslipidemia is addressed in focus 6 of the WRP.</i>	90%
		7.	<i>Focus 6 for Dyslipidemia has appropriate objectives and interventions for this condition.</i>	69%
		8.	<i>A dietary consultation was considered and the recommendation followed, as applicable.</i>	67%
		9.	<i>BMI is less than or equal to 25 and the waist circumference is less than 40 (males) and less than 35 (females) or a weight management program has been initiated.</i>	55%
		10.	<i>An exercise program has been initiated.</i>	55%
		11.	<i>If non-pharmacological interventions have been ineffective to control Dyslipidemia, medications have been considered or initiated.</i>	86%
		<p>To improve compliance, PSH reported the same plan of correction described under Diabetes Mellitus.</p> <p>Asthma/COPD:</p>		
		1.	<i>The individual has been evaluated and supporting documentation completed at least quarterly.</i>	54%
		2.	<i>For individuals with a diagnosis of COPD, a baseline chest x-ray has been completed.</i>	67%
		3.	<i>If a rescue inhaler is being used more than 2 days a week, the individual has been assessed and an</i>	44%

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		<table border="1"> <tr> <td data-bbox="989 191 1066 232"></td> <td data-bbox="1066 191 1776 232"><i>appropriate plan of care has been developed.</i></td> <td data-bbox="1776 191 1892 232"></td> </tr> <tr> <td data-bbox="989 232 1066 342">4.</td> <td data-bbox="1066 232 1776 342"><i>If the individual is currently a smoker, a smoking cessation program has been discussed and included in the WRP.</i></td> <td data-bbox="1776 232 1892 342">50%</td> </tr> <tr> <td data-bbox="989 342 1066 383">5.</td> <td data-bbox="1066 342 1776 383"><i>Asthma or COPD is addressed in focus 6 of the WRP.</i></td> <td data-bbox="1776 342 1892 383">83%</td> </tr> <tr> <td data-bbox="989 383 1066 456">6.</td> <td data-bbox="1066 383 1776 456"><i>Focus 6 for Asthma/COPD has appropriate objectives and interventions.</i></td> <td data-bbox="1776 383 1892 456">69%</td> </tr> <tr> <td data-bbox="989 456 1066 496">7.</td> <td data-bbox="1066 456 1776 496"><i>The individual has been assessed for a flu vaccination.</i></td> <td data-bbox="1776 456 1892 496">54%</td> </tr> <tr> <td data-bbox="989 496 1066 607">8.</td> <td data-bbox="1066 496 1776 607"><i>If the individual has a diagnosis of COPD, a Pneumococcal vaccine has been offered, unless contraindicated.</i></td> <td data-bbox="1776 496 1892 607">31%</td> </tr> </table>		<i>appropriate plan of care has been developed.</i>		4.	<i>If the individual is currently a smoker, a smoking cessation program has been discussed and included in the WRP.</i>	50%	5.	<i>Asthma or COPD is addressed in focus 6 of the WRP.</i>	83%	6.	<i>Focus 6 for Asthma/COPD has appropriate objectives and interventions.</i>	69%	7.	<i>The individual has been assessed for a flu vaccination.</i>	54%	8.	<i>If the individual has a diagnosis of COPD, a Pneumococcal vaccine has been offered, unless contraindicated.</i>	31%	
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F.7.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>To improve compliance, PSH reported the same plan of correction described under Diabetes Mellitus.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor this requirement using the DMH standardized tools for specific medical conditions, based on at least a 20% sample. 2. Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period). 	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Ensure that the indicators used in the physician peer review system are aligned with the standardized monitoring forms regarding admission medical assessments, medical-surgical progress notes, emergency medical response, medical transfer to outside facilities, integration of medical conditions into the WRP and quality of care monitors regarding</p>																		

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		<p>specific medical conditions.</p> <p>Findings: The new DMH audit tools for Diabetes Mellitus, hypertension, dyslipidemia, asthma, and COPD have been adopted by the Department of Medicine for purposes of peer review, except for those physicians who do not have unit responsibilities. In addition, the Medical Executive Committee has approved a Department of Medicine Physician Performance Profile, to be used quarterly, which will include a summary of findings based on the above audit tools.</p> <p>Recommendation 2, November 2007: Continue to update practice guidelines guided by current literature and relevant clinical experience.</p> <p>Findings: No new guidelines were developed during this reporting period. However, the guidelines regarding osteoporosis, seizures, physical exams, dysphagia, fall risk, hypertension and diabetes that were updated during the previous reporting period have been implemented during this reporting period.</p> <p>Recommendation 3, November 2007: Ensure that practice guidelines are aligned with the standardized monitoring forms regarding quality of care for specific conditions.</p> <p>Findings: PSH has implemented this recommendation. The facility reported that it provided input into the development of DMH audit tools for diabetes and hypertension based on PSH's practice guidelines in these areas. The template for the new quarterly Med-Surg Physician's Progress Note is aligned with the standardized monitoring forms.</p>
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		<p>Recommendation 4, November 2007: Provide peer review data analysis regarding practitioner and group trends, with corrective actions, as indicated.</p> <p>Findings: PSH has yet to implement this recommendation.</p> <p>Recommendation 5, November 2007: Identify trends and patterns in the health status of individuals based on clinical and process outcomes, with corrective actions, as indicated.</p> <p>Findings: PSH did not provide specific information regarding this recommendation.</p> <p>Recommendation 6, November 2007: Finalize efforts to automate data systems to facilitate data collection and analysis.</p> <p>Findings: PSH reported that a medical conditions database is under development.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Implement the Physician Performance profile and utilize the data in the processes of reappointment and reprivileging.2. Continue to update practice guidelines guided by current literature and relevant clinical experience.3. Provide peer review data analysis regarding practitioner and group trends, with corrective actions, as indicated.4. Identify trends and patterns in the health status of individuals
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		<p>based on clinical and process outcomes, with corrective actions, as indicated.</p> <p>5. Finalize efforts to automate data systems to facilitate data collection and analysis.</p>
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8. Infection Control		
	<p>Each State hospital shall develop and implement infection control policies and procedures to prevent the spread of infections or communicable diseases, consistent with generally accepted professional standards of care.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Chloe Cummings, PHN II 2. Cindy Blaire, RN 3. Donna Rowe, PHN II 4. Mary Lou Remetir, RN, Infection Control Nurse 5. Rose Bui, MD, PHO <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. PSH's progress report and data 2. Medical records for the following 86 individuals: AC, AG, AM, AS, BD, BJA, BJN, BP, BTB, CB, CD, CH, CR, DB, DP, DW, EC, EG, FA, FD, FW, GAG, GAQ, GB, GC, GG, GW, HDG, HL, JA, JC, JD, JDD, JF, JGM, JM, JP, JPD, JS, JW, KB, KLS, LB, LC, LL, LM, MA, MAG, MAM, MBR, MC, MH, MIH, MM, MP, MS, MT, NG, PAB, PD, PH, PLS, QDB, RB, RCH, RH, RN, RT, SBH, SD, SDG, SE, SGG, SK, SML, SRD, TL, TLE, TPL, TS, VB, VRS, VW, WDT, WK and WMC 3. Infection Control Meeting minutes dated 12/13/07, 1/10/08, 2/14/08, 3/13/08 and 4/17/08 4. Department of Medicine Meeting minutes dated 12/5/07, 1/2/08 and 3/5/08 5. Department of Medicine/Psychiatry Meeting minutes dated 2/27/08 and 4/23/08 6. PSH Quality Improvement Meeting minutes dated 11/6/07, 12/18/07, 1/22/08, 2/26/08 and 3/4/08 7. PSH Infection Control Report: Interpretation of January 2008 Data 8. Evaluation of the Effectiveness of the Patton State Hospital Infection Control Program, 2007 9. Memos dated 2/25/08 and 2/28/08 regarding Respiratory Illnesses Outbreak in Patton and update

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		<p>10. PSH Infection Control Report: Interpretation of April 2008 Data</p> <p>11. 2008 Risk Assessment for Infection Control at Patton State Hospital</p> <p>12. Course outline for Nursing Plans of Care for Health & Wellness</p> <p>13. PSH Infection Control Plan, June 2008-June 2009</p> <p>14. Memos dated 2/14/08, 3/5/08, 4/2/08 and 5/7/08 regarding Annual PPD Tracking Forms compliance per unit</p> <p>15. PSH training rosters</p>
F.8.a	Each State hospital shall establish an effective infection control program that:	<p>Compliance: Partial.</p>
F.8.a.i	actively collects data regarding infections and communicable diseases;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Implement Access data base as scheduled.</p> <p>Findings: PSH's progress report indicated that the current database was adequate.</p> <p>Recommendation 2, November 2007: Develop and implement plans of correction for areas out of acceptable compliance range.</p> <p>Findings: See F.8.a.iv.</p> <p>Recommendation 3, November 2007: Provide necessary training to unit staff regarding their responsibilities for policies and procedures related to Infection Control activities.</p>

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		<p>Findings: Training data provided by PSH verified that Nursing staff were trained regarding the audit requirements and provided the audit results. Also, the training data indicated that "Nursing Plans of Care for Health & Wellness" focusing on Infection Control issues was conducted on May 19, 2008.</p> <p>Recommendation 4, November 2007: Continue to monitor this requirement.</p> <p>Findings:</p> <p><u>Admission PPDs</u> PSH's data from the DMH IC Admission PPD audit for November 2007-April 2008, based on a 76% mean sample of the number of individuals admitted in the review months, indicated the following mean compliance rates for the items listed below:</p> <table border="1" data-bbox="991 857 1885 1308"> <tr> <td>1.</td> <td><i>Notification by the unit via a PPD form is sent to the Infection Control Department for all PPD readings.</i></td> <td>47%</td> </tr> <tr> <td>2.</td> <td><i>PPDs were ordered by the physician during the admission procedure</i></td> <td>93%</td> </tr> <tr> <td>3.</td> <td><i>A chest x-ray was ordered by the physician, if indicated.</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>PPDs were administered by the nurse within 24 hours of the physicians order.</i></td> <td>82%</td> </tr> <tr> <td>5.</td> <td><i>First-step PPDs were read by the nurse within seven days of administration.</i></td> <td>87%</td> </tr> <tr> <td>6.</td> <td><i>Second-step PPDs were read by the nurse within 48-72 hours of administration.</i></td> <td>82%</td> </tr> </table> <p>A review of 20 individuals' admission PPDs (AS, BP, CB, DP, DW, EC, FD, JD, JM, JP, KB, LC, LL, MA, MS, NG, PD, RT, SE and VW) found that all</p>	1.	<i>Notification by the unit via a PPD form is sent to the Infection Control Department for all PPD readings.</i>	47%	2.	<i>PPDs were ordered by the physician during the admission procedure</i>	93%	3.	<i>A chest x-ray was ordered by the physician, if indicated.</i>	100%	4.	<i>PPDs were administered by the nurse within 24 hours of the physicians order.</i>	82%	5.	<i>First-step PPDs were read by the nurse within seven days of administration.</i>	87%	6.	<i>Second-step PPDs were read by the nurse within 48-72 hours of administration.</i>	82%
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		<p>had orders for PPDs; 17 were given within 24 hours of the order; 18 had documentation that the first step was read within seven days; and 16 had documentation that they were read within 48-72 hours.</p> <p><u>Annual PPDs</u> PSH's data from the DMH IC Annual PPD audit for November 2007-April 2008, based on a 65% mean sample of individuals due for an annual review during the review months, indicated the following mean compliance rates for the items listed below:</p> <table border="1" data-bbox="991 561 1887 862"> <tr> <td>1.</td> <td><i>Notification by the unit via a PPD form is sent to the Infection Control Department for all PPD readings.</i></td> <td>22%</td> </tr> <tr> <td>2.</td> <td><i>PPDs were ordered by the physician during the annual review procedure.</i></td> <td>93%</td> </tr> <tr> <td>3.</td> <td><i>PPDs were administered by the nurse within 24 hours of the order.</i></td> <td>64%</td> </tr> <tr> <td>4.</td> <td><i>PPDs were read by the nurse between 48-72 hours after administration.</i></td> <td>87%</td> </tr> </table> <p>A review of 20 individuals' annual PPDs (AG, CH, DB, GG, HL, JA, JC, JD, LM, MC, MP, MT, RH, RN, RT, SD, SK, TL, VB and WK) found that all had orders for PPDs; 12 were administered within 24 hours of the order; and; 17 were read within 48-72 hours.</p> <p><u>Positive PPDs</u> PSH's data from the DMH IC Positive PPD audit for November 2007-April 2008, based on a 99% mean sample of individuals who had a positive PPD upon admission each month, indicated the following mean compliance rates for the items listed below:</p> <table border="1" data-bbox="991 1308 1887 1421"> <tr> <td>1.</td> <td><i>Notification by the unit via a PPD form is sent to Public Health Office for all PPD readings.</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>All positive PPDs received PA and Lateral chest x-</i></td> <td>84%</td> </tr> </table>	1.	<i>Notification by the unit via a PPD form is sent to the Infection Control Department for all PPD readings.</i>	22%	2.	<i>PPDs were ordered by the physician during the annual review procedure.</i>	93%	3.	<i>PPDs were administered by the nurse within 24 hours of the order.</i>	64%	4.	<i>PPDs were read by the nurse between 48-72 hours after administration.</i>	87%	1.	<i>Notification by the unit via a PPD form is sent to Public Health Office for all PPD readings.</i>	100%	2.	<i>All positive PPDs received PA and Lateral chest x-</i>	84%
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			<i>rays.</i>	
		3.	<i>All positive PPDs received an evaluation by the Med-Surg physician</i>	84%
		4.	<i>If active disease is identified, then individual is transferred to medical isolation and appropriate treatment is provided.</i>	N/A
		5.	<i>If active disease is present there is a focus opened.</i>	N/A
		6.	<i>If there is active disease there are appropriate objectives written to provide treatment and to prevent spread of disease.</i>	N/A
		7.	<i>If there is active disease there are appropriate interventions written to prevent the progression of the disease.</i>	N/A
<p>A review of 10 individuals with positive PPDs (AM, CD, CR, EG, FA, JC, JDD, JS, PH and WMC) found that all had received chest x-rays and were seen by the Med/Surg physician. None of the individuals were found to have active disease.</p> <p><u>Refused Admitting or Annual Work or PPDs</u> PSH's data from the DMH IC Refused Admitting or Annual Lab Work or Diagnostic Test audit for November 2007-April 2008, based on a 100% sample of individuals who have refused admitting PPD, annual PPD or admitting lab work (N) during the review months, indicated the following mean compliance rates for the items listed below:</p>				
		1.	<i>Notification by the unit that the individual refused his/her admission or annual lab work or admission or annual PPD is sent to the Infection Control Department.</i>	22%
		2.	<i>There is a focus opened for the lab work or PPD refusal.</i>	5%
		3.	<i>There are appropriate objectives written for the lab</i>	6%

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		<table border="1"> <tr> <td></td> <td><i>work or PPD refusal</i></td> <td></td> </tr> <tr> <td>4.</td> <td><i>There are appropriate interventions written for the lab work or PPD refusal.</i></td> <td>12%</td> </tr> </table>		<i>work or PPD refusal</i>		4.	<i>There are appropriate interventions written for the lab work or PPD refusal.</i>	12%						
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4.	<i>There are appropriate interventions written for the lab work or PPD refusal.</i>	12%												
<p>A review of 26 individuals who refused labs or PPDs (AC, BD, BJA, BJN, BTB, EC, FW, GAQ, GB, HDG, JPD, LB, MAM, MH, MIH, MM, PLS, QDB, RB, SBH, SDG, SGG, SRD, TPL, TS and WDT) found that seven had an open focus for addressing the refusal and none had appropriate objectives or interventions.</p>														
<p><u>Immunizations</u> PSH's data from the DMH IC Immunization audit for November 2007-April 2008, based on a 88% mean sample of individuals admitted in the review months, indicated the following mean compliance rates for the items listed below:</p>														
<table border="1"> <tr> <td>1.</td> <td><i>Notification by the lab was made to the infection control department of an individual's immunity status.</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>Notification by the lab was made to the unit housing the individual of their immunity status.</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>Immunizations were ordered by the physician within five days of receiving notification by the lab</i></td> <td>56%*</td> </tr> <tr> <td>4.</td> <td><i>Immunizations were administered by the nurse within 24 hours of the physicians order and completed within timeframes.</i></td> <td>67%</td> </tr> </table>			1.	<i>Notification by the lab was made to the infection control department of an individual's immunity status.</i>	100%	2.	<i>Notification by the lab was made to the unit housing the individual of their immunity status.</i>	100%	3.	<i>Immunizations were ordered by the physician within five days of receiving notification by the lab</i>	56%*	4.	<i>Immunizations were administered by the nurse within 24 hours of the physicians order and completed within timeframes.</i>	67%
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4.	<i>Immunizations were administered by the nurse within 24 hours of the physicians order and completed within timeframes.</i>	67%												
<p>*PSH reported that for item # 3 above, the tool will be changed to allow a 30-day timeframe due to some individuals needing HIV testing prior to receiving immunizations that would not be within a five-day timeframe affecting compliance rates.</p>														
<p>A review of 20 individuals' admission PPDs (AS, BP, CB, DP, DW, EC, FD, JD, JM, JP, KB, LC, LL, MA, MS, NG, PD, RT, SE and VW) found that all</p>														

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		<p>had lab work in the medical records indicating immunity status notification to the unit and IC and 13 had received immunizations within 24 hours of the physician order.</p> <p><u>Immunization Refusals</u> PSH's data from the DMH IC Immunization Refusal audit for November 2007-April 2008, based on a 100% sample of individuals who refused immunizations in the review months, indicated the following mean compliance rates for the items listed below:</p> <table border="1" data-bbox="991 561 1885 1049"> <tr> <td data-bbox="991 561 1066 672">1.</td> <td data-bbox="1066 561 1774 672"><i>Notification by the unit to the infection control department of the individual's refusal of the immunization(s).</i></td> <td data-bbox="1774 561 1885 672">8%</td> </tr> <tr> <td data-bbox="991 672 1066 748">2.</td> <td data-bbox="1066 672 1774 748"><i>There is a focus opened for the refusal of the immunization(s).</i></td> <td data-bbox="1774 672 1885 748">12%</td> </tr> <tr> <td data-bbox="991 748 1066 824">3.</td> <td data-bbox="1066 748 1774 824"><i>There are appropriate objective(s) developed for the refusal of the immunization(s).</i></td> <td data-bbox="1774 748 1885 824">4%</td> </tr> <tr> <td data-bbox="991 824 1066 935">4.</td> <td data-bbox="1066 824 1774 935"><i>There are appropriate interventions written for the objective(s) developed for the refusal of the immunization(s).</i></td> <td data-bbox="1774 824 1885 935">4%</td> </tr> <tr> <td data-bbox="991 935 1066 1049">5.</td> <td data-bbox="1066 935 1774 1049"><i>The unit notified the infection control department when the individual consented and received the immunization(s).</i></td> <td data-bbox="1774 935 1885 1049">12%</td> </tr> </table> <p>A review of the charts of four individuals who refused immunizations (CB, JF, LB and MBR) found that three had a focus opened for refusal and none had appropriate objectives or interventions.</p> <p><u>STDs</u> PSH's data from the DMH IC Sexually Transmitted Disease audit for November 2007-April 2008, based on a 94% mean sample of individuals admitted and testing positive for an STD in the review months, indicated the following mean compliance rates for the items listed</p>	1.	<i>Notification by the unit to the infection control department of the individual's refusal of the immunization(s).</i>	8%	2.	<i>There is a focus opened for the refusal of the immunization(s).</i>	12%	3.	<i>There are appropriate objective(s) developed for the refusal of the immunization(s).</i>	4%	4.	<i>There are appropriate interventions written for the objective(s) developed for the refusal of the immunization(s).</i>	4%	5.	<i>The unit notified the infection control department when the individual consented and received the immunization(s).</i>	12%
1.	<i>Notification by the unit to the infection control department of the individual's refusal of the immunization(s).</i>	8%															
2.	<i>There is a focus opened for the refusal of the immunization(s).</i>	12%															
3.	<i>There are appropriate objective(s) developed for the refusal of the immunization(s).</i>	4%															
4.	<i>There are appropriate interventions written for the objective(s) developed for the refusal of the immunization(s).</i>	4%															
5.	<i>The unit notified the infection control department when the individual consented and received the immunization(s).</i>	12%															

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		<p>below:</p> <table border="1"> <tr> <td data-bbox="991 266 1066 337">1.</td> <td data-bbox="1066 266 1774 337"><i>Notification by the lab was made to the infection control department of a positive STD.</i></td> <td data-bbox="1774 266 1887 337">100%</td> </tr> <tr> <td data-bbox="991 337 1066 409">2.</td> <td data-bbox="1066 337 1774 409"><i>Notification by the lab was made to the unit housing the individual that she/he has an STD.</i></td> <td data-bbox="1774 337 1887 409">99%</td> </tr> <tr> <td data-bbox="991 409 1066 480">3.</td> <td data-bbox="1066 409 1774 480"><i>An RPR is ordered during the admission process for each individual.</i></td> <td data-bbox="1774 409 1887 480">100%</td> </tr> <tr> <td data-bbox="991 480 1066 552">4.</td> <td data-bbox="1066 480 1774 552"><i>An HIV antibody test is offered to every individual upon admission</i></td> <td data-bbox="1774 480 1887 552">80%</td> </tr> <tr> <td data-bbox="991 552 1066 623">5.</td> <td data-bbox="1066 552 1774 623"><i>A Chlamydia and Gonorrhea test are ordered during the admission procedure for all female individuals.</i></td> <td data-bbox="1774 552 1887 623">91%</td> </tr> <tr> <td data-bbox="991 623 1066 695">5.a</td> <td data-bbox="1066 623 1774 695"><i>A Chlamydia test was ordered during the admission procedure for all female individuals.</i></td> <td data-bbox="1774 623 1887 695">91%</td> </tr> <tr> <td data-bbox="991 695 1066 766">5.b</td> <td data-bbox="1066 695 1774 766"><i>A Gonorrhea test was ordered during the admission procedure for all female individuals.</i></td> <td data-bbox="1774 695 1887 766">91%</td> </tr> <tr> <td data-bbox="991 766 1066 837">6.</td> <td data-bbox="1066 766 1774 837"><i>If an individual was involved in a sexual incident, he/she was offered appropriate testing.</i></td> <td data-bbox="1774 766 1887 837">N/A</td> </tr> <tr> <td data-bbox="991 837 1066 909">7.</td> <td data-bbox="1066 837 1774 909"><i>A focus 6 is opened for all individuals testing positive for a STD.</i></td> <td data-bbox="1774 837 1887 909">75%</td> </tr> <tr> <td data-bbox="991 909 1066 980">8.</td> <td data-bbox="1066 909 1774 980"><i>Appropriate objective(s) are written</i></td> <td data-bbox="1774 909 1887 980">50%</td> </tr> <tr> <td data-bbox="991 980 1066 1019">9.</td> <td data-bbox="1066 980 1774 1019"><i>Appropriate interventions are written</i></td> <td data-bbox="1774 980 1887 1019">0%</td> </tr> </table> <p><u>Hepatitis C</u> PSH's data from the DMH IC Hepatitis C audit for November 2007-April 2008, based on a 73% mean sample of individuals diagnosed with Hepatitis C in the review months, indicated the following mean compliance rates for the items listed below:</p> <table border="1"> <tr> <td data-bbox="991 1279 1066 1318">1.</td> <td data-bbox="1066 1279 1774 1388"><i>Notification by the lab was made to the infection control department identifying the individual with a positive Hepatitis C antibody.</i></td> <td data-bbox="1774 1279 1887 1318">100%</td> </tr> </table>	1.	<i>Notification by the lab was made to the infection control department of a positive STD.</i>	100%	2.	<i>Notification by the lab was made to the unit housing the individual that she/he has an STD.</i>	99%	3.	<i>An RPR is ordered during the admission process for each individual.</i>	100%	4.	<i>An HIV antibody test is offered to every individual upon admission</i>	80%	5.	<i>A Chlamydia and Gonorrhea test are ordered during the admission procedure for all female individuals.</i>	91%	5.a	<i>A Chlamydia test was ordered during the admission procedure for all female individuals.</i>	91%	5.b	<i>A Gonorrhea test was ordered during the admission procedure for all female individuals.</i>	91%	6.	<i>If an individual was involved in a sexual incident, he/she was offered appropriate testing.</i>	N/A	7.	<i>A focus 6 is opened for all individuals testing positive for a STD.</i>	75%	8.	<i>Appropriate objective(s) are written</i>	50%	9.	<i>Appropriate interventions are written</i>	0%	1.	<i>Notification by the lab was made to the infection control department identifying the individual with a positive Hepatitis C antibody.</i>	100%
1.	<i>Notification by the lab was made to the infection control department of a positive STD.</i>	100%																																				
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1.	<i>Notification by the lab was made to the infection control department identifying the individual with a positive Hepatitis C antibody.</i>	100%																																				

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		2.	<i>Notification by the lab was made to the unit housing the individual that he/she has a positive hepatitis C antibody test</i>	100%
		3.	<i>Hepatitis C tracking sheet was initiated for each individual testing positive for Hepatitis C Antibody.</i>	71%
		4.	<i>The individual's medication plan was evaluated and immunizations for Hepatitis A and B were considered.</i>	67%
		5.	<i>A focus 6 is opened for Hepatitis C.</i>	91%
		6.	<i>Appropriate objective(s) are written to include treatment as required by the Hepatitis C tracking sheet.</i>	23%
		6.a	<i>All objectives for Focus 6 problem of Hepatitis C are written in measurable, observable and/or behavioral terms.</i>	24%
		6.b	<i>The objectives align with the Hepatitis C Tracking Form.</i>	57%
		7.	<i>Appropriate interventions are written to include treatment as required by the Hepatitis C tracking sheet.</i>	0%
		7.b	<i>The interventions include risk factors for transmission</i>	35%
		7.c	<i>The interventions include teaching about the importance of adherence to treatment and use of the Hepatitis C Video.</i>	0%
		7.d	<i>The interventions include teaching on treatment availability</i>	6%
	<p>A review of the charts of 14 individuals who are Hepatitis C positive (AG, GAG, GC, GW, JGM, JW, KLS, MA, MAG, PAB, RCH, SML, TLE and VRS) found that all had lab work in the medical records indicating notification to the units and IC Department. There was documentation in all but one chart that the medication plan was reviewed and that immunizations for Hepatitis A and B were considered (JGM). All had a</p>			

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		<p>focus 6 opened for Hepatitis C. However, objectives were not measurable, observable, or behavioral and interventions were inadequate.</p> <p><u>MRSA</u></p> <p>PSH's data from the DMH IC MRSA audit for November 2007-April 2008, based on a 93% mean sample of individuals diagnosed with MRSA in the review months, indicated the following mean compliance rates for the items listed below:</p> <table border="1" data-bbox="991 561 1887 1424"> <tr> <td data-bbox="991 561 1066 672">1.</td> <td data-bbox="1066 561 1774 672"><i>Notification by the lab was made to the infection control department when an individual has a positive culture for MRSA.</i></td> <td data-bbox="1774 561 1887 672">100%</td> </tr> <tr> <td data-bbox="991 672 1066 782">2.</td> <td data-bbox="1066 672 1774 782"><i>Notification by the lab was made to the unit housing the individual that a positive culture for MRSA was obtained.</i></td> <td data-bbox="1774 672 1887 782">100%</td> </tr> <tr> <td data-bbox="991 782 1066 862">3.</td> <td data-bbox="1066 782 1774 862"><i>The individual is placed on contact precautions per MRSA policy.</i></td> <td data-bbox="1774 782 1887 862">92%</td> </tr> <tr> <td data-bbox="991 862 1066 938">4.</td> <td data-bbox="1066 862 1774 938"><i>The appropriate antibiotic was ordered for treatment of the infection(s).</i></td> <td data-bbox="1774 862 1887 938">96%</td> </tr> <tr> <td data-bbox="991 938 1066 1049">5.</td> <td data-bbox="1066 938 1774 1049"><i>The public health office contacts the unit RN and provides MRSA protocol and guidance for the care of the individual</i></td> <td data-bbox="1774 938 1887 1049">77%</td> </tr> <tr> <td data-bbox="991 1049 1066 1089">6.</td> <td data-bbox="1066 1049 1774 1089"><i>A focus 6 is opened for MRSA.</i></td> <td data-bbox="1774 1049 1887 1089">85%</td> </tr> <tr> <td data-bbox="991 1089 1066 1166">7.</td> <td data-bbox="1066 1089 1774 1166"><i>Appropriate objective is written to include prevention of spread of infection.</i></td> <td data-bbox="1774 1089 1887 1166">60%</td> </tr> <tr> <td data-bbox="991 1166 1066 1242">7.a</td> <td data-bbox="1066 1166 1774 1242"><i>All objectives for Focus 6 are written in measurable, observable and/or behavioral terms</i></td> <td data-bbox="1774 1166 1887 1242">66%</td> </tr> <tr> <td data-bbox="991 1242 1066 1318">7.b</td> <td data-bbox="1066 1242 1774 1318"><i>The objectives include prevention of the spread of infection</i></td> <td data-bbox="1774 1242 1887 1318">60%</td> </tr> <tr> <td data-bbox="991 1318 1066 1395">8.</td> <td data-bbox="1066 1318 1774 1395"><i>Appropriate interventions are written to include contact precautions.</i></td> <td data-bbox="1774 1318 1887 1395">36%</td> </tr> <tr> <td data-bbox="991 1395 1066 1424">8.b</td> <td data-bbox="1066 1395 1774 1424"><i>The interventions include contact precautions</i></td> <td data-bbox="1774 1395 1887 1424">82%</td> </tr> </table>	1.	<i>Notification by the lab was made to the infection control department when an individual has a positive culture for MRSA.</i>	100%	2.	<i>Notification by the lab was made to the unit housing the individual that a positive culture for MRSA was obtained.</i>	100%	3.	<i>The individual is placed on contact precautions per MRSA policy.</i>	92%	4.	<i>The appropriate antibiotic was ordered for treatment of the infection(s).</i>	96%	5.	<i>The public health office contacts the unit RN and provides MRSA protocol and guidance for the care of the individual</i>	77%	6.	<i>A focus 6 is opened for MRSA.</i>	85%	7.	<i>Appropriate objective is written to include prevention of spread of infection.</i>	60%	7.a	<i>All objectives for Focus 6 are written in measurable, observable and/or behavioral terms</i>	66%	7.b	<i>The objectives include prevention of the spread of infection</i>	60%	8.	<i>Appropriate interventions are written to include contact precautions.</i>	36%	8.b	<i>The interventions include contact precautions</i>	82%
1.	<i>Notification by the lab was made to the infection control department when an individual has a positive culture for MRSA.</i>	100%																																	
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		8.c	<i>The interventions include hand washing</i>	73%
		8.d	<i>The interventions include teaching the individual the importance of proper housekeeping in his or her bedroom environment</i>	45%
		<p>A review of the charts of 14 individuals with MRSA (AJM, AJW, DL, DLW, DV, KS, LAB, MG, MLB, MM, PS, RJC, TA and TN) found that all had lab work indicating the presence of MRSA and three did not have an order for Contact Precautions. All contained documentation that the appropriate antibiotic was ordered according to the sensitivity profiles and that the public health staff provided the MRSA protocol. All but one had a focus 6 opened (DLW). However, only three had appropriate objectives and one had appropriate interventions.</p> <p><u>Positive HIV</u></p> <p>PSH's data from the DMH IC HIV Positive audit for November 2007-April 2008, based on a 80% mean sample (n=4) of individuals diagnosed with HIV in the review months, indicated the following mean compliance rates for the items listed below:</p>		
		1.	<i>Notification by the lab was made to the infection control department identifying the individual with a positive HIV antibody.</i>	N/A
		2.	<i>Notification was made to the unit housing the individual that he/she has a positive HIV antibody test.</i>	N/A
		3.	<i>If the individual was admitted with a diagnosis of HIV positive, a referral was made to the appropriate clinic during the admission process.</i>	100%
		4.	<i>If the individual was diagnosed with HIV during hospitalization, a referral was made to the appropriate clinic.</i>	N/A
		5.	<i>The individual is seen by the appropriate clinic every</i>	75%

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		<table border="1"> <tr> <td></td> <td><i>three months for ongoing care and treatment, unless another timeframe is ordered by the physician.</i></td> <td></td> </tr> <tr> <td>6.</td> <td><i>A focus 6 is opened for HIV (unspecified viral illness).</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Appropriate objective(s) are written to address progression of the disease.</i></td> <td>0%</td> </tr> <tr> <td>8.</td> <td><i>Appropriate interventions are written.</i></td> <td>0%</td> </tr> </table> <p>A review of the charts of four individuals with HIV (ACM, EV, JSL, and RH) found that the appropriate lab work was in the medical records and that all were referred to the appropriate clinic. One individual was not seen as required in the clinic (ACM). All had an open focus 6; however, none had appropriate objectives or interventions.</p> <p>Other findings: Overall, these findings aligned with PSH findings in the above areas. The data continues to indicate that systems within Infection Control (IC) are consistent and reliable. However, compliance continues to be low when IC activities are dependent on implementation at the unit level.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>		<i>three months for ongoing care and treatment, unless another timeframe is ordered by the physician.</i>		6.	<i>A focus 6 is opened for HIV (unspecified viral illness).</i>	100%	7.	<i>Appropriate objective(s) are written to address progression of the disease.</i>	0%	8.	<i>Appropriate interventions are written.</i>	0%
	<i>three months for ongoing care and treatment, unless another timeframe is ordered by the physician.</i>													
6.	<i>A focus 6 is opened for HIV (unspecified viral illness).</i>	100%												
7.	<i>Appropriate objective(s) are written to address progression of the disease.</i>	0%												
8.	<i>Appropriate interventions are written.</i>	0%												
F.8.a.ii	assesses these data for trends;	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Continue to monitor this requirement.</p> <p>Findings: From PSH's progress report and minutes of the IC meetings, the</p>												

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		<p>following trends were adequately identified:</p> <p><u>DMH IC Admission PPD Auditing Trends</u></p> <ul style="list-style-type: none">• Orders for admission PPDs are at over 90% compliance.• First-step PPDs were read by the nurse within seven days of administration and the facility is close to substantial compliance. <p><u>DMH IC Annual PPD Auditing Trends</u></p> <ul style="list-style-type: none">• Orders for annual PPDs were over 90% compliance.• PPDs were read by the nurse within 48-72 hours of administration and the facility is close to substantial compliance.• There were no trends identified of individuals converting from negative to positive PPDs while in the hospital. <p><u>DMH IC Positive PPD Auditing Trends</u></p> <ul style="list-style-type: none">• Notification of the Infection Control Department has remained at substantial compliance throughout the review period.• There have been no cases of active TB disease during the review period. <p><u>DMH IC Refused Admitting or Annual Lab Work or Diagnostic Test Auditing Trends</u></p> <ul style="list-style-type: none">• There has been some progress made regarding notifying the Infection Control Department when an individual has refused lab work or diagnostic tests as compared to the last review, at which time compliance was 0%. <p><u>DMH IC Immunization Auditing Trends</u></p> <ul style="list-style-type: none">• Notification of need for immunizations to both the Infection Control Department and the unit has remained at nearly 100%. <p><u>DMH IC Sexually Transmitted Disease Auditing Trends</u></p> <ul style="list-style-type: none">• Notification of the Infection Control Department and the unit with
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		<p>the results of all STD testing and ordering STD testing during admissions has achieved substantial compliance.</p> <ul style="list-style-type: none"> • There have been no trends in sexually transmitted diseases over the reporting period. <p><u>DMH IC Hepatitis C Auditing Trends</u></p> <ul style="list-style-type: none"> • Notification of the Infection Control Department and the unit when an individual tests positive for Hepatitis B and opening a focus 6 problem for Hepatitis C has achieved substantial compliance. • There have been no trends identified of Hepatitis C conversion. <p><u>DMH IC MRSA Auditing Trends</u></p> <ul style="list-style-type: none"> • Notification of the Infection Control Department and the unit when an individual tests positive for MRSA has achieved substantial compliance. • There have been no trends identified in MRSA infections. <p><u>DMH IC HIV Positive Auditing Trends</u></p> <ul style="list-style-type: none"> • Notification of HIV disease to the Infection Control Department and the unit has achieved substantial compliance. • There have been no trends identified in HIV disease. <p>Other findings: Minutes of the Infection Control Committee Meeting validated that the trends listed above, as well as additional trends regarding nosocomial infection rates; infections; personnel infections, isolated organisms; Hepatitis B vaccine; HIV testing; antibiotic usage; influenza outbreak; and sharp objects injuries were assessed and discussed. In addition, the PSH Infection Control Report: Interpretation of January 2008 Data; PSH Infection Control Report: Interpretation of April 2008 Data; the Evaluation of the Effectiveness of the Patton State Hospital Infection Control Program, 2007; 2008 Risk Assessment for Infection Control at Patton State Hospital, and; the PSH Infection Control Plan,</p>
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		<p>June 2008-June 2009 provided impressive comprehensive assessments of trends at PSH regarding all surveillance data that the Infection Control Department collects.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
F.8.a.iii	initiates inquiries regarding problematic trends;	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Continue to monitor this requirement.</p> <p>Findings: The IC meeting minutes validated that the problematic trends found on the IC audits (see data in F.8.a.i) were addressed in the Standard Compliance and Performance/Quality Improvement sections of the minutes.</p> <p>Other findings: Minutes of the Infection Control Committee Meeting and other reports noted in F.8.a.ii validated that additional inquiries were made regarding problematic trends of poor compliance with units notifying IC about PPDs and Hepatitis C and immunization tracking forms; opening up focus problem for refusals; appropriate interventions for positive PPDs, lab refusals, immunization refusals, HIV, Hepatitis C, MRSA and STDs; a separate waste stream for pharmaceutical waste; housekeeping procedures; and employee PPDs.</p> <p>Compliance: Substantial.</p>

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		<p>Current recommendation: Continue to monitor this requirement.</p>
F.8.a.iv	identifies necessary corrective action;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Include information regarding plans of corrections/interventions regarding problematic compliance rates.</p> <p>Findings: PSH's progress report indicated corrective actions for each problematic area of the IC audit results:</p> <p><u>DMH IC Admission PPD Auditing Issues</u> In April 2008, the Public Health Office implemented the use of a liaison nurse to assist the unit staff regarding compliance with notification of the Infection Control department regarding PPD results. In addition, each month the Infection Control physician and the Quality Improvement Team discuss units that are not compliant regarding returning PPD tracking forms to the Infection Control Department. Also, each month the Infection Control Department notifies the unit supervisor of deficiencies within his/her unit. Finally, the Infection Control physician addresses areas of noncompliance with the physicians during the monthly Department of Medicine meeting.</p> <p><u>DMH IC Annual PPD Auditing Issues</u> Along with the actions above, the physicians are given via a memo the names of the individuals to be evaluated during the month.</p> <p><u>DMH IC Positive PPD Auditing Issues</u> No corrective action is necessary at this time.</p>

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		<p><u>DMH IC Refused Admitting or Annual Lab Work or Diagnostic Test Auditing Issues</u> Continued training will be conducted for nursing staff regarding notification of the IC Department when an individual refuses admitting or annual lab work and/or diagnostic tests. The liaison nurse will follow up after the training to assist nurses that are out of compliance.</p> <p><u>DMH IC Immunization Auditing Issues</u> Discussions with Nursing occurred in December 2007 and again in January 2008 regarding the use of the immunization tracking form. Also, the physicians were reminded at the Department of Medicine meeting to order immunizations within five days of receipt of the lab work.</p> <p><u>DMH IC Immunization Refusal Auditing Issues</u> PSH indicated that training has had a limited effect on compliance in this area. Thus, the IC liaison nurse will be working with the unit staff toward meeting the requirements of the EP. The department has implemented a procedure whereby when the Department receives notification from the unit that an individual has refused immunizations, examples of possible foci statements, objectives and interventions will be faxed to the unit. During an interview with the liaison nurse, it was discussed and agreed that the unit staff need to be responsible for individualizing these examples.</p> <p><u>DMH IC Sexually Transmitted Disease Auditing Issues</u> No corrective action required at this time.</p> <p><u>DMH IC Hepatitis C Auditing Issues</u> The physicians were reminded of the use of the Hepatitis C tracking sheet at the Department of Medicine meetings and Nursing was also trained.</p>
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		<p><u>DMH IC MRSA Auditing Issues</u> The physicians were reminded to write orders for contact precautions. In addition, the nurse liaison will be working directly with nursing staff when they have an individual with MRSA. This registered nurse role is to educate staff on the disease process and provide educational materials that include samples of appropriate objectives and interventions in the WRP. Also, a member of the Department brings the protocol to the unit staff and is available for questions and assistance.</p> <p><u>DMH IC HIV Positive Auditing Issues</u> The liaison nurse will be working with the unit staff to improve the WRPs for individuals with HIV disease.</p> <p>A review of the minutes of the IC committee meetings, the Department of Medicine and Medicine/Psychiatry Meeting minutes, and the PSH Quality Improvement Meeting minutes found that the Actions/Recommendations were documented and implemented regarding corrective actions for the issues noted above.</p> <p>Recommendation 2, November 2007: Continue to monitor this requirement.</p> <p>Findings: Same as above.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Continue current practices.2. Continue to monitor this requirement.
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<p>F.8.a.v</p>	<p>monitors to ensure that appropriate remedies are achieved; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Continue to monitor this requirement.</p> <p>Findings: PSH's progress indicated that the Public Health Staff review the Plato data to identify areas out of acceptable compliance range. Training rosters indicated that all Public Health Staff were trained on how to access the Infection Control data from Plato. The Public Health staff meets monthly (November 2007-January 2008) with the Standards Compliance Director and auditors to discuss the interpretation of the data. Since that time, the Public Health Staff review and interpret their data monthly.</p> <p>A review of the IC minutes and interviews with the IC staff found that they are implementing a number of interventions to increase areas of low compliance and are regularly monitoring the data regarding the effectiveness of their interventions. They have taken steps by adding a liaison nurse to work with directly with the unit staff on the areas in which the Department is not solely responsible for the deficits in compliance. This action should bring the Infection Control Department into substantial compliance in all areas within the next few reviews.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
<p>F.8.a.vi</p>	<p>integrates this information into each State hospital's quality assurance review.</p>	<p>Current findings on previous recommendations:</p>

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		<p>Recommendation 1, November 2007: Ensure that follow-up is documented regarding issues identified in the Quality Improvement meeting.</p> <p>Findings: See findings below.</p> <p>Recommendation 2, November 2007: Continue to monitor this requirement.</p> <p>Findings: According to the PSH Quality Improvement Meeting minutes, the Infection Control Physician provides a report regarding IC issues and EP compliance issues, verifying compliance with this requirement. PSH reported that although the corrective action is ongoing with some improvements noted from the last review, problematic issues continue in spite of training regarding the PPD tracking, refusals, appropriate objectives and interventions in WRPs regarding infectious diseases. PSH indicated that the Department will be requesting a formal workgroup to initiate a Performance Improvement Corrective Action Team to assist in gaining compliance in problematic areas.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
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9. Dental Services		
	<p>Each State hospital shall provide individuals with adequate, appropriate and timely routine and emergency dental care and treatment, consistent with generally accepted professional standards of care.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Amy Santimalapong, DDS, Chief Dentist 2. Kathryn Smith, Nurse Auditor <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. DMH Dental Services Audit form and instructions 2. PSH Dental Services Policy and Procedure Manual 3. Charts of the following 65 individuals: AC, ADT, AG, AR, AS, BJB, BR, CDH, CH, CT, DB, DET, DW, FP, FS, GG, HDM, HL, JA, JAB, JAC, JBP, JC, JD, JEA, JH, JP, JS, KCS, KF, KPS, KT, LBP, LM, MC, MDC, MP, MT, NG, PB, PJK, RBC, RF, RH, RHB, RN, RS, RT, SD, SH, SK, SM, SML, SRV, TA, TL, TLA, TO, TT, VB, VEB, VGC, VGR, VJW and WK 4. Memo dated 11/16/07 regarding Transitional Administrative Directive #10.14 (Dental Services), outlining exceptions to implementation of AD #10.14 until further resources acquired 5. Dental Assistant Meeting Minutes dated 5/28/08 6. Dental Staff Meeting Minutes dated 10/31/07, 1/23/08, 3/23/08, 5/21/08 7. PSH's progress report and data
F.9.a	<p>Each State hospital shall retain or contract with an adequate number of qualified dentists to provide timely and appropriate dental care and treatment to all individuals it serves;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Continue to evaluate the need for additional dentists, dental auxiliary staff, and clerical staff for the dental department.</p> <p>Findings: PSH's progress report indicated that the Budget Change Proposal of 2007/2008 to add more dental staff was not approved. However, the</p>

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		<p>Chief Dentist indicated that the 2008/2009 Budget Change Proposal for additional staff was submitted to PSH Administration in May 2008. PSH's current dental staffing includes one Chief Dentist, two Staff Dentists, two Registered Dental Assistants and two Dental Assistants for nearly 1,500 individuals.</p> <p>Recommendation 2, November 2007: Continue efforts to obtain a dental management software package to reduce time spent on recordkeeping and to ensure accurate data.</p> <p>Findings: PSH's progress report indicated that the State is in the final process of obtaining the dental management software and necessary hardware for all state facilities.</p> <p>Recommendation 3, November 2007: Continue to monitor this requirement.</p> <p>Findings: Same as above.</p> <p>Other findings: PSH's data is now more reflective of actual dental practices. Aside from emergency appointments and extractions, the data indicates that routine preventative and restorative care is not being provided. Dr. Amy Santimalapong, Chief Dentist, reported that staffing issues and refusals are major barriers to increasing compliance with many of the EP requirements.</p> <p>Compliance: Partial.</p>
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		<p>Current recommendation: Continue to monitor this requirement.</p>
F.9.b	Each State hospital shall develop and implement policies and procedures that require:	<p>Compliance: Partial.</p>
F.9.b.i	comprehensive and timely provision of dental services;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Implement system to monitor and track comprehensive dental services.</p> <p>Findings: PSH's progress report indicated that in February 2008, the Standards Compliance Directors from each hospital developed standardized Plato dental tools and standardized the monitoring processes using an auditor from Standards Compliance. In addition, the dental access database was revised to facilitate data collection. In an interview with this monitor, the dental auditor, she verified that she audits all of the dental requirements with the exception of extractions, which are still audited by the Chief Dentist.</p> <p>Recommendation 2, November 2007: Continue to revise dental policies and procedures, including requirements for dental documentation.</p> <p>Findings: This monitor's review of PSH's Dental Services Policy and Procedure Manual found that revisions included the Comprehensive Admission Examination and the documentation of the dental plan of care. However, a memo dated 11/16/07 indicated that AD # 10.14 Dental Services would not be fully implemented until required resources were available.</p>

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		<p>Recommendation 3, November 2007: Continue to monitor this requirement.</p> <p>Findings: At the time of this review, PSH had only one auditor for dental. Consequently, there is no inter-rater reliability. In addition, since the standardized tool and monitoring was implemented in February, PSH data is representative of the February-April 2008 period.</p> <p>PSH's data from the DMH Dental Services audit, based on a 19% mean sample of admissions (90 days), indicated that 88% were timely seen for an admission dental examination. Data from the same audit, based on a 67% mean sample of individuals due for an annual dental exam, indicated that 54% were seen timely.</p> <p>PSH's data from the DMH Dental Services audit, based on a 17% mean sample of individuals scheduled for comprehensive exam during each month (N), indicated the following mean compliance rate for each item listed below:</p> <table border="1" data-bbox="989 927 1881 1268"> <tr> <td>Comprehensive and timely provision of dental services</td> <td>39%</td> </tr> <tr> <td><i>A comprehensive dental exam was completed and included oral hard and soft tissue exam.</i></td> <td>52%</td> </tr> <tr> <td><i>A comprehensive dental exam was completed and included review of x-rays.</i></td> <td>40%</td> </tr> <tr> <td><i>A comprehensive dental exam was completed and included periodontal exam.</i></td> <td>50%</td> </tr> <tr> <td><i>A comprehensive dental exam was completed and included review of prosthetics, if present.</i></td> <td>7%</td> </tr> </table> <p>PSH indicated that the timeliness of follow-up care for individuals with problems identified in admission or annual exams could not be determined due to the lack of a system to track this issue. PSH's</p>	Comprehensive and timely provision of dental services	39%	<i>A comprehensive dental exam was completed and included oral hard and soft tissue exam.</i>	52%	<i>A comprehensive dental exam was completed and included review of x-rays.</i>	40%	<i>A comprehensive dental exam was completed and included periodontal exam.</i>	50%	<i>A comprehensive dental exam was completed and included review of prosthetics, if present.</i>	7%
Comprehensive and timely provision of dental services	39%											
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<i>A comprehensive dental exam was completed and included review of prosthetics, if present.</i>	7%											

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		<p>progress report indicated that efforts are being made to resolve this issue.</p> <p>This monitor's review of 20 individuals' admission dental evaluations (ADT, AR, AS, BJB, BR, DET, FS, JAB, JBP, KCS, KF, LBP, RBC, RF, RHB, SML, TLA, TT, VGR and VJW) found that all were completed in a timely manner.</p> <p>This monitor's review of 20 annual dental assessments found that eight were completed timely (GG, JC, JD, MP, RT, SD, SK and TL) and 12 were not completed due to refusals (AG, CH, DB, HL, JA, LM, MC, MT, RH, RN, VB and WK).</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop a system to track timely follow-up care for individuals with problems identified in admission and annual exams. 2. Continue to monitor this requirement.
F.9.b.ii	documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care:	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Revise monitoring instrument to include all elements of this requirement.</p> <p>Findings: PSH implemented the DMH Dental Services Audit Form in February 2008.</p> <p>Recommendation 2, November 2007: Implement data collection.</p> <p>Findings: PSH's data from the DMH Dental Services Audit, based on a 27% mean</p>

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		<p>sample of individuals seen for follow-up dental care excluding annual and admission exams and emergencies (N), indicated the following compliance rates for the items listed below:</p> <table border="1" data-bbox="991 337 1885 753"> <tr> <td data-bbox="991 337 1774 451"><i>Documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care.</i></td> <td data-bbox="1774 337 1885 451">75%</td> </tr> <tr> <td data-bbox="991 451 1774 526"><i>There is documentation in the individual's record of the current status.</i></td> <td data-bbox="1774 451 1885 526">80%</td> </tr> <tr> <td data-bbox="991 526 1774 600"><i>There is documentation in the individual's record of findings of the examination.</i></td> <td data-bbox="1774 526 1885 600">80%</td> </tr> <tr> <td data-bbox="991 600 1774 675"><i>There is documentation in the individual's record of plan of care.</i></td> <td data-bbox="1774 600 1885 675">78%</td> </tr> <tr> <td data-bbox="991 675 1774 753"><i>There is documentation in the individual's record of the plans of care are consistent with examination findings.</i></td> <td data-bbox="1774 675 1885 753">75%</td> </tr> </table> <p>This monitor's review of the charts of 11 individuals (AC, CT, DW, FP, JH, JP, KT, PB, RS, SH and TA) found that four did not have documentation in the chart of their current status or findings of the examination. In addition, there was no plan of care in any of the 11 charts reviewed. This issue may be due to the documentation of plans of care being implemented after these individuals were seen by Dental.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	<i>Documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care.</i>	75%	<i>There is documentation in the individual's record of the current status.</i>	80%	<i>There is documentation in the individual's record of findings of the examination.</i>	80%	<i>There is documentation in the individual's record of plan of care.</i>	78%	<i>There is documentation in the individual's record of the plans of care are consistent with examination findings.</i>	75%
<i>Documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care.</i>	75%											
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<i>There is documentation in the individual's record of the plans of care are consistent with examination findings.</i>	75%											
F.9.b.iii	use of preventive and restorative care whenever possible; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Implement data collection for this requirement.</p> <p>Findings: Data collection and findings presented below.</p>										

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		<p>PSH's data from the DMH Dental Services Audit, based on a 67% mean sample of individuals seen for annual routine dental examinations for each of the review months (N), indicated the following compliance rates for the items listed below:</p> <table border="1" data-bbox="991 414 1890 641"> <tr> <td></td> <td>Use of preventive care whenever possible.</td> <td>18%</td> </tr> <tr> <td>3.a</td> <td><i>There is documentation of one of the following: Preventative care was provided, including but not limited to cleaning, root planning, sealant, fluoride application</i></td> <td>17%</td> </tr> <tr> <td>3.b</td> <td><i>Oral hygiene instruction</i></td> <td>51%</td> </tr> </table> <p>PSH reported that in February 2008, the Dental Clinic was short-staffed on 13 out of 20 working days, which contributed to the low compliance rates.</p> <p>PSH's data from the DMH Dental Services Audit, based on a 42% mean sample of individuals seen for routine annual dental examinations for each of the review months (N), indicated the following compliance rates for the items listed below:</p> <table border="1" data-bbox="991 1010 1890 1161"> <tr> <td></td> <td>Use of restorative care whenever possible.</td> <td>80%</td> </tr> <tr> <td>3.c</td> <td><i>There is documentation of one of the following: Restorative care was provided including permanent or temporary restorations (fillings)</i></td> <td>80%</td> </tr> </table> <p>This monitor's review of the charts of 20 individuals scheduled for annual dental assessments (AG, CH, DB, GG, HL, JA, JC, JD, LM, MC, MP, MT, RH, RN, RT, SD, SK, TL, VB and WK) found that of the eight that were actually seen, two had preventative care documented and six were provided and/or scheduled for restorative care. Twelve annual assessments were not completed due to refusals.</p>		Use of preventive care whenever possible.	18%	3.a	<i>There is documentation of one of the following: Preventative care was provided, including but not limited to cleaning, root planning, sealant, fluoride application</i>	17%	3.b	<i>Oral hygiene instruction</i>	51%		Use of restorative care whenever possible.	80%	3.c	<i>There is documentation of one of the following: Restorative care was provided including permanent or temporary restorations (fillings)</i>	80%
	Use of preventive care whenever possible.	18%															
3.a	<i>There is documentation of one of the following: Preventative care was provided, including but not limited to cleaning, root planning, sealant, fluoride application</i>	17%															
3.b	<i>Oral hygiene instruction</i>	51%															
	Use of restorative care whenever possible.	80%															
3.c	<i>There is documentation of one of the following: Restorative care was provided including permanent or temporary restorations (fillings)</i>	80%															

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		<p>Current recommendation: Continue to monitor this requirement.</p>
<p>F.9.b.iv</p>	<p>tooth extractions be used as a treatment of last resort, which, when performed, shall be justified in a manner subject to clinical review.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Revise the monitoring tool for this requirement to include consistent and specific criteria.</p> <p>Findings: The DMH Dental Services monitoring form adequately addressed this recommendation.</p> <p>Recommendation 2, November 2007: Provide training to the dentists once requirements for dental documentation is determined.</p> <p>Findings: Minutes of the Dental Assistant Meetings and Dental Staff Meetings confirm that the recommended training has been conducted.</p> <p>Recommendation 3, November 2007: Implement data collection for this requirement.</p> <p>Findings: Since PSH implemented the auditing tool for this requirement in April 2008, the data presented represents only April 2008.</p> <p>PSH's data for April 2008 from the DMH Dental Services Audit, based on a 22% sample of individuals who had tooth extraction during April 2008, indicated 100% compliance with the requirement that justification for extraction includes documentation of one or more of the following: periodontal conditions, requirements for dentures</p>

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		<p>construction, non-restorable tooth or severe decay; and 100% compliance with the requirement that if none of the above reasons is included, any other reason stated is clinically appropriate.</p> <p>This monitor's review of the charts of 19 individuals who had a tooth extraction (AC, AG, CDH, FP, HDM, JAC, JC, JEA, JS, KPS, MDC, MP, NG, PJK, SM, SRV, TO, VEB and VGC) found that all 19 included documentation justifying the extraction(s).</p> <p>Other findings: PSH needs to increase the sample size for this requirement to achieve substantial or full compliance.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Increase audited sample size. 2. Continue to monitor this requirement.
F.9.c	<p>Each State hospital shall ensure that dentists demonstrate, in a documented fashion, an accurate understanding of individuals' physical health, medications, allergies, and current dental status and complaints.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Revise monitoring tool to include each of the elements of this requirement as a separate item.</p> <p>Findings: See F.9.b.iv.</p> <p>Recommendation 2, November 2007: Implement data collection.</p> <p>Findings: PSH's data from the DMH Dental Services audit, based on a 20% mean sample of individuals who received comprehensive dental exam and/or follow-up dental care during the February-April 2008 period (N),</p>

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		<p>indicated the following men compliance for each item listed below:</p> <table border="1" data-bbox="991 264 1890 865"> <tr> <td data-bbox="991 264 1066 451">5.</td> <td data-bbox="1066 264 1774 451"><i>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.</i></td> <td data-bbox="1774 264 1890 451">48%</td> </tr> <tr> <td data-bbox="991 451 1066 527">5.a</td> <td data-bbox="1066 451 1774 527"><i>There is documentation of the individual's physical health that impact on dental services.</i></td> <td data-bbox="1774 451 1890 527">48%</td> </tr> <tr> <td data-bbox="991 527 1066 604">5.b</td> <td data-bbox="1066 527 1774 604"><i>There is documentation of the individual's medications.</i></td> <td data-bbox="1774 527 1890 604">48%</td> </tr> <tr> <td data-bbox="991 604 1066 680">5.c</td> <td data-bbox="1066 604 1774 680"><i>There is documentation of the individual's allergies that impact on dental services.</i></td> <td data-bbox="1774 604 1890 680">48%</td> </tr> <tr> <td data-bbox="991 680 1066 756">5.d</td> <td data-bbox="1066 680 1774 756"><i>There is documentation of the individual's general condition of oral environment.</i></td> <td data-bbox="1774 680 1890 756">54%</td> </tr> <tr> <td data-bbox="991 756 1066 865">5.e</td> <td data-bbox="1066 756 1774 865"><i>When the individual complaint is noted within the findings, there is documentation related to exam results.</i></td> <td data-bbox="1774 756 1890 865">76%</td> </tr> </table> <p>This monitor's review of the charts of 11 individuals (AC, CT, DW, FP, JH, JP, KT, PB, RS, SH and TA) found that five contained documentation of the individuals' physical health, allergies, and medications, while nine contained documentation of oral condition and complaint(s) related to the exam results.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	5.	<i>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.</i>	48%	5.a	<i>There is documentation of the individual's physical health that impact on dental services.</i>	48%	5.b	<i>There is documentation of the individual's medications.</i>	48%	5.c	<i>There is documentation of the individual's allergies that impact on dental services.</i>	48%	5.d	<i>There is documentation of the individual's general condition of oral environment.</i>	54%	5.e	<i>When the individual complaint is noted within the findings, there is documentation related to exam results.</i>	76%
5.	<i>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.</i>	48%																		
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5.c	<i>There is documentation of the individual's allergies that impact on dental services.</i>	48%																		
5.d	<i>There is documentation of the individual's general condition of oral environment.</i>	54%																		
5.e	<i>When the individual complaint is noted within the findings, there is documentation related to exam results.</i>	76%																		
F.9.d	Each State hospital shall ensure that transportation and staffing issues do not preclude	Current findings on previous recommendations:																		

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	<p>individuals from attending dental appointments, and individuals' refusals are addressed to facilitate compliance.</p>	<p>Recommendation 1, November 2007: Provide data regarding all elements of this requirement.</p> <p>Findings: PSH's data, based on a 97% mean sample of scheduled appointments during the February-April 2008 period (N), indicated that 1% of missed appointments were due to transportation issues; 23% were due to staff-related reasons (illness, vacation, etc); 7% were due to individuals returning to court prior to their appointments; and 69% were due to individuals refusing appointments.</p> <p>Recommendation 2, November 2007: Continue implementation and training regarding the refusal process for dental appointments.</p> <p>Findings: Since the last review, PSH has hired "Seniors" for a number of disciplines (excluding nursing) that are assigned to the Programs to provide WRP training and mentoring. The Seniors attend two conferences per week and in addition to providing feedback, are expected to assist the WRPTs in incorporating refusals (psychiatric or medical) into the Case Formulation, Foci, Objectives and Interventions of the WRP.</p> <p>A report is generated from the Seniors and provided to Dr. Christison, the Psychiatrist who is overseeing the WRP mentoring process.</p> <p>Recommendation 3, November 2007: Continue to monitor this requirement.</p> <p>Findings: No data was provided regarding individuals' refusals.</p>
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		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement collection of data regarding dental refusals, addressing this requirement. 2. Continue to monitor this requirement.
F.9.e	<p>Each State hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals to participate in dental appointments.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Revise current monitoring tool to reflect each element being monitored and tracked.</p> <p>Findings: See F.9.b.iv.</p> <p>Recommendation 2, November 2007: Implement and train staff regarding the Clinic Appointment Refusal Process.</p> <p>Findings: See F.9.d.</p> <p>Recommendation 3, November 2007: Implement collection of data regarding this requirement.</p> <p>Findings: PSH's progress report indicated that data collection regarding this requirement will begin when the revised DMH Integration of Medical Conditions into WRP Audit Form is available.</p>

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		<p>Other findings: This monitor's review of the charts of 12 individuals whose annual examinations were not completed due to refusals (AG, CH, DB, HL, JA, LM, MC, MT, RH, RN, VB and WK) found no mention of this issue in the WRPs.</p> <p>Compliance: Partial.</p> <p>Current recommendations: See F.9.d.</p>
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Section G: Documentation

G. Documentation		
G	<p>Each State hospital shall ensure that an individual's records accurately reflect the individual's response to all treatment, rehabilitation and enrichment activities identified in the individual's therapeutic and rehabilitation service plan, including for children and adolescents, their education plan, consistent with generally accepted professional standards of care. Each State hospital shall develop and implement policies and procedures setting forth clear standards regarding the content and timeliness of progress notes, transfer notes, school progress notes, and discharge notes, including, but not limited to, an expectation that such records include meaningful, accurate, and coherent assessments of the individual's progress relating to treatment plans and treatment goals, and that clinically relevant information remains readily accessible.</p>	<p>Summary of Progress: Please refer to Sections D, E, F and H for judgments on the progress PSH has made towards aligning documentation practices with the requirements of the EP.</p> <p>Specific judgments regarding the quality of documentation, as well as progress towards substantial EP compliance and remaining deficiencies, are contained in the discipline-specific subsections of Sections D and F, as well as in Sections E and H. Please refer to these sections for findings (including compliance) and recommendations pertaining to documentation.</p>

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

H. Restraints, Seclusion, and PRN and Stat Medication		
H		<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. PSH has eliminated the use of restraints or seclusion as part of behavior interventions. 2. PSH has eliminated the use of side rails as restraints.
H	Each State hospital shall ensure that restraints, seclusion, psychiatric PRN medications, and Stat medications are used consistent with generally accepted professional standards of care.	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Anthony Coley, Senior PT 2. Armond Vizcarra, Senior PT 3. Benita Burwell, RN 4. Beverlee Davis, Unit Supervisor 5. Charles Allen, RN, Nursing Coordinator 6. Christi Smith, Senior PT 7. Daria Bigelow, PT 8. Diane Farelas, RN, Assistant Coordinator of Nursing Services 9. Gabriel Hernandez, Unit Supervisor 10. Gari-Lyn Richardson, Standards Compliance Director 11. George Christison, MD, Acting Chief of Psychiatry 12. Harry Oreol, Program Director 13. Kathy Wood, Nursing Coordinator 14. Kim Stokes, Senior PT 15. Laura Glenn, Training Officer Staff Development Center 16. Lidia Lau, RN, Assistant Coordinator of Nursing Services 17. Lisa Pajak, PT EB12 18. Marzina Scott, Auditor 19. Merrie Gail Lemond, Senior PT 20. Regina Olender, Nurse Administrator 21. Richard Rose, Unit Supervisor 22. Ruth Lang, Unit Supervisor

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

		<p>Reviewed:</p> <ol style="list-style-type: none"> 1. PSH's progress report and data 2. Training rosters for AD #15.14 Seclusion or Restraint 3. AD #15.14, Seclusion or Restraint 4. DMH Restraint, Seclusion and PRN and Stat Medication Monitoring Form and instructions 5. Training rosters for PMAB 6. PSH Trigger Action Sheet for PRN and Stat Medications 7. Training rosters for Principles of Medications 8. Medical records for the following 49 individuals: AC, AJV, AP, AV, BA, BGW, CC, CES, CLC, CW, DAR, DIR, DJ, DL, DS, FS, GB, HR, JB, JCB, JDG, JP, JR, JS, JVH, KD, KLK, LC, LUR, MB, ME, ML, MLB, MS, NMK, RDT, RJ, RS, RTH, RZ, SB, SC, SEJ, SLK, SLW, SR, TA, VMC and YB
<p>H.1</p>	<p>Each State hospital shall revise, as appropriate, and implement policies and procedures regarding the use of seclusion, restraints, psychiatric PRN medications, and Stat Medications consistent with generally accepted professional standards of care. In particular, the policies and procedures shall expressly prohibit the use of prone restraints, prone containment and prone transportation and shall list the types of restraints that are acceptable for use.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, November 2007:</p> <ul style="list-style-type: none"> • Continue to provide training regarding this requirement. • Continue to monitor this requirement. <p>Findings:</p> <p>PSH's training data verified that as of April 2008, 95% of staff have been trained regarding AD #15.14, Seclusion or Restraint. This is a significant increase from 12% compliance noted in November 2007. In addition, a review of medical charts, Behavior Guidelines and Positive Behavior Support plans found no indication of the use of prone restraint, containment or transportation.</p> <p>Compliance:</p> <p>Substantial.</p>

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		<p>Current recommendations: Continue current practice.</p>
H.2	Each State hospital shall ensure that restraints and seclusion:	<p>Compliance: Partial.</p>
H.2.a	are used in a documented manner and only when individuals pose an imminent danger to self or others and after a hierarchy of less restrictive measures has been considered in a clinically justifiable manner or exhausted;	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Continue to monitor this requirement.</p> <p>Findings: PSH initiated use of the draft DMH Restraints, Seclusion, and PRN and Stat Medication Monitoring form in April 2008. Thus, only data for April 2008 was presented.</p> <p>PSH's data from the draft DMH Restraints, Seclusion, and PRN and Stat Medication Monitoring audit for one incident of seclusion indicated 0% compliance with the requirements that: each State hospital shall ensure that seclusion is used in a documented manner; the IDN described specific behavior that was imminently dangerous to self or others; the Physician's Order described specific behavior that was imminently dangerous to self or others; each State hospital shall ensure that seclusion is only used when individuals pose an imminent danger to self or others (did not include harm from others); each State hospital shall ensure that seclusion is only used after a hierarchy of less restrictive measures has been considered in a clinically justifiable manner or exhausted; specific, less-restrictive interventions that were tried prior to the use of seclusion are documented or there is clinical justification when less restrictive interventions were not used, and; the individual's specific response to each intervention used is documented in the IDN or there is clinical justification when less-restrictive interventions were not used.</p>

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		<p>PSH's data the draft DMH Restraints, Seclusion, and PRN and Stat Medication Monitoring audit for an 89% sample of restraint episodes for April 2008 indicated the following compliance rates for each item listed below:</p> <table border="1" data-bbox="991 414 1894 1198"> <tr> <td data-bbox="991 414 1066 488">2.</td> <td data-bbox="1066 414 1774 488"><i>Each State hospital shall ensure that restraint is used in a documented manner.</i></td> <td data-bbox="1774 414 1894 488">92%</td> </tr> <tr> <td data-bbox="991 488 1066 563">2.a</td> <td data-bbox="1066 488 1774 563"><i>The IDN described specific behavior that was imminently dangerous to self or others.</i></td> <td data-bbox="1774 488 1894 563">97%</td> </tr> <tr> <td data-bbox="991 563 1066 638">2.b</td> <td data-bbox="1066 563 1774 638"><i>The Physician's Order described specific behavior that was imminently dangerous to self or others.</i></td> <td data-bbox="1774 563 1894 638">93%</td> </tr> <tr> <td data-bbox="991 638 1066 745">3.</td> <td data-bbox="1066 638 1774 745"><i>Each State hospital shall ensure that restraint is only used when individuals pose an imminent danger to self or others (did not include harm from others).</i></td> <td data-bbox="1774 638 1894 745">96%</td> </tr> <tr> <td data-bbox="991 745 1066 898">4.</td> <td data-bbox="1066 745 1774 898"><i>Each State hospital shall ensure that restraint is only used after a hierarchy of less restrictive measures has been considered in a clinically justifiable manner or exhausted;</i></td> <td data-bbox="1774 745 1894 898">78%</td> </tr> <tr> <td data-bbox="991 898 1066 1050">4.a</td> <td data-bbox="1066 898 1774 1050"><i>Specific, less-restrictive interventions that were tried prior to the use of restraint are documented or there is clinical justification when less restrictive interventions were not used.</i></td> <td data-bbox="1774 898 1894 1050">90%</td> </tr> <tr> <td data-bbox="991 1050 1066 1198">4.b</td> <td data-bbox="1066 1050 1774 1198"><i>The individual's specific response to each intervention used is documented in the IDN or there is clinical justification when less-restrictive interventions were not used.</i></td> <td data-bbox="1774 1050 1894 1198">79%</td> </tr> </table> <p data-bbox="991 1242 1894 1421">A review of 15 episodes of seclusion for eight individuals (AP, AV, BGW, GB, HR, ML, SEJ and SLK) found that three had adequate documentation indicating the specific reason for the placement and that alternative measures were adequately documented in two of the episodes.</p>	2.	<i>Each State hospital shall ensure that restraint is used in a documented manner.</i>	92%	2.a	<i>The IDN described specific behavior that was imminently dangerous to self or others.</i>	97%	2.b	<i>The Physician's Order described specific behavior that was imminently dangerous to self or others.</i>	93%	3.	<i>Each State hospital shall ensure that restraint is only used when individuals pose an imminent danger to self or others (did not include harm from others).</i>	96%	4.	<i>Each State hospital shall ensure that restraint is only used after a hierarchy of less restrictive measures has been considered in a clinically justifiable manner or exhausted;</i>	78%	4.a	<i>Specific, less-restrictive interventions that were tried prior to the use of restraint are documented or there is clinical justification when less restrictive interventions were not used.</i>	90%	4.b	<i>The individual's specific response to each intervention used is documented in the IDN or there is clinical justification when less-restrictive interventions were not used.</i>	79%
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		<p>A review of 50 episodes of restraint for 17 individuals (AJV, CLC, CW, DJ, GB, JDG, JR, JS, JVH, KLK, LUR, MLB, NMK, RDT, RZ, SLW and VMC) found that the documentation for 20 episodes supported the decision to place the individual in restraints. There was some improvement in the documentation of least restrictive alternatives tried in 15 of the episodes reviewed. In addition, the review found that much of the documentation contained inconsistencies regarding the time an individual was placed in restraints and several records lacked documentation as to when the individual actually was released. Many of the Use of Seclusion and Restraint forms were not adequately completed. It was very difficult at times to determine from the IDNs when the individual was actually released from restraints. In addition, the Post-Incident Debriefing forms were not consistently found in the records and when they were present, they were usually incomplete.</p> <p>Other findings: The number of forms that are required for seclusion and restraint episodes as well as the lack of order to the IDNs makes it difficult, if not impossible at times, to chronologically follow the sequences of events surrounding incidents of seclusion and restraints. PSH needs to streamline its documentation system regarding seclusion and restraint so that clinical information is easily accessible and accurately represents the event.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Streamline documentation system for seclusion and restraints. 2. Continue to monitor this requirement.
H.2.b	are not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Clarify data regarding active treatment.</p>

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		<p>Findings: Use of the DMH Restraints, Seclusion, and PRN and Stat Medication Monitoring form will adequately address this recommendation.</p> <p>Recommendation 2, November 2007: Monitor this requirement.</p> <p>Findings: PSH's data from the draft DMH Restraints, Seclusion, and PRN and Stat Medication Monitoring audit, based on one incident of seclusion, indicated the following compliance rate with each item listed below:</p> <table border="1" data-bbox="991 636 1890 1421"> <tr> <td data-bbox="991 636 1066 748">5.</td> <td data-bbox="1066 636 1774 748"><i>Each State hospital shall ensure that seclusion is not used in the absence of, or as an alternative to, active treatment.</i></td> <td data-bbox="1774 636 1890 748">0%</td> </tr> <tr> <td data-bbox="991 748 1066 860">5.a</td> <td data-bbox="1066 748 1774 860"><i>There is a Focus of Hospitalization that targets the behavior that required the individuals to be placed in Seclusion.</i></td> <td data-bbox="1774 748 1890 860">0%</td> </tr> <tr> <td data-bbox="991 860 1066 899">5.b</td> <td data-bbox="1066 860 1774 899"><i>There is a linked objective.</i></td> <td data-bbox="1774 860 1890 899">0%</td> </tr> <tr> <td data-bbox="991 899 1066 1049">5.c</td> <td data-bbox="1066 899 1774 1049"><i>There is linked intervention (any formal group, individual therapy, or behavioral intervention) for the target behavior that required the individual to be placed in seclusion.</i></td> <td data-bbox="1774 899 1890 1049">0%</td> </tr> <tr> <td data-bbox="991 1049 1066 1125">6.</td> <td data-bbox="1066 1049 1774 1125"><i>Each state hospital shall ensure that seclusion is not used as punishment.</i></td> <td data-bbox="1774 1049 1890 1125">0%</td> </tr> <tr> <td data-bbox="991 1125 1066 1237">6.a</td> <td data-bbox="1066 1125 1774 1237"><i>The staff did not use seclusion in a abusive manner (i.e., threaten the individual - if you don't do this I will put you in seclusion.)</i></td> <td data-bbox="1774 1125 1890 1237">100%</td> </tr> <tr> <td data-bbox="991 1237 1066 1313">6.b</td> <td data-bbox="1066 1237 1774 1313"><i>The staff did not keep the individual in seclusion even when the individual was calm</i></td> <td data-bbox="1774 1237 1890 1313">0%</td> </tr> <tr> <td data-bbox="991 1313 1066 1421">6.c</td> <td data-bbox="1066 1313 1774 1421"><i>The staff did not use seclusion in a manner to show power differential that exists between staff and the individual, as evidenced in the documentation.</i></td> <td data-bbox="1774 1313 1890 1421">100%</td> </tr> </table>	5.	<i>Each State hospital shall ensure that seclusion is not used in the absence of, or as an alternative to, active treatment.</i>	0%	5.a	<i>There is a Focus of Hospitalization that targets the behavior that required the individuals to be placed in Seclusion.</i>	0%	5.b	<i>There is a linked objective.</i>	0%	5.c	<i>There is linked intervention (any formal group, individual therapy, or behavioral intervention) for the target behavior that required the individual to be placed in seclusion.</i>	0%	6.	<i>Each state hospital shall ensure that seclusion is not used as punishment.</i>	0%	6.a	<i>The staff did not use seclusion in a abusive manner (i.e., threaten the individual - if you don't do this I will put you in seclusion.)</i>	100%	6.b	<i>The staff did not keep the individual in seclusion even when the individual was calm</i>	0%	6.c	<i>The staff did not use seclusion in a manner to show power differential that exists between staff and the individual, as evidenced in the documentation.</i>	100%
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6.c	<i>The staff did not use seclusion in a manner to show power differential that exists between staff and the individual, as evidenced in the documentation.</i>	100%																								

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		6.d	<i>The staff did not use seclusion as coercion, as evidenced in the documentation.</i>	100%	
		7.	<i>Each state hospital shall ensure that seclusion is not used for the convenience of staff.</i>	0%	
		7.a	<i>Staff used and documented the use of information in the Seclusion or Restraint Preference and Family Notification form regarding helpful measures in gaining control of behavior as provided by the individual or there is documentation as to why they were not used.</i>	0%	
		<p>PSH's data from the draft DMH Restraints, Seclusion, and PRN and Stat Medication Monitoring audit, based on an 89% sample of restraint episodes for April 2008, indicated the following compliance rate for each item listed below:</p>			
		5.	<i>Each State hospital shall ensure that restraint is not used in the absence of, or as an alternative to, active treatment.</i>	85%	
		5.a	<i>There is a Focus of Hospitalization that targets the behavior that required the individuals to be placed in Restraint.</i>	85%	
		5.b	<i>There is a linked objective</i>	89%	
		5.c	<i>There is linked intervention (any formal group, individual therapy, or behavioral intervention) for the target behavior that required the individual to be placed in restraint.</i>	91%	
		6.	<i>Each state hospital shall ensure that restraint is not used as punishment.</i>	42%	
		6.a	<i>The staff did not use restraint in a abusive manner (i.e., threaten the individual - if you don't do this I will put you in seclusion.)</i>	95%	
		6.b	<i>The staff did not keep the individual in restraint</i>	48%	

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			<i>even when the individual was calm</i>	
		6.c	<i>The staff did not use restraint in a manner to show power differential that exists between staff and the individual, as evidenced in the documentation.</i>	90%
		6.d	<i>The staff did not use restraint as coercion, as evidenced in the documentation</i>	95%
		7.	<i>Each state hospital shall ensure that restraint is not used for the convenience of staff</i>	0%
		7.a	<i>Staff used and documented the use of information in the Seclusion or Restraint Preference and Family Notification form regarding helpful measures in gaining control of behavior as provided by the individual or there is documentation as to why they were not used.</i>	0%
		<p>Review of seclusion and restraints episodes (see H.2.b) found that the documentation overall did not support the decision to place the individual in seclusion or restraints. In addition, there were several episodes that indicated that the individual was calm but was maintained in restraints. In the case of RDT, he was released for a fresh-air break, ambulated for 10 minutes and was then placed back in restraints for no apparent reason. The review also found two incidents of fading in which the individuals (AJV and SEJ) were calm, released from restraints but then placed in seclusion.</p> <p>Current recommendations: Continue to monitor this requirement.</p>		
H.2.c	are not used as part of a behavioral intervention; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Continue to monitor this requirement.</p>		

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		<p>Findings: PSH's data from the DMH Psychology Services Monitor audit for November 2007-April 2008, based on a 100% sample of Behavior Guidelines and PBS plans, indicated that none included restraint or seclusion as part of a behavioral intervention.</p> <p>A review of 19 individuals' Behavior Guidelines (AC, AV, BA, DS, JB, JCB, JP, JS, KD, KK, LC, MB, ME, MS, NK, RZ, SC, SR and YB) and six individuals' Positive Behavior Support Plans (KK, LL, ME, RJ, SB and TA) found that none contained seclusion or restrain as a behavioral intervention.</p> <p>Current recommendations: Continue current practice.</p>			
H.2.d	are terminated as soon as the individual is no longer an imminent danger to self or others.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Continue to provide training regarding appropriate release criteria for restraint/seclusion.</p> <p>Findings: See H.1.</p> <p>Recommendation 2, November 2007: Continue to monitor this requirement.</p> <p>Findings: PSH's data from the draft DMH Restraints, Seclusion, and PRN and Stat Medication Monitoring audit, based on one incident of seclusion, indicated the following compliance rate with each item listed below:</p> <table border="1" data-bbox="991 1377 1890 1414"> <tr> <td data-bbox="991 1377 1066 1414">9.</td> <td data-bbox="1066 1377 1774 1414"><i>Each State hospital shall ensure that seclusion is</i></td> <td data-bbox="1774 1377 1890 1414">0%</td> </tr> </table>	9.	<i>Each State hospital shall ensure that seclusion is</i>	0%
9.	<i>Each State hospital shall ensure that seclusion is</i>	0%			

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			<i>terminated as soon as the individual is no longer an imminent danger to self or others.</i>	
		9.a	<i>The individual was released from seclusion as soon as the violent or dangerous behavior that created the emergency was no longer displayed (met the release criteria on the Seclusion order?)</i>	0%
		9.b	<i>The individual was released from seclusion when he/she has been calm in the last 15 minutes.</i>	0%
		9.c	<i>The individual was released from seclusion even if he/she was unable to contract for safety.</i>	0%
		9.d	<i>The individual was released from seclusion even if he/she was unable to cease using offensive language.</i>	0%
		9.e	<i>The individual was released from seclusion even if he/she did not cease making verbal threats.</i>	0%
		9.f	<i>The individual was released from seclusion even if he/she was unable to say he/she recognizes what behavior prompted the seclusion episode.</i>	0%
		9.g	<i>The individual was released from seclusion even if he/she was unable to say he/she is sorry for his/her actions.</i>	0%
		<p>PSH's data from the draft DMH Restraints, Seclusion, and PRN and Stat Medication Monitoring audit, based on an 89% sample of restraint episodes for April 2008, indicated the following compliance rate for each item listed below:</p>		
		9.	<i>Each State hospital shall ensure that restraints are terminated as soon as the individual is no longer an imminent danger to self or others.</i>	41%
		9.a	<i>The individual was released from restraints as soon as the violent or dangerous behavior that created the emergency was no longer displayed</i>	44%

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			<i>(met the release criteria on the Restraints order?)</i>			
		9.b	<i>The individual was released from restraints when he/she has been calm in the last 15 minutes.</i>	44%		
		9.c	<i>The individual was released from restraints even if he/she was unable to contract for safety.</i>	56%		
		9.d	<i>The individual was released from restraints even if he/she was unable to cease using offensive language.</i>	59%		
		9.e	<i>The individual was released from restraints even if he/she did not cease making verbal threats.</i>	61%		
		9.f	<i>The individual was released from restraints even if he/she was unable to say he/she recognizes what behavior prompted the restraint episode.</i>	60%		
		9.g	<i>The individual was released from restraints even if he/she was unable to say he/she is sorry for his/her actions.</i>	63%		
		<p>See H.2.b</p> <p>Current recommendations: Continue to monitor this requirement.</p>				
H.3	<p>Each State hospital shall comply with 42 C.F.R. § 483.360(f), requiring assessments by a physician or licensed clinical professional of any individual placed in seclusion or restraints within one hour. Each State hospital shall also ensure that any individual placed in seclusion or restraints is continuously monitored by a staff person who has successfully completed competency-based training on the administration of seclusion and restraints.</p>	<p>Current findings on previous recommendations</p> <p>Recommendation 1, November 2007: Continue competency-based training addressing this requirement.</p> <p>Findings: PSH's data and training rosters indicated that as of April 2008, 81% of staff have completed the Prevention and Management of Seclusion or Restraint Training. In addition, PSH plans to add PMAB training classes in June 2008 to increase the availability of the training.</p>				

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		<p>Recommendation 2, November 2007: Continue to monitor this requirement.</p> <p>Findings: PSH's data from the draft DMH Restraints, Seclusion, and PRN and Stat Medication Monitoring audit, based on one incident of seclusion, indicated the following compliance rate with each item listed below:</p> <table border="1" data-bbox="991 522 1887 974"> <tr> <td data-bbox="991 522 1087 673">10.</td> <td data-bbox="1087 522 1774 673"><i>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 within one hour.</i></td> <td data-bbox="1774 522 1887 673">100%</td> </tr> <tr> <td data-bbox="991 673 1087 824">10.a</td> <td data-bbox="1087 673 1774 824"><i>The physician or registered nurse conducted a face-to-face evaluation of the individual in seclusion within one hour from the initiation of seclusion.</i></td> <td data-bbox="1774 673 1887 824">100%</td> </tr> <tr> <td data-bbox="991 824 1087 899">10.b</td> <td data-bbox="1087 824 1774 899"><i>The results of the face-to-face evaluation are documented in the progress note.</i></td> <td data-bbox="1774 824 1887 899">100%</td> </tr> <tr> <td data-bbox="991 899 1087 974">10.c</td> <td data-bbox="1087 899 1774 974"><i>The order was obtained within 15 minutes from the initiation of seclusion.</i></td> <td data-bbox="1774 899 1887 974">100%</td> </tr> </table> <p>PSH's data the draft DMH Restraints, Seclusion, and PRN and Stat Medication Monitoring audit, based on an 89% sample of restraint episodes for April 2008, indicated the following compliance rate for each item listed below:</p> <table border="1" data-bbox="991 1195 1887 1421"> <tr> <td data-bbox="991 1195 1087 1346">10.</td> <td data-bbox="1087 1195 1774 1346"><i>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 restraints within one hour.</i></td> <td data-bbox="1774 1195 1887 1346">90%</td> </tr> <tr> <td data-bbox="991 1346 1087 1421">10.a</td> <td data-bbox="1087 1346 1774 1421"><i>The physician or registered nurse conducted a face-to-face evaluation of the individual in</i></td> <td data-bbox="1774 1346 1887 1421">96%</td> </tr> </table>	10.	<i>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 within one hour.</i>	100%	10.a	<i>The physician or registered nurse conducted a face-to-face evaluation of the individual in seclusion within one hour from the initiation of seclusion.</i>	100%	10.b	<i>The results of the face-to-face evaluation are documented in the progress note.</i>	100%	10.c	<i>The order was obtained within 15 minutes from the initiation of seclusion.</i>	100%	10.	<i>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 restraints within one hour.</i>	90%	10.a	<i>The physician or registered nurse conducted a face-to-face evaluation of the individual in</i>	96%
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			<i>restraints within one hour from the initiation of restraints</i>		
		10.b	<i>The results of the face-to-face evaluation are documented in the progress note.</i>	98%	100%
		10.c	<i>The order was obtained within 15 minutes from the initiation of restraints.</i>	92%	100%
H.4	Each State hospital shall ensure the accuracy of data regarding the use of restraints, seclusion, psychiatric PRN medications, or Stat medications.	<p>A review of 15 episodes of seclusion for eight individuals (AP, AV, BGW, GB, HR, ML, SEJ and SLK), found that all were assessed within one hour of placement.</p> <p>A review of 50 episodes of restraints for 17 individuals (AJV, CLC, CW, DJ, GB, JDG, JR, JS, JVH, KLK, LUR, MLB, NMK, RDT, RZ, SLW and VMC) found that 48 were assessed within one hour of placement.</p> <p>Compliance: Partial (due to PSH's data representing one month only).</p> <p>Current recommendation: Continue to monitor this requirement.</p> <p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Implement MedSelect System to ensure accuracy of PRN and Stat data.</p> <p>Findings: PSH has implemented the MedSelect System on all 33 units.</p> <p>Recommendation 2, November 2007: Continue to monitor this requirement.</p>			

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		<p>Findings: PSH's progress report indicated that seclusion and restraint data is taken from the HSS report and entered into the Quick Hits WaRMSS database; then, when an individual is released from seclusion or restraints, the Program enters that data into the Oryx system. A monthly comparison of the data in these two systems is conducted to detect discrepancies. An auditor from Standards Compliance reviews the chart to determine which database needs to be reconciled. Ensuring reliability of data regarding PRN and Stat medications is similar in that the HSS report is reviewed for PRN and Stat medications and entered into the Quick Hits WaRMSS database by the Trigger Specialist from Standards Compliance. In addition, the use of PRNs and Stats are reported nightly to the Central Nursing Department and entered into the CIS database. Again, a monthly review of each database is conducted to identify any discrepancies, which are resolved by Standards Compliance based on chart reviews, and the appropriate database is corrected.</p> <p>Although PSH's description of these systems was very comprehensive, there was no data presented indicating the number of identified and corrected discrepancies to determine compliance.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Present data regarding this requirement. 2. Continue to monitor this requirement.
H.5	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	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Separate data regarding this requirement.</p>

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	<p>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: See below.</p> <p>Recommendation 2, November 2007: Continue to monitor this requirement.</p> <p>Findings: There have been no seclusion events meeting this requirement during this review period.</p> <p>PSH's data for April 2008 from the draft DMH Restraints, Seclusion, and PRN and Stat Medication Monitoring audit, based on a 100% sample (5) of individuals who were in restraints more than three times in four weeks, indicated the following compliance rate for each item listed below:</p>	
13.	<p><i>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 restraints more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate.</i></p>	20%	
13.a	<p><i>The review was held within three business days for any individual who had more than three episodes of restraints within the last four weeks.</i></p>	40%	
13.b	<p><i>The Present Status in the Case Formulation section of the WRP documented that a review of the incident(s) was done.</i></p>	50%	
13.c	<p><i>If the team decided to revise the WRP, a statement as to what part of the WRP was revised, was documented in the Present Status in</i></p>	0%	

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		<p><i>the Case Formulation section of the WRP or if the team decided not to revise the WRP, a brief description as to why, was documented in the Present Status in the Case Formulation Section of the WRP.</i></p>
H.6	<p>Each State hospital shall develop and implement policies and procedures consistent with generally accepted professional standards of care governing the use of psychiatric PRN medication and Stat medication, requiring that:</p>	<p>A review of the charts of 10 individuals who had been placed in restraints more than three times in any four-week period (AV, CC, CW, GB, JS, KKK, MB, NMK, SB and VMC), found that only one chart (NMK) contained documentation indicating that the WRPT reviewed the WRP.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Continue to monitor this requirement.</p>
H.6.a	<p>such medications are used in a manner that is clinically justified and are not used as a substitute for adequate treatment of the underlying cause of the individual's distress.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Continue to monitor this requirement.</p> <p>Findings: This monitor's review validated PSH's progress report, which indicated that out of 18 individuals receiving 15 or more PRNs in 30 consecutive days from November 2007-April 2008, two were reviewed by the WRPTs utilizing the PRN Trigger Activation Sheet. There were no</p>

		<p>high-risk Stat triggers during this review period. PSH indicated that the results of the PRN trigger audit would be reviewed with the Chair of the Department of Psychiatry and the Senior Psychiatrists.</p> <p>Other findings: A review of the charts of five individuals (CLC, CW, KLK, MLB and RZ) was conducted regarding PRN/Stat medications in relation to the individuals' incidents of seclusion/restraints. The review focused on the nurses' clinical decisions regarding PRN/Stat medication use and the resulting impact on the seclusion/restraint event.</p> <p>In the case of CLC, the IDNs indicated that she was intermittently screaming and posturing on the floor on 3/17/08. She had received a PRN of Zyprexa and Ativan earlier that day; however, there was no indication from the documentation of the effectiveness. An IDN later that day briefly stated that she had thrown herself on the floor of her room and was banging her head. She was placed in five-point restraints at that time. The IDNs indicated that after an hour in restraints, she continued to yell and thrash around in her bed. There was no indication that CLC was provided an additional PRN to assist her in calming down. The documentation from other days indicated that when she received a PRN, she usually calmed down to the point of falling asleep. The use of a PRN may not have averted the use of restraints, but it may have decreased the time she was in them. The brief documentation regarding the placement of the five-point restraints makes it difficult to assess if she was having problems keeping in control prior to the placement of the restraints.</p> <p>Additional findings for CLC's episode include:</p> <ol style="list-style-type: none"> 1. No route documented for PRN; 2. Effectiveness of PRN not documented; 3. IDNs significantly out order; 4. Documentation poor regarding release from restraints.
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		<p>In the case of CW, the IDNs indicated that she felt like swallowing an object and requested to go into restraints. She was given a PRN of Ativan and Haldol shortly after she was placed in restraints. In this situation, the interventions used appeared to assist her in keeping in control.</p> <p>Additional findings for CW's episode include:</p> <ol style="list-style-type: none">1. No site documented for PRN injection;2. IDNs significantly out of order. <p>In the case of KLK, the IDNs indicated that she had been pacing, demanding, and yelling. She was given a PRN of Haldol but was unable to calm down and was placed in restraints. The IDNs indicated that she was getting restless prior to this episode. Giving KLK the PRN at the first signs of her agitated behaviors may have avoided the need for restraint placement.</p> <p>Additional findings for KLK's episode include:</p> <ol style="list-style-type: none">1. No site documented for PRN injection;2. No IDN found documenting her release from restraints. <p>In the case of MLB, the IDNs indicated that while she was in the shower, she began to harm herself. The IDN indicated that she received a PRN of Haldol and Ativan at that time, but became more agitated and combative and was placed in restraints. The IDNs indicated that staff provided her with a PRN at the time she became self-abusive. However, the use of the restraints was unavoidable.</p> <p>Additional findings for MLB's episode include:</p> <ol style="list-style-type: none">1. No site documented for PRN injection;2. IDNs significantly out of order.
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		<p>In the case of RZ, the Use of Restraint form indicated that he was placed in restraints on 2/20/08. However, there were no IDNs found indicating the reason he was placed in restraints. In addition, there were no observations documented or an IDN indicating when he was released from restraints.</p> <p>Additional findings for RZ's episode include:</p> <ul style="list-style-type: none"> • IDNs significantly out of order. <p>Current recommendation: Continue to monitor this requirement.</p>																																				
H.6.b	PRN medications, other than for analgesia, are prescribed for specified and individualized behaviors.	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Continue to monitor this requirement.</p> <p>Findings: PSH's data from the DMH Monthly PPN audit for February 2008-April 2008, based on an 11% mean sample of all individuals who have been in the hospital for 90 days or more (N), indicated the following compliance rates for the items listed below:</p> <table border="1" data-bbox="991 1044 1890 1421"> <thead> <tr> <th colspan="5">DMH Monthly PPN Audit Form (Overall mean reliability = 90%)</th> </tr> <tr> <th></th> <th>Feb 08</th> <th>Mar 08</th> <th>Apr 08</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>1220</td> <td>1237</td> <td>1215</td> <td>1224</td> </tr> <tr> <td>n</td> <td>145</td> <td>161</td> <td>116</td> <td>141</td> </tr> <tr> <td>%S</td> <td>12</td> <td>13</td> <td>10</td> <td>11</td> </tr> <tr> <td>%C</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>4.</td> <td><i>Timely review of the use of "pro re nata" or "as needed" ("PRN") and</i></td> <td>28</td> <td>20</td> <td>25</td> <td>24</td> </tr> </tbody> </table>	DMH Monthly PPN Audit Form (Overall mean reliability = 90%)						Feb 08	Mar 08	Apr 08	Mean	N	1220	1237	1215	1224	n	145	161	116	141	%S	12	13	10	11	%C					4.	<i>Timely review of the use of "pro re nata" or "as needed" ("PRN") and</i>	28	20	25	24
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			<i>"Stat" (i.e., emergency psychoactive) medications and adjustment of regular treatment, as indicated, based on such use.</i>				
	4.a		<i>Describes the rationale/specific indication for all PRN orders.</i>	43	39	47	
	4.b		<i>Reviews the PRNs and Stats during the interval period.</i>	42	40	65	
	4.c		<i>Discusses use of PRN/Stat as indicated to reduce the risk of restrictive interventions.</i>	31	23	33	
	4.d		<i>Describes modifications of regularly scheduled medication regimen based on the use of PRN/Stat medications.</i>	24	15	20	
<p>N=All individuals who have been in the hospital for 90 days or more n=Number of audits conducted</p> <p>PSH's progress report indicated that there may be some confusion about what needs to be documented regarding this requirement and that training will be conducted to clarify this issue.</p>							

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

		<p>A review of PRN orders for 12 individuals (AV, CES, DAR, DIR, DL, FS, KLK, MLB, RS, RTH, SLK and VMC) found that four were prescribed for specific and individualized behaviors.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
H.6.c	PRN medications are appropriately time limited.	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Continue to monitor this requirement.</p> <p>Findings: In November 2007, AD #15.14, Seclusion or Restraint included the limiting of PRN orders to a maximum of 15 days. In addition, in March 2008 PSH implemented the procedure of initiating a Medication Variance Report (MVR) for PRN orders that lack an appropriate time limit. Now the Central Nursing Services Office notifies the Medical Director of any MVR related to a PRN order with inappropriate time frames.</p> <p>PSH's data, based on a mean of 716 PRN orders written for March and April 2008, indicated 98% mean compliance with the requirement that PRN medication orders were appropriately time-limited.</p> <p>A review of PRN orders (see H.6.b) found that all were time-limited according to PSH's policy.</p> <p>Current recommendation: Continue to monitor this requirement.</p>

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<p>H.6.d</p>	<p>nursing staff assess the individual within one hour of the administration of the psychiatric PRN medication and Stat medication and documents the individual's response.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Continue to provide training regarding appropriate assessment and documentation of responses to PRN and Stat medications.</p> <p>Findings: See H.7.</p> <p>Recommendation 2, November 2007: Continue to monitor this requirement.</p> <p>Findings: PSH's data from the DMH Nursing Services Monitoring audit for January-April 2008, based on an 8% mean sample of psychiatric PRNs administered in the review months (N), indicated 4% mean compliance with the requirement that there was documentation of the individual's response to the PRN medication on the Medication Treatment Record (MTR) and in the IDNs.</p> <p>PSH's data from the DMH Nursing Services Monitoring audit for January-April 2008, based on a 16% mean sample of psychiatric Stat medication administered in the review months (N), indicated 12% mean compliance with the requirement that there was documentation of the individual's response to the Stat medication on the Medication Treatment Record (MTR) and in the IDNs.</p> <p>See F.3.a.iii.</p> <p>Current recommendations: Continue to monitor this requirement.</p>
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Section H: Restraints, Seclusion, and PRN and Stat Medication

H.6.e	A psychiatrist conducts a face-to-face assessment of the individual within 24 hours of the administration of a Stat medication. The assessment shall address reason for Stat administration, individual's response, and, as appropriate, adjustment of current treatment and/or diagnosis.	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Same as in D.1.f, F.1.b and H.6.a.</p> <p>Findings: Same as in D.1.f, F.1.b and H.6.a</p> <p>Current recommendations: Same as in D.1.f, F.1.b and H.6.a.</p>
H.7	Each State hospital shall ensure that all staff whose responsibilities include the implementation or assessment of seclusion, restraints, psychiatric PRN medications, or Stat medications successfully complete competency-based training regarding implementation of all such policies and the use of less restrictive interventions.	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Continue to monitor this requirement.</p> <p>Findings: PSH's training rosters indicated that as of April 2008, 83% of the nursing staff have completed competency-based training regarding this requirement. With ongoing training, the facility should achieve substantial compliance with this requirement within the next review period. See also H.3.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
H.8	Each State hospital shall:	<p>Compliance: Substantial.</p>

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

<p>H.8.a</p>	<p>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>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Continue to monitor this requirement.</p> <p>Findings: According to this monitor's review and discussions with Nursing, PSH has not used side rails as a manner of restraint during this review period. The two individuals who have side rails were adequately evaluated by Utilization Review, which found that the use of side rails was not restrictive.</p> <p>Current recommendations: Continue to monitor this requirement.</p>
<p>H.8.b</p>	<p>ensure that, as to individuals who need side rails, their therapeutic and rehabilitation service plans expressly address the use of side rails, including identification of the medical symptoms that warrant the use of side rails, methods to address the underlying causes of such medical symptoms, and strategies to reduce the use of side rails, if appropriate.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Present data to accurately reflect the elements of this requirement.</p> <p>Recommendation 2, November 2007: Continue to monitor this requirement.</p> <p>Findings: See F.8.a.</p> <p>Current recommendations: Continue to monitor this requirement.</p>

Section I: Protection from Harm

I. Protection from Harm		
I	<p>Each State hospital shall provide the individuals it serves with a safe and humane environment and ensure that these individuals are protected from harm.</p>	<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. Most of the investigation reports reviewed demonstrated that the incidents were competently investigated. 2. AD #15.13: Patient Abuse and Neglect has been revised to use the revised incident definitions. The investigation reports are also using the revised definitions. 3. The Incident Review Committee has expanded its scope and is reviewing the quality of investigations and returning for additional work those that raise questions or leave questions unanswered. 4. The Incident Review Committee is tracking recommendations resulting from incident investigations. The responsible party is expected to report back on progress/implementation. 5. The facility has identified a plan for developing business rules for data entry into the Records Management System (hospital police incident information system). 6. The facility has initiated a multi-disciplinary review of deaths. 7. Standards Compliance has ensured that units receive timely notification of triggers and is tracking the responses. 8. The facility has plans to train Program Directors, Department Chairs and other holders of leadership positions in the Plato information management system which will give the user real-time access to trigger information. 9. Standards Compliance is monitoring incontinence care on a sample basis using the state-approved form. 10. The facility has developed several exceptional risk management initiatives. These include daily feedback to units identifying individuals with high or low blood glucose levels; study of individuals taking new generation antipsychotic medication at risk for cardio-metabolic syndrome; immediate attention for individuals who reach the same trigger more than once in a given period; and a focused study of falls.

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		<p>11. The facility has taken steps to address the need to improve the cleanliness of the units. These measures include twice-daily cleaning of bathrooms, the installation of bathroom fans, revision of the form for monthly inspections by Unit Supervisors, unannounced spot checks, and the opportunity within the context of the Council meetings for individuals to present their environmental concerns in writing.</p>
<p>1. Incident Management</p>		
<p>I.1</p>	<p>Each State hospital shall develop and implement across all settings, including school settings, an integrated incident management system that is consistent with generally accepted professional standards of care.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. B. DePalmer, RN, Standards Compliance 2. B. Sherer, Hospital Administrator 3. G. Richardson, Director of Standards Compliance 4. J. Baca, Standards Compliance 5. K. Clark, Standards Compliance <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Headquarters Reportable Briefs for March 2008 2. Five completed Headquarters Reportable Briefs 3. AD #10.49: Fall Reduction Program 4. AD #10.03: Suicide Prevention and Intervention 5. Draft #AD 15.13: Patient Abuse and Neglect 6. 15 incident investigation reports 7. Incident Review Committee minutes for November 2007-April 2008 8. Surgery, Mortality/Morbidity Committee minutes for October 2007–March 2008 9. Minutes of two Mortality Interdisciplinary Review Committee meetings 10. Investigation Monitoring data

Section I: Protection from Harm

<p>I.1.a</p>	<p>Each State hospital shall review, revise, as appropriate, and implement incident management policies, procedures and practices that are consistent with generally accepted professional standards of care. Such policies, procedures and practices shall require:</p>	<p>Findings (regarding risk management requirements as set forth in the Amended Consent Judgment): PSH has implemented initiatives and projects that direct professional attention to individuals in certain high-risk circumstances. [These initiatives and studies are described in the Performance Improvement section of this report.] The facility has yet to assign a hierarchy of interventions and timeframes for implementation appropriate to the level of risk when an individual reaches a trigger and when outcomes do not show improvement. The integration of the initiatives and studies into a risk management system that benefits the entire population, the assignment of a hierarchy of interventions, and efforts to improve the response of WRPTs to triggers will be part of an inter-facility conference held in June. It is expected that facilities will share their experiences and determine next steps that will benefit all of the hospitals.</p> <p>Compliance: Partial.</p>
<p>I.1.a.i</p>	<p>that each State hospital not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Review AD #15.13 and revise it to align with the new SIR definitions. Eliminate reference to the "unauthorized" use of chemical restraint.</p> <p>Findings: A draft of the revised AD #15.13 Patient Abuse and Neglect was prepared on April 8, 2008 and is pending approval. It eliminates the reference to "unauthorized use of chemical restraint."</p> <p>Recommendation 2, November 2007: Identify during investigations any incidents of failure to report abuse or neglect and take appropriate action.</p>

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		<p>Findings: This monitor did not find any instances of failure to report allegations in the investigations reviewed. AD #15.13 (draft) clearly states the responsibility to report allegations and events that constitute abuse.</p> <p>Recommendation 3, November 2007: The Incident Review Committee should review the failure to report verbal abuse documented in the 9/8/07 incident involving LFR.</p> <p>Findings: The IRC minutes of April 7, 2008 state that follow-up on corrective action regarding the employee failure to report an allegation of verbal abuse will be reviewed and a verbal report will be made to the IRC in May.</p> <p>Other findings: See I.1.a.v for revision to AD #15.13 necessary to ensure that corrective actions are forthcoming when a staff member fails to report abuse or neglect.</p> <p>Current recommendation: Revise AD #15.13 as recommended in I.1.a.v.</p>
I.1.a.ii	<p>identification of the categories and definitions of incidents to be reported, and investigated; immediate reporting by staff to supervisory personnel and each State hospital's executive director (or that official's designee) of serious incidents, including but not limited to, death, abuse, neglect, and serious injury, using standardized reporting across all settings, including school settings;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Continue current practice.</p> <p>Findings: AD #15.13 Patient Abuse and Neglect (draft) addresses the identification, reporting and investigation of serious injuries. Most of the selected incidents reviewed were competently investigated;</p>

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		<p>exceptions are noted in the cells below.</p> <p>Current recommendation: Continue current practice while providing close supervision of investigations and final reports to detect and correct deficiencies.</p>
I.1.a.iii	<p>mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, and/or serious injury occur, staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators from direct contact with the involved individuals pending the outcome of the facility's investigation;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Review and revise AD #15.13 to provide protection to individuals in all instances when there is a credible allegation of abuse.</p> <p>Findings: The proposed draft of AD #15.13 establishes the responsibility of the immediate supervisor to "provide protection to the individual in all instances when there is an allegation of abuse. This includes providing the individual with counseling and debriefing."</p> <p>Recommendation 2, November 2007: The Incident Review Committee should ensure that consideration of separation is documented in those cases where appropriate.</p> <p>Findings: Beginning in June 2008, the decision whether to remove a staff member following an incident until the investigation has reached a conclusion will be made by the Clinical Administrator.</p> <p>Other findings: Mention was made of whether the named staff was removed in several but not all of the 15 investigation reports reviewed. The reports specifically stating the named staff member was removed include the following:</p>

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		<ul style="list-style-type: none"> • 1/27/08 allegation of physical abuse involving LL • 2/10/08 allegation of physical abuse involving KK • 3/5/08 allegation of physical abuse involving DP <p>The investigation report of the allegation of sexual abuse of JT does not make clear whether the named staff was removed from duty during the period of time between the reporting of the event on 1/31/08 and the return of DNA evidence on 3/25/08. The investigation report states that on 3/25/08 two investigators "went to the suspect's work station" and asked to interview him in the Special Investigator's office. The staff member was arrested and booked on 3/25/08. If the named staff member was working with individuals during the time in question, this was a serious mistake.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement plan to have Clinical Administrator make the decision whether to remove a staff member named in an allegation of wrongdoing. 2. Document in the investigation report the decision of the Clinical Administrator. 3. IRC should review the sexual abuse incident and determine if the named staff member was removed from contact with individuals. If not, determine what went wrong and take appropriate remedial action.
I.1.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>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Begin tracking staff who are seriously out of compliance as planned.</p> <p>Findings: PSH is tracking this information and has been successful in reducing the number of staff members out of compliance for annual abuse/neglect training to 78 in March 2008, according to facility data.</p>

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		<p>Recommendation 2, November 2007: Review and refine the procedures for ensuring that staff members take annual training in a timely manner.</p> <p>Findings: See above.</p> <p>Other findings: A review of the Abuse/Neglect annual training, criminal background clearance, and signing of the mandatory reporter form for nine staff members revealed that all had signed the mandatory reporter form, documentation of criminal background clearance was available for eight, and all were current in A/N training. The review indicates that the facility is successfully using the annual training as an opportunity to ensure that the mandatory reporter form is completed.</p> <table border="1" data-bbox="991 820 1881 1240"> <thead> <tr> <th>Staff member</th> <th>Background clearance</th> <th>Mandatory Reporter signed</th> <th>A/N training</th> </tr> </thead> <tbody> <tr> <td>_B</td> <td>11/8/05</td> <td>12/16/05</td> <td>5/19/08</td> </tr> <tr> <td>_J</td> <td>9/17/01</td> <td>10/22/01</td> <td>3/17/08</td> </tr> <tr> <td>_L</td> <td>6/22/86</td> <td>5/16/86</td> <td>2/7/08</td> </tr> <tr> <td>_L</td> <td>1/27/96</td> <td>12/1/95</td> <td>3/5/08</td> </tr> <tr> <td>_C</td> <td>1/28/05</td> <td>12/13/05</td> <td>4/28/08</td> </tr> <tr> <td>_A</td> <td>7/16/79</td> <td>1/14/08</td> <td>1/14/08</td> </tr> <tr> <td>_V</td> <td>1/15/94</td> <td>2/1/95</td> <td>Not taken</td> </tr> <tr> <td>_F</td> <td>3/2/81</td> <td>1/8/08</td> <td>1/8/08</td> </tr> <tr> <td>_C</td> <td>Not in file</td> <td>12/2/97</td> <td>1/8/08</td> </tr> </tbody> </table> <p>(Only last initials are provided to protect confidentiality.)</p> <p>Current recommendation: Continue current practice.</p>	Staff member	Background clearance	Mandatory Reporter signed	A/N training	_B	11/8/05	12/16/05	5/19/08	_J	9/17/01	10/22/01	3/17/08	_L	6/22/86	5/16/86	2/7/08	_L	1/27/96	12/1/95	3/5/08	_C	1/28/05	12/13/05	4/28/08	_A	7/16/79	1/14/08	1/14/08	_V	1/15/94	2/1/95	Not taken	_F	3/2/81	1/8/08	1/8/08	_C	Not in file	12/2/97	1/8/08
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_V	1/15/94	2/1/95	Not taken																																							
_F	3/2/81	1/8/08	1/8/08																																							
_C	Not in file	12/2/97	1/8/08																																							

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<p>I.1.a.v</p>	<p>notification of all staff when commencing employment and adequate training thereafter of their obligation to report abuse or neglect to each State hospital and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept with their personnel records evidencing their recognition of their reporting obligations. Each State hospital shall not tolerate any mandatory reporter's failure to report abuse or neglect;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Continue to use annual training as an opportunity to ensure the staff member has signed the mandatory reporter form.</p> <p>Findings: See table above which demonstrates that annual training was the occasion in several instances for signing the mandatory reporter form.</p> <p>Recommendation 2, November 2007: Revise AD #15.13 to state that failure to report abuse or neglect <u>will</u> result in progressive corrective or disciplinary action.</p> <p>Findings: This recommendation was not implemented. The draft form of AD #15.13 continues to state that failure to report <u>may</u> result in progressive corrective or disciplinary action. At a minimum, a letter of instruction should be addressed to a staff member who fails to report abuse or neglect.</p> <p>Recommendation 3, November 2007: Revise Slide 11 in the annual abuse training presentation.</p> <p>Findings: This recommendation has been implemented. The slide presentation now includes the revised incident definitions as specified in Special Order 227.07.</p> <p>Recommendation 4, November 2007: Include the equivalent of "What Have We Learned" slides in the training presentations. Use clear and concise language that addresses abuse and neglect in an institutional setting.</p>
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		<p>Findings: These slides have been developed and included in the training presentations.</p> <p>Other findings: See table in I.1.a.iv for mandatory reporter form signing dates for nine employees selected only because their names appeared in or on documents reviewed.</p> <p>Current recommendation: Reconsider revising draft AD #15.13 to state affirmatively that the failure to report an allegation/incident of abuse or neglect will result in corrective or disciplinary action.</p>																
I.1.a.vi	mechanisms to inform individuals and their conservators how to identify and report suspected abuse or neglect;	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Continue with plans to discuss rights and responsibilities at annual conferences and ask individuals to sign the form at that time.</p> <p>Findings: A review of the Rights and Responsibility forms for 12 individuals revealed that three (25%) had been signed within the last year.</p> <table border="1" data-bbox="999 1079 1451 1421"> <thead> <tr> <th>Individual</th> <th>Date of most recent signing</th> </tr> </thead> <tbody> <tr> <td>KJ</td> <td>9/26/05</td> </tr> <tr> <td>MK</td> <td>5/14/08</td> </tr> <tr> <td>JK</td> <td>2/21/03</td> </tr> <tr> <td>AF</td> <td>7/14/05</td> </tr> <tr> <td>SC</td> <td>3/28/00</td> </tr> <tr> <td>EP</td> <td>9/16/05</td> </tr> <tr> <td>SC</td> <td>2/8/02</td> </tr> </tbody> </table>	Individual	Date of most recent signing	KJ	9/26/05	MK	5/14/08	JK	2/21/03	AF	7/14/05	SC	3/28/00	EP	9/16/05	SC	2/8/02
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JP	9/16/05												
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KF	4/18/08												
I.1.a.vii	posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to pursue such rights and how to report violations of such rights;	<p>Other findings: Several staff spoken with on the units were not aware that individuals should be asked to sign the Rights and Responsibilities form at the time of their annual WRPCs.</p> <p>Current recommendation: Take additional measures to ensure that rights and responsibilities are discussed with individuals at annual WRPCs and ask individuals to sign the form at that time.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Identify the units where "office calls" remains a problem, initiate an equitable solution and monitor compliance.</p> <p>Findings: This recommendation was implemented using an interview of individuals on each of the units. The most recent survey reported that 10 units still enforced "office calls," down from 21 units. The 10 units were identified to the Program Directors who supervised them.</p> <p>Recommendation 2, November 2007: Continue Therapeutic Milieu Observation Monitoring and distribute the results hospital-wide.</p>										

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		<p>Findings: This monitoring has continued and the information supplied to Program Directors. When Program Directors have been trained in the use of the Plato information system, they will be able to access this information directly.</p> <p>Other findings: All units visited had the Patients Rights poster hung in a common area. All units were able to produce a blank form that would be provided to individuals if they wished to make a complaint to the Patients Rights Advocate when requested. The Patients Rights Advocate noted that in the week of the Court Monitor's visit, her office had received no calls up to the time of our conversation. She believed this suggested that staff were providing exceptionally constructive attention to the individuals.</p> <p>Current recommendation: Continue to ask individuals if "office hours" restrictions are in place and take steps to discontinue the practice.</p>
I.1.a.viii	procedures for referring, as appropriate, allegations of abuse or neglect to law enforcement; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Continue training on the hospital police information system and use it initially to generate reports of individuals who are repeat aggressors and repeat victims. Expand tracking of other variables as more information is put into the system.</p> <p>Findings: The facility has determined that several problems remain before the Records Management System will be useful in tracking and generating reports on repeat victims, repeat aggressors and other incident variables.</p>

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		<p>First, there are no business rules governing data entry. Consequently, the data presently in the RMS are not reliable. Second, the system does not have a component for tracking the work of the Office of Special Investigations. Third, without adaptations by the vendor, the RMS is not capable of producing the reports on multiple incident variables that the state believed it could produce.</p> <p>Other findings: The Hospital Administrator was aware of the problems with data reliability and was planning to work with the hospital police on data entry rules.</p> <p>In this monitor's review of investigation reports, a determination was made in the relevant cases whether to forward the case to the DA. In the sexual abuse of JT, the named staff member was arrested.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Determine business rules for data entry into the RMS and make them applicable to all of the facilities if that is possible.2. On a state level, work with the vendor to develop the capacity in the RMS for producing trending and pattern reports on incidents.3. Until the facility has developed and trained staff on data entry rules, include a copy of the RMS incident data sheet with the investigation report that is sent to the Incident Review Committee. This will provide a second check on data accuracy.
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I.1.a.ix	<p>mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Proceed with plans to revise AD #15.13 to include protections for individuals, family members and visitors against retaliation for reporting incidents.</p> <p>Findings: This recommendation has been implemented. The draft AD #15.13 states, "Hospital employees, individuals, individuals' family members or visitors shall not be subject to retaliation for reporting known or alleged abuse."</p> <p>Current recommendation: Continue current practice.</p>
I.1.b	<p>Each State hospital shall review, revise, as appropriate, and implement policies and procedures to ensure the timely and thorough performance of investigations, consistent with generally accepted professional standards of care. Such policies and procedures shall:</p>	<p>Compliance: Partial.</p>
I.1.b.i	<p>require investigations of all deaths, as well as allegations of abuse, neglect, serious injury, and theft. The investigations shall be conducted by qualified investigator(s) who have no reporting obligations to the program or elements of the facility associated with the allegation and have expertise in conducting investigations and working with persons with mental disorders;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2007: The Court Monitor will be providing guidance and practice standards to the hospitals regarding the process of death reviews. Revise current policies and practice to come into compliance with the Court Monitor's recommendations.</p> <p>Findings: The facility has initiated a Mortality Interdisciplinary Review process that has functioned in the review of two deaths. The minutes of these</p>

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		<p>two meetings indicate that the members have had access to the death investigation report, the nursing death summary and the medical death summary. At the close of the meeting (May 2, 2008), a list of recommendations was compiled that included the staff member responsible and the target date.</p> <p>Review of the medical death summary in both cases indicates a more thorough review was completed in the second review. Findings and areas identified for performance improvement in the review of the death of ST (reviewed in the committee on 3/6/08) focused on inadequacies in documentation in the WRP, without reference to implementation and outcomes.</p> <p>Review of the minutes for the Surgical Mortality/Morbidity Committee for October 2007 through March 2008 (there was no April 2008 meeting) found that the death of RR (10/23/07) was not recorded or reviewed.</p> <p>Waiting for autopsies has impeded the closing of death reviews in the SM/M Committee. It is unclear if long waits for autopsies are common in the community or if there is another explanation.</p> <table border="1" data-bbox="991 1003 1717 1273"> <thead> <tr> <th>Individual</th> <th>Date of death</th> <th>Autopsy reviewed/ case closed</th> </tr> </thead> <tbody> <tr> <td>CK</td> <td>7/29/07</td> <td>1/22/08</td> </tr> <tr> <td>FC</td> <td>12/25/07</td> <td>Still pending</td> </tr> <tr> <td>JA</td> <td>12/26/07</td> <td>Still pending</td> </tr> <tr> <td>DP</td> <td>12/27/07</td> <td>Still pending</td> </tr> <tr> <td>PL</td> <td>1/5/08</td> <td>Still pending</td> </tr> </tbody> </table> <p>Recommendation 2, October 2007: Continue to provide Incident Management Training for all hospital police officers and any other administrators, Program Directors and</p>	Individual	Date of death	Autopsy reviewed/ case closed	CK	7/29/07	1/22/08	FC	12/25/07	Still pending	JA	12/26/07	Still pending	DP	12/27/07	Still pending	PL	1/5/08	Still pending
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		<p>department heads who have not yet received Incident Management training.</p> <p>Findings: The facility reports that no training was held in February, March and April 2008. The next training is scheduled for July 2008.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that medical and nursing death reviews focus on outcomes and provision of treatment as well as documentation and treatment planning. 2. Continue current practice of identifying actions for improving case with timeframes and responsible parties identified. Monitor implementation. 3. Determine why autopsy results are not being provided in a timely manner and take reasonable steps to address the problem if possible. 4. Take any additional steps necessary to implement SO #205.04: Mortality Review.
I.1.b.ii	<p>ensure that only the State Hospital staff who have successfully completed competency-based training on the conduct of investigations be allowed to conduct investigations of allegations of petty theft and all other unusual incidents;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Continue current practice.</p> <p>Findings: All incidents are investigated by members of the hospital police force.</p> <p>Current recommendation: Continue current practice.</p>
I.1.b.iii	<p>investigations required by paragraph I.1.b.i, (above) provide for the safeguarding of</p>	<p>Current findings on previous recommendation:</p>

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	<p>evidence;</p>	<p>Recommendation, November 2007: Continue current practice.</p> <p>Findings: This monitor found no evidence in the investigation reports reviewed that evidence was mishandled. In the investigation of the sexual abuse of JT on 1/29/08, the investigators safeguarded the material evidence collected by the victim and DNA evidence from both the named staff member and the victim and transferred these to the California DOJ Bureau of Forensic Services for analysis. Investigators also took pictures of the scene and showed the victim photos to secure a positive identification of the assailant.</p> <p>Current recommendation: Continue current practice.</p>
<p>I.1.b.iv</p>	<p>investigations required by paragraph I.1.b.i, (above) require the development and implementation of standardized procedures and protocols for the conduct of investigations that are consistent with generally accepted professional standards. Such procedures and protocols shall require that:</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Determine and implement a plan for an objective review of investigations and accurate completion of the Investigation Compliance Monitoring form.</p> <p>Findings: This recommendation has been partially implemented. The facility reports that the Incident Review Committee, in its review of the investigation reports of incidents involving allegations of abuse, neglect, exploitation and assault with major injury, is addressing the quality of the investigation as well as making recommendations for corrective actions. They are informally using the monitoring form to guide their reviews of the quality of the investigation.</p>

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		<p>Recommendation 2, November 2007: Add a question to the monitoring form asking if all relevant parties were interviewed.</p> <p>Findings: The facility reports that the Incident Review Committee, in its review of investigation reports, is addressing the question of whether all witnesses were interviewed and is returning investigations for more work when issues are raised. See also I.1.b.iv.3(ii) and I.1.b.iv.4.</p> <p>Current recommendation: Continue to provide an independent review of the incident investigation reports through the work of the Incident Review Committee.</p>
I.1.b.iv.1	investigations commence within 24 hours or sooner, if necessary, of the incident being reported	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Continue current practice.</p> <p>Findings: Several investigations reviewed completed by the Office of Special Investigations did not begin in a timely manner. In these instances, either an investigator was not assigned or the first interviews were not conducted speedily. Tardiness compromises the reliability of the parties' recollections. Examples include the following:</p> <ul style="list-style-type: none"> • The first interviews with the alleged victim (JT) of psychological abuse that occurred and was reported on 2/21/08 did not occur until 4/2/08. • In the investigation of physical abuse of AS reported on 2/1/08, the first interviews occurred on 3/6/08. The alleged perpetrator was not interviewed until 3/27/08 and said he could not remember the incident.

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		<ul style="list-style-type: none"> • The first interviews related to the physical abuse allegation made by LL on 2/4/08 were not conducted until 3/3/08. • On 12/28/07, an investigator was assigned to investigate the verbal abuse allegation made by SV on 12/4/07. First interviews were conducted on 2/7/08. • An allegation of physical abuse made by CT on 10/30/07 was assigned for investigation on 11/14/07. First interviews were completed the following day. The named staff person, however, was interviewed on 12/4/07 and the case was closed that day. <p>Current recommendation: The IRC and the Supervising Special Investigator should address the issues of timely assignment of investigations and prompt initiation of interviews.</p>									
I.1.b.iv. 2	<p>investigations be completed within 30 business days of the incident being reported, except that investigations where material evidence is unavailable to the investigator, despite best efforts, may be completed within 5 business days of its availability;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Continue current practice of completing investigations in a timely manner.</p> <p>Findings: Based on the sample of investigation reports reviewed, the timeliness of investigations is hampered by processes within the Office of Special Investigations that result in delays in assigning cases, conducting the first interviews (as detailed above) and completing the reports. Review of the timeliness of completion of a sample of investigation reports yielded mixed results as shown below:</p> <table border="1" data-bbox="991 1263 1860 1416"> <thead> <tr> <th>Incident type</th> <th>Date incident reported</th> <th>Date investigation closed</th> </tr> </thead> <tbody> <tr> <td>Sexual battery</td> <td>1/25/08</td> <td>2/25/08</td> </tr> <tr> <td>Physical abuse</td> <td>1/31/08</td> <td>3/14/08</td> </tr> </tbody> </table>	Incident type	Date incident reported	Date investigation closed	Sexual battery	1/25/08	2/25/08	Physical abuse	1/31/08	3/14/08
Incident type	Date incident reported	Date investigation closed									
Sexual battery	1/25/08	2/25/08									
Physical abuse	1/31/08	3/14/08									

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		Physical abuse	2/1/08	4/8/08
		Physical abuse	1/27/08	3/10/08
		Assault on staff	2/9/08	2/20/08
		Physical abuse	2/10/08	4/18/08
		Psychological abuse	2/21/08	4/30/08
		Physical abuse	2/29/08	3/20/08
		Physical abuse	3/5/08	3/26/08
		Physical abuse	10/27/07	12/4/08
		Verbal abuse	12/4/07	2/7/08
		Sexual battery (between individuals)	1/16/08	2/6/08
		Sexual abuse	1/31/08	3/25/08 (waiting DNA testing results)
		Verbal abuse	1/6/08	2/8/08
		Physical abuse	12/20/07	1/25/08
		<p>The findings above for the month of April are not consistent with the monitoring data presented by the hospital, which reports that all five cases monitored that were closed in April were completed within 30 business days. A total of seven cases were closed in that month. The data above indicates that in the limited sample reviewed, three of the cases closed in April were not completed in 30 business days.</p> <p>Recommendation 2, November 2007: Expand the size of the sample of investigations monitored to at least 25%, since the total number (N) of investigations each month is small, having averaged 24 investigations per month in the six- month period from May to October 2007.</p> <p>Findings: A sample of at least 33% of investigations was selected and monitored each month from November 2007 through April 2008. The smallest percentage was reviewed in December (the facility figure of 67% is a</p>		

		<p>calculation error) and the highest percentage was reviewed in February, when all five of the investigations completed were monitored. In the same six-month period, a total of 44 investigations were completed by the Office of Special Investigations and 26 (59%) were monitored using the compliance monitoring tool.</p> <p>Other findings: In the investigations reviewed, the average length of time from the date the incident was reported until it was received in the OSI was three days. In three investigations reviewed, delays occurred in assigning a Special Investigator to the case as shown below:</p> <ul style="list-style-type: none">• The allegation of psychological abuse of JT was reported to the OSI on 2/21/08, but was not assigned to an investigator until 2/27/08.• The physical abuse allegation involving JP was received in the OSI on 12/21/07, but not assigned for investigation until 1/4/08.• The assignment of an investigator to the incident of alleged verbal abuse involving SV that was reported to the OSI on 12/4/07 did not occur until 12/28/07. <p>Not all investigation reports reviewed documented the date the case was reported to the Office of Special Investigations.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Identify on all incident investigations completed by Special Investigators the dates on which the Office of Special Investigations was notified and the case was assigned.2. Continue work on identifying a method whereby an objective person monitors a sample of investigation reports using the state-approved monitoring tool.
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<p>I.1.b.iv. 3</p>	<p>each investigation result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action. The report's contents shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately:</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Reference the SIR incident definitions in making determinations in investigations.</p> <p>Findings: This recommendation has been implemented. SIR definitions were referenced in making determinations in the sample of investigation reports reviewed.</p> <p>Recommendation 2, November 2007: The Incident Review Committee should review the investigation report discussed above (ST 9/7/2007) and determine whether appropriate actions have been taken.</p> <p>Findings: Relevant portions of the report were read to the IRC members during the April 7, 2008 minutes. The IRC minutes do not reflect any discussion or determination by the committee.</p> <p>Recommendation 3, November 2007: Ensure that the discussion of the use of the C-clamp includes alternatives, the frequency with which it has been necessary to use it, and the safety risks associated with its use.</p> <p>Findings: This recommendation has not resulted in its intended effect. A second instance of the use of a chokehold occurred on 3/5/08 when it was used by a hospital police officer on DP. The investigation determined that the officer used necessary force to control DP. One of the recommendations from that investigation was for DMH to determine whether to authorize or prohibit the use of the hold. The ED sent a</p>
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		<p>memo to Cindy Radavsky that included a copy of the Executive Committee review of the incident. The memo notes that the hold is taught at the Police Academy and there is no DMH or facility policy prohibiting its use. The memo does not explicitly ask DMH to make a finding on whether this hold is appropriate in a hospital setting.</p> <p>Other findings: Most of the investigations reviewed drew reasonable conclusions/ determinations based on a competent review of the circumstances of the incident. Exceptions are noted in the cells that follow. See particularly I.1.b.iv.3(iii), I.1.b.iv.3(ix) and I.1.c.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. DMH should determine if or under what circumstances the use of a chokehold is an acceptable form of restraint in the facilities and make its determination clear to the hospital administrators, police officers and facility staff members. 2. Encourage the IRC and the Supervising Special Investigator to review incident investigations carefully and ensure that oversights are addressed.
I.1.b.iv.3(i)	each allegation of wrongdoing investigated;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Address the reason for the investigation by providing a description of the alleged misconduct being investigated in the synopsis on the face sheet of the investigation report.</p> <p>Findings: This recommendation has been implemented. The incident type is clearly identified at the top of the face sheet and the synopsis describes the circumstances of the incident.</p>

		<p>Recommendation 2, November 2007: Classify incidents and make determinations based on the SIR definitions finalized in July 2007 when conducting administrative, as distinct from criminal, investigations.</p> <p>Findings: This recommendation has been implemented except that in several investigation reports, the writer concluded that the named staff person in incidents involving allegations of abuse and neglect had been exonerated. Examples include the reports of the 2/29/08 allegation of physical abuse of KK and the 3/5/08 allegation of abuse involving DP. Determinations should be made as to whether the allegation is sustained or not. Use of the term exoneration is inappropriate.</p> <p>Recommendation 3, November 2007: Ensure that compound allegations are fully investigated. Divide them into separate incidents and investigations if necessary.</p> <p>Findings: In one incident reviewed (incident date: 1/6/08), the victim alleged that in addition to being verbally abused in the courtyard, the named staff member "comes into his room and yells at him to get up." The individual has two roommates. This portion of the allegation was not investigated.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Cease making determinations that the named staff person in incidents involving allegations of abuse and neglect is exonerated. Make determinations, based on the preponderance of the evidence, whether the allegation is or is not sustained.2. Ensure that compound allegations are fully investigated. Divide them into separate incidents and investigations if necessary.
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<p>I.1.b.iv. 3(ii)</p>	<p>the name(s) of all witnesses;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Take steps to identify all witnesses, document these efforts in the investigation report and interview all witnesses identified or explain why an interview was not completed.</p> <p>Findings: In several of the investigations reviewed, specific mention is made of attempts to find additional witnesses or reference is specifically made to the lack of witnesses to the incident. For example in the incident involving the physical abuse allegation made on behalf of BK, the investigator concluded that there were no witnesses to the event, which allegedly occurred several months earlier but was being reported months after the event. The investigation report of alleged physical abuse on 12/20/07 specifically states that the individual stated there were no witnesses to the event. In the investigation of the allegation of physical abuse made by KK on 2/29/08, wherein KK alleged she was medicated against her will, the investigator randomly asked 10 individuals if they had witnessed the incident.</p> <p>Current recommendation: Continue current practice of identifying witnesses or the absence of witnesses. Make attempts to find additional witnesses when the circumstances of the incident indicate it is reasonable to do so, for example when the incident occurred in a location where other staff and individuals were likely to be present.</p>
<p>I.1.b.iv. 3(iii)</p>	<p>the name(s) of all alleged victims and perpetrators;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Identify the alleged perpetrator (with title) and the alleged victim on the face sheet of each investigation report.</p>

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		<p>Findings: This recommendation has been implemented.</p> <p>Other findings: When the alleged perpetrator was known, the person was identified on the investigation report face sheet. In the investigation of the 2/1/08 allegation of physical abuse of AS, the staff person was not known by name but was described by the victim and was later tentatively identified during the course of the investigation. Neither the alleged victim nor a witness (the individual with whom AS was having an altercation) were provided the opportunity to make a positive identification using photos or direct observation. The case was determined "not sustained" because the staff aggressor could not be identified.</p> <p>Current recommendation: The IRC and the Supervising Special Investigator should review the investigations carefully and ensure that the final accepted report reflects a competent and thorough investigation.</p>
I.1.b.iv. 3(iv)	the names of all persons interviewed during the investigation;	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Identify and interview all witnesses, including individuals, who might have seen or heard an incident.</p> <p>Findings: See I.1.b.iv.3(ii).</p> <p>Current recommendation: See I.1.b.iv.3(ii).</p>

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<p>I.1.b.iv. 3(v)</p>	<p>a summary of each interview;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: The Incident Review Committee should consider the date of the incident, date reported and date sent to the Office of Special Investigations when it reviews incidents to identify problems and trace them back to the source, so that appropriate actions can be taken.</p> <p>Findings: The Hospital Administrator indicated that the IRC will begin to look at the timeliness of the investigations beginning in May 2008. This review will include a review of when the Office of Special Investigator was notified of the need for an investigation and when an investigator was assigned. This information was provided on most of the investigation reports reviewed.</p> <p>In the investigations reviewed, the average length of time from the date the incident was reported until it was received in the OSI was three days. See also I.1.b.iv.2 and I.1.b.iv.1.</p> <p>Other findings: A summary of each of the interviews conducted or attempted was present in each of the investigation summaries reviewed. Interviews are taped at the time they are conducted and summarized in the reports.</p> <p>Current recommendation: Continue current practice of taping interviews and providing a summary in the investigation report.</p>
<p>I.1.b.iv. 3(vi)</p>	<p>a list of all documents reviewed during the investigation;</p>	<p>Current findings on previous recommendation:</p>

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		<p>Recommendation, November 2007: Expand the incident history search of both staff and individuals as the technology becomes available.</p> <p>Findings: See Other Findings in cell I.1.b.iv.3(vii) below.</p> <p>Other findings: All of the investigation reports reviewed listed the documents reviewed. For example, in the investigation of the alleged abuse occurring on 2/10/08, the investigator secured a copy of the staffing schedule for the date in question and documented a review of relevant sections of the individual's clinical record.</p> <p>Current recommendation: Continue current practice.</p>
<p>I.1.b.iv.3(vii)</p>	<p>all sources of evidence considered, including previous investigations and their results, involving the alleged victim(s) and perpetrator(s);</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: See I.1.b.iv.3(vi).</p> <p>Findings: A review of the 12 sample investigations indicates variable attention to documentation of a review of the incident history of the named staff person and the individual(s) involved in an incident. For example, a review of the incident history of both the individual and the staff member was documented in the investigation reports related to the following incidents:</p> <ul style="list-style-type: none"> • Verbal abuse allegation made by SV on 12/4/07 • Physical abuse allegation made by JP on 12/20/07 • Verbal abuse allegation made by ML on 1/7/08

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		<ul style="list-style-type: none"> • Physical abuse of LL that allegedly occurred on 1/27/08 • Physical abuse allegation made by BK on 1/31/08 • Psychological abuse allegation made by JT on 2/21/08 • Physical abuse allegation made by KK on 2/29/08 <p>In the investigation of the physical abuse allegation made by AS and reported on 2/1/08, the investigation report notes that AS had made no prior complaints, but it is silent on the incident history of the named staff person. The investigation report of the sexual battery (individual on individual) occurring on 1/25/08 does not address the incident history of either individual. The investigation report of the sexual abuse incident (1/29/08) that resulted in the arrest of the named staff member does not address the incident history of either party.</p> <p>Current recommendation: Ensure that all investigations include information about the incident history of the named staff member(s) and the individual(s) when conducting an investigation.</p>
<p>I.1.b.iv. 3(viii)</p>	<p>the investigator's findings, including findings related to the substantiation of the allegations as well as findings about staff's adherence to programmatic requirements; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Provide the full investigation summary to IRC members. Develop procedures to ensure confidentiality of this material.</p> <p>Findings: This recommendation has been implemented. Members of the Incident Review Committee receive copies of the full investigation reports of allegations of abuse/neglect/exploitation and assaults resulting in major injuries prior to the meeting.</p> <p>Other findings: The investigation of the sexual abuse of JT on 1/29/08 failed to</p>

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		<p>address the question of how the assault occurred without the knowledge of other staff members who were allegedly making rounds. The IRC also identified this problem in the investigation during its deliberations on April 7, 2008 along with several other issues that required clarification. The IRC recommended that the Supervising Special Investigator address the shortcomings and report back to the IRC at the May meeting. The Root Cause Analysis (in draft form and not yet completed at the time of the tour) prepared by Standards Compliance addressed the night rounds issue and supervision of NOC shift.</p> <p>The failure to make rounds and questionable documentation of night rounds has figured in this and other serious incidents and deaths in other state facilities. This is an issue that requires DMH attention. Issues include revision of the form used to document the rounds, the expectation for staggered rounds, the workload of night staff members, procedures for ensuring that sleeping individuals are breathing, the presence of supervisors on the night shift and any other relevant issues that arise.</p> <p>Random review of the night rounds check sheet for 6/11/08 indicated the sheet was not signed for rounds between 4 AM and 5:30 AM on Unit EB11.</p> <p>Current recommendation: DMH should convene a work group to address the issues related to night rounds and make recommendations to be implemented by all of the facilities.</p>
I.1.b.iv. 3(ix)	the investigator's reasons for his/her conclusions, including a summary indicating how potentially conflicting evidence was reconciled; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Improve documentation of attempts to reconcile conflicting evidence.</p>

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		<p>Findings: One of the investigations reviewed revealed inadequate efforts to reconcile conflicting evidence. JL alleged that he was thrown back, causing his face and knee to hit the floor and that the named staff member put his knee on JL's chest while restraining him and then placed him in five-point restraints. There is conflicting testimony as to which staff members restrained JL and which restrained the individual he was fighting with. The investigator did not review the restraint record to see if the named staff member appeared or alternately did not state that the five-point restraint did not occur. The case was determined unfounded.</p> <p>Current recommendation: Improve documentation of attempts to reconcile conflicting evidence</p>
<p>I.1.b.iv. 4</p>	<p>staff supervising investigations review the written report, together with any other relevant documentation, to ensure that the investigation is thorough and complete and that the report is accurate, complete, and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly. As necessary, staff responsible for investigations shall be provided with additional training and/or technical assistance to ensure the completion of investigations and investigation reports consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Develop procedures for a more rigorous and objective review of investigations and completion of the monitoring form.</p> <p>Findings: In the last several months, the IRC has begun to review the investigations more thoroughly and has identified several investigations that required further work. This was the case in the investigation of the sexual abuse case discussed during the April meeting and in the allegation of verbal abuse discussed in the March meeting, in which the committee recommended that the investigator follow up with interviews of other individuals present at the time of the incident.</p> <p>Recommendation 2, November 2007: Provide the Incident Review Committee with copies of the complete investigation summaries so that they can fulfill their responsibilities</p>

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		<p>for a thorough review of serious incidents.</p> <p>Findings: This recommendation has been implemented. Members of the IRC receive the complete investigation summary prior to meeting.</p> <p>Other findings: The minutes of the March and April meetings of the IRC reflect, as noted above, a more comprehensive review of the quality of the investigations as well as the identification of corrective measures. Corrective measures are presently tracked through the minutes. As this work continues, it will become more difficult to track recommendations using this method solely. Development of a simple database to track recommendations and implementation would facilitate this work.</p> <p>Current recommendation: Develop a simple database to track IRC recommendations and the responses. Review outstanding recommendations at each meeting.</p>
I.1.c	<p>Each State Hospital shall ensure that whenever disciplinary or programmatic action is necessary to correct a situation or prevent reoccurrence, each State hospital shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Supply the IRC with the complete investigation summary for all investigations completed by the Office of Special Investigations so that it can identify needed systemic and programmatic corrective actions.</p> <p>Findings: This recommendation has been implemented.</p> <p>Other findings: Review of the minutes of the February, March and April meetings of</p>

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		<p>the IRC reveal follow-up of several disciplinary actions.</p> <p>In a separate matter, an incident occurring on EB01, in which a sheet was placed over an individual's face to prevent him from spitting, resulted in a search by the Medical Director for any directives concerning the use of a sheet in this way. Several directives were found that prohibited this practice. (This did not, however, change the determination of the investigation that the actions by staff were necessary. The search for directives concerning the use of the sheet should have occurred during the investigation in order to determine if programmatic violations had occurred as required by cell I.1.b.iv.3(viii).) The recommendation was made that staff on EB01 receive training on the prohibition of this practice. Review of the training records indicated that only three staff from the unit attended the training.</p> <p>Compliance: Partial.</p> <p>Current recommendation: The IRC and the Supervising Special Investigator should pay careful attention to the determinations made at the close of investigations to ensure they are based on a thorough examination of all relevant facts, including consideration of programmatic violations.</p>
I.1.d	Each State hospital shall have a system to allow the tracking and trending of investigation results. Trends shall be tracked by at least the following categories:	<p>Compliance: Partial.</p>
I.1.d.i	type of incident;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Continue work in the implementation of the statewide Incident Management System.</p>

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		<p>Findings: This work continues. IT staff are ready to present some of the screens to Standards Compliance staff from all of the facilities for approval.</p> <p>Recommendation 2, November 2007: Determine the business rules for ensuring that the information in the statewide Incident Management system is corrected when necessary.</p> <p>Findings: See above.</p> <p>Other findings: The facility has not yet produced trending reports based on incident type on a consistent basis. Recent IRC minutes reflect a focus on identifying information sources and methods for producing these reports in the near future.</p> <p>Current recommendation: Until the statewide Incident Management System is operational, continue work on using other data sources to produce trending reports based on incident type.</p>
I.1.d.ii	staff involved and staff present;	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Begin using the hospital police information system as quickly as possible.</p> <p>Findings: See I.1.a.viii for a description of the problems with the Records Management System and the work that needs to be done in order for the system to produce the kind of reports it was believed it was</p>

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		<p>capable of producing.</p> <p>Other findings: As reported, investigators are able to access information about past allegations made by individuals and information on whether a named staff member had been the target in any sustained allegations of abuse/neglect/exploitation.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue with plans to work with the vendor to enable the facilities to use the Records Management System to produce tracking and trending reports. 2. Take measures to ensure that data entered into the Records Management System is accurate. 3. Continue the practice of reviewing the incident history of staff members to the degree that the information is available and reporting this review in investigation reports.
I.1.d.iii	individuals directly and indirectly involved;	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Remind WRPTs, Unit Supervisors and Program Directors that they are responsible for identifying repeat victims and taking protective measures, in the absence of a data system that provides this information.</p> <p>Findings: The facility reports that this reminder is provided during the Quality Team meetings. Centralized identification and tracking of victims will not occur until the statewide incident management information system is operational.</p> <p>Other findings:</p>

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		<p>There is presently no way, except by a review of incident reports and/or investigation reports, to track individuals indirectly involved in incidents.</p> <p>Current recommendation: DMH should continue work on the statewide Incident Management System.</p>
I.1.d.iv	location of incident;	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Continue training staff to use the hospital police information system and continue to work on reconciling that system with the statewide Incident Management System.</p> <p>Findings: See I.1.a.viii.</p> <p>Other findings: The facility has not produced reports on the location of incidents.</p> <p>Current recommendation: Begin producing reports on the location of incidents as soon as the technology allows.</p>
I.1.d.v	date and time of incident;	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Begin putting information into the hospital police information system as soon as possible.</p> <p>Findings: The Incident Management System is presently not capable of producing</p>

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		<p>the kind of reports that reflect trends and patterns that it was described as able to produce.</p> <p>Other findings: The facility has not yet produced reports on the date and time of incidents.</p> <p>Current recommendation: Begin producing reports on the time and day of the week incidents are occurring as soon as the technology permits.</p>
I.1.d.vi	cause(s) of incident; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Begin completing the Headquarters briefing forms.</p> <p>Findings: None of the nine Headquarters Reportable Briefs reviewed covering incidents occurring in March had been completed and finalized. The facilities have 60 days to complete the briefs.</p> <p>Other findings: The facility has finalized five Headquarters Reportable Briefs during the review period—three related to April incidents and two related to incidents in May. The facility reported that training on completing the Briefs was held in early April and the response in returning completed forms has improved since then.</p> <p>Current recommendation: Complete the Headquarters Reportable Briefs and focus on contributing factors. Ask the Incident Review Committee or other bodies/staff members who could be helpful for assistance.</p>

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<p>I.1.d.vii</p>	<p>outcome of investigation.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Continue to train staff on the hospital police information system so that the facility can begin using it as soon as possible and can provide outcome information to the Incident Review Committee and in other appropriate forums.</p> <p>Findings: At the present time, the Record Management System is not capable of producing the kind of reports on investigations that had been expected.</p> <p>Other findings: The statewide Incident Management System will be capable of providing outcome data.</p> <p>Current recommendation: Continue work on the statewide Incident Management System.</p>
<p>I.1.e</p>	<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</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Continue current practice.</p> <p>Findings: See the table in I.1.a.iv.</p> <p>Other findings: See the question raised in I.1.a.iii regarding the removal of a staff member alleged to have sexually assaulted an individual. Until this question is resolved and every investigation of abuse and neglect documents either the decision to remove a named staff member until the investigation is complete or a rationale for not removing him/her,</p>

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	<p>person or volunteer may pose a risk of harm to such individuals.</p>	<p>the facility is not is substantial compliance.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Ensure that every investigation of an allegation of abuse and neglect addresses the question of the removal of a staff member alleged to have engaged in serious misconduct.</p>
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2. Performance Improvement		
I.2	Each State hospital shall develop, revise as appropriate, and implement performance improvement mechanisms that enable it to comply fully with this Plan, to detect timely and adequately problems with the provision of protections, treatment, rehabilitation, services and supports, and to ensure that appropriate corrective steps are implemented. Each State hospital shall establish a risk management process to improve the identification of individuals at risk and the provision of timely interventions and other corrective actions commensurate with the level of risk. The performance improvement mechanisms shall be consistent with generally accepted professional standards of care and shall include:	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. B. Behnam, MD 2. B. DePalmer, RN, Standards Compliance 3. B. Sherer, Hospital Administrator 4. G. Richardson, Director of Standards Compliance 5. S. Velasquez, PhD, Coordinator of Psychology Specialized Services <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. AD #15.45: Key Indicator/Trigger Reporting 2. Aggregate trigger data 3. Selected data from the Quick Hits information system 4. Selected data from the Plato information system 5. Cardio-Metabolic Syndrome study 6. Documentation from Repeat Trigger Project 7. Suicide/Homicide Risk Report (March 08)
I.2.a	Mechanisms for the proper and timely identification of high-risk situations of an immediate nature as well as long-term systemic problems. These mechanisms shall include, but not be limited to:	<p>Compliance:</p> <p>Partial.</p>
I.2.a.i	data collection tools and centralized databases to capture and provide information on various categories of high-risk situations;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2007: Identify ways to use the trigger information (e.g. patterns, trends) to assist WRPTs and Program Directors to identify effective interventions on individual and unit levels.</p>

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		<p>Findings: The facility has initiated several studies and projects to address high-risk situations. These include the monthly Suicide/Homicide Prevention and Intervention report; the rapid response team meetings when an individual triggers for restraint, seclusion or aggression resulting in a major injury; the identification of individuals who re-trigger in the same category; daily reporting to teams of individuals whose blood glucose levels are outside normal limits; and the Cardio-Metabolic Syndrome study.</p> <p>Other findings: The behavioral trigger data for the time periods September-December 2007 (period 1) and January-April 2008 (period 2) revealed an increase in the frequency of the behaviors as indicated below. These findings should be addressed with the project leaders (above) and hospital leadership.</p> <table border="1" data-bbox="991 821 1890 1411"> <thead> <tr> <th>Trigger</th> <th>Period 1</th> <th>Period 2</th> </tr> </thead> <tbody> <tr> <td>Aggression to self resulting in major injury</td> <td>10</td> <td>16</td> </tr> <tr> <td>Individuals with two or more aggressive acts to self in seven consecutive days</td> <td>14</td> <td>18</td> </tr> <tr> <td>Individuals with four or more aggressive acts to self in 30 consecutive days</td> <td>9</td> <td>14</td> </tr> <tr> <td>Peer-to-peer aggression resulting in major injury</td> <td>28</td> <td>35</td> </tr> <tr> <td>Aggression to staff resulting in major injury</td> <td>64</td> <td>66</td> </tr> <tr> <td>Individuals with four or more aggressive acts to others in 30 consecutive days</td> <td>24</td> <td>37</td> </tr> <tr> <td>Individuals alleging abuse/neglect or exploitation</td> <td>46</td> <td>58</td> </tr> <tr> <td>Homicidal threats</td> <td>30</td> <td>31</td> </tr> </tbody> </table>	Trigger	Period 1	Period 2	Aggression to self resulting in major injury	10	16	Individuals with two or more aggressive acts to self in seven consecutive days	14	18	Individuals with four or more aggressive acts to self in 30 consecutive days	9	14	Peer-to-peer aggression resulting in major injury	28	35	Aggression to staff resulting in major injury	64	66	Individuals with four or more aggressive acts to others in 30 consecutive days	24	37	Individuals alleging abuse/neglect or exploitation	46	58	Homicidal threats	30	31
Trigger	Period 1	Period 2																											
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Homicidal threats	30	31																											

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		Suicide attempts	4	14
		Suicide threats	107	129
I.2.a.ii	establishment of triggers and thresholds that address different levels of risk, as set forth in Appendix A; and	<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Review the data above and investigate further to determine the factors that account for the increases. 2. Continue identifying issues for special attention and expand the work that is already being done through the initiatives and studies cited above. <p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: See recommendation in I.2.a.i.</p> <p>Findings: AD #15.45 establishes high-risk triggers. The facility has ensured that teams are advised in a timely manner when an individual reaches a high-risk trigger. AD #15.45 requires a timely response within one work day back to Standards Compliance. The breadth of the response is left to the team. There are no written expectations that dictate certain responses in particular circumstances.</p> <p>Standards Compliance audited a small sample of Trigger Action Sheets (between 12-19%) and found that on average over the period November 2007–April 2008, 88% were completed and signed and 80% had been implemented. The facility stated in its progress report that psychiatrists are now required to address triggers and their response in their monthly note, and auditors will be reading those notes. This may improve the implementation compliance rating.</p>		

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		<p>Current recommendation: Assign appropriate staff to review the quality of the trigger response and determine what minimum standards should be set for high-risk trigger responses.</p>
I.2.a.iii	<p>identification of systemic trends and patterns of high-risk situations.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Identify ways to use the trigger information (e.g. patterns, historical data on individuals) to assist WRPTs and Program Directors to identify effective interventions on individual and unit levels.</p> <p>Findings: The facility reports that in the next reporting period it will produce trending and pattern reports on the outcomes of the several of the initiatives identified in I.2.a.i.</p> <p>Other findings: The facility is using the Plato data system to track responses from WRPTs to triggers. Training of Program Directors, Discipline Chiefs, senior psychiatrists and others is ongoing. Competence in using the data system will allow these staff members access to the information in real time. The facility expects to have leadership staff using the system by the next reporting period.</p> <p>Two of the initiatives mentioned in I.2.a.i. are discussed below as they target high-risk situations:</p> <p>The Coordinator of Psychology Specialized Services began a project in January to provide a rapid respond to triggers related to restraint and seclusion, and harm to self or others resulting in major injury. The short discussion on each individual addresses issues such as the interventions presently being used, current status section of WRP,</p>

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		<p>interventions that might be helpful, whether assessments are needed, and whether behavioral guidelines are needed. Most often the psychologist, Program Director, Clinical Director and Psychology Chair attend. The Coordinator maintains a database that tracks the recommendations made and follow-up. It became apparent that recommendations from these meetings may not be the same as the response sent back to Standards Compliance from the unit on the Trigger Action Sheet. This is easily be remedied by giving the Coordinator access to the Plato information system. She could then see if and how the unit responded to the trigger and coordinate the meeting's recommendations with the units if necessary. It was agreed with the Director of Standards Compliance that the Coordinator would be given access to Plato.</p> <p>The Cardio-Metabolic Syndrome Study produced data that showed that of the 199 individuals in Program 3, one-third had metabolic syndrome and an additional 40% were at high risk for the syndrome. This data followed Dr. Behnam's written request to the Medical Director a week earlier asking that senior psychiatrists be urged to provide him data on metabolic syndrome in their Programs. . It also followed his request that individuals with the syndrome and those at risk for the syndrome be provided a minimum of two hours of education a week on the syndrome and its potential consequences.</p> <p>In matching the printout titled "All current medications in the last 30 days for individuals at risk for metabolic syndrome" with the blood glucose readings for the period May 2 through June 4, two individuals selected (PB and EQ) illustrate the need for broader attention to this issue and the usefulness of using the two reports to track particularly vulnerable individuals. PB receives 40 mg of olanzapine daily and had high glucose levels ranging from 200 to 321 on 23 occasions during the 33-day report period. EQ receives 30 mg of olanzapine daily and had high glucose levels ranging from 212 to 374 on 37 occasions during the</p>
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		<p>report period.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue providing training to leadership staff in using the Plato system for tracking triggers. 2. Continue with plans to give the Coordinator of Psychology Specialized Services access to the trigger response data in Plato. 3. Take measures to bring the benefits of Dr. Behnam's work to all individuals with cardio-metabolic syndrome and those at risk for the syndrome. Use the blood glucose data matched with the list of persons with the syndrome or at risk for it or matched with any other data that is helpful to identify individuals in need of attention.
I.2.b	<p>Mechanisms for timely interventions and other corrective actions by teams and disciplines to prevent or minimize risk of harm to individuals. These mechanisms shall include, but not be limited to:</p>	<p>Compliance: Partial.</p>
I.2.b.i	<p>a hierarchy of interventions by clinical teams that correspond to triggers and thresholds;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Continue to monitor the timeliness of interventions, a sample of interventions for implementation, and provide historical trigger data to teams for individuals. Share tracking and trending information when this becomes available.</p> <p>Findings: See I.2.a.ii. Trending information is not presently available, but should be available during the next report period. The rapid response team is one effort to provide timely and clinically appropriate attention to persons who reach certain high-risk triggers. This team meets once each week in each compound. Continue with plans to give the</p>

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		<p>Coordinator of Psychology Specialized Services access to the trigger response data in Plato. The facility is also tracking individuals who reach the same trigger more than once.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue and expand the initiatives that target high-risk individuals. 2. Ensure that in dealing with persons involved in aggressive incidents resulting in serious injury, equal attention is paid to identifying and providing psychological services as well as physical services to individuals who are victims.
I.2.b.ii	<p>timely corrective actions by teams and/or disciplines to address systemic trends and patterns;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Continue current practice of Standards Compliance staff checking the implementation of a sample of actions reported by WRPTs.</p> <p>Findings: The facility implemented this recommendation and presented data for the November 2007—April 2008 period. Of the 92 responses to triggers in the monitoring sample, 54 (59%) were completed and returned in a timely manner. There was no significant difference in the rate of compliance in the first three months of the period as compared to the second three months.</p> <p>Recommendation 2, November 2007: Produce historical trigger data by individual to the WRPTs on a periodic basis to enhance the ability of teams to determine whether their interventions are producing positive results. The frequency of these reports should be determined in collaboration with Program Directors.</p>

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		<p>Findings: When Program Directors have been trained in the use of the Plato data system, they will have access to this information whenever they need it. The identification of individuals who reach the same trigger more than once in a month is also addressing this issue. See I.2.b.iii.</p> <p>Other findings: A review of the entries in the Plato data system (one function of which is to track the responses from WRPTs to triggers) for seven individuals who reached a high-risk trigger between December 16, 2007 and March 30, 2008 (total of seven triggers) revealed entries were not present for two of the seven. The two not present were triggers for SV on 3/30/08 and for GB on 3/1/08.</p> <p>The Suicide/Homicide Risk Report (March 2008) states that CNS had previously been advised to alert nursing staff to stagger environmental rounds and enhanced observation. The facility was not able to provide documentation that units had been made aware of this directive.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. The Risk Manager should continue to track recommendations from the Suicide/Homicide Risk Report. The Quality Improvement Team should take measures to ensure timely implementation or provide a rationale why the recommendation should not be implemented. 2. Continue plans to train more leadership staff on the use of Plato.
I.2.b.iii	formalized systems for the notification of teams and needed disciplines to support appropriate interventions and other corrective actions;	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Identify the source of the problem in timely notification to the units of high-risk triggers and take appropriate action.</p>

		<p>Findings: A review of seven randomly selected trigger actions sheets (notifications sent to the units that identify the individual and the trigger) revealed that all had been sent to the units in a timely manner.</p> <p>Other findings: PSH developed a report that summarizes data on the number and percentage of individuals who triggered multiple times between November 2007 and April 2008. Accompanying this report is a list of the individuals by name and the dates of the specific trigger events. The triggers where the percent of individuals who triggered multiple times was 20% or greater are:</p> <ul style="list-style-type: none"> • Two PRNs in 24 hours and three PRNS in seven days • 15 PRNs in 30 consecutive days • Two aggressive acts to self in seven days • Suicide threats • Six or more restraints in 30 consecutive days • Seclusion for more than four hours • Four or more episodes of seclusion in seven consecutive days and six or more in 30 days • 1:1 over 24 hours in seven days <p>There is an error in the count of individuals who triggered on aggression toward a peer resulting in a major injury. It should read 4, not 5. These four individuals triggered a total of eight times. A response indicating the actions taken was provided by the WRPT in five of the eight instances.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that WRPs respond when presented with material indicating an individual has triggered multiple times. 2. Consider recommending a hierarchy of interventions that must be
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		implemented for individuals who trigger multiple times.
I.2.b.iv	formalized systems for feedback from teams and disciplines to the standards compliance department regarding completed actions; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: See previous recommendations for continuing current practice and expanding the uses of the trigger information.</p> <p>Findings: AD #15.45 Key Indicator/Trigger Reporting requires that WRPTs respond to notice of a high-risk trigger within one weekday and return the completed Trigger Action Sheet to Standards Compliance.</p> <p>Other findings: See I.2.b.ii and I.2.a.ii for data on trigger response compliance.</p> <p>Current recommendation: Continue to gather data on response rates, timeliness and implementation of the actions cited. Present this information in leadership meetings that include the Program Directors.</p>
I.2.b.v	monitoring and oversight systems to support timely implementation of interventions and corrective actions and appropriate follow up.	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: See I.2.b.ii.</p> <p>Findings: See I.2.b.ii and I.2.a.ii for data on trigger response compliance.</p> <p>Current recommendation: See I.2.b.v.</p>

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I.2.c	Utilize, on an ongoing basis, appropriate performance improvement mechanisms to assess and address the facility's compliance with its identified service goals.	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Finalize the business rules for triggers with the approval of the Court Monitor. If there is a need for additional triggers, add them as necessary, but keep the rules firm for the triggers already operating.</p> <p>Findings: PSH reports that the business rules for triggers have been finalized. There is discussion of adding triggers related to restraint and seclusion.</p> <p>Other findings: See cells below for descriptions of ways the facility is using trigger data to enhance performance improvement.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Continue to develop initiatives and refine current procedures with the goal of managing risk through close attention to triggers on an individual and system level.</p>
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3. Environmental Conditions		
I.3	<p>Each State hospital shall develop and implement a system to review regularly all units and areas of the hospital to which individuals being served have access to identify any potential environmental safety hazards and to develop and implement a plan to remedy any identified issues, consistent with generally accepted professional standards of care. Such a system shall require that:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. B. Ray, Health & Safety Office 2. B. Sherer, Hospital Administrator 3. D. Booth, Chief of Plant Operations 4. E. Haskell, Chief of Plant Operations III <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Report of Spot Check Environmental Rounds by Health and Safety Office for April 08. 2. Environmental Inspections Comparison Record dated May 7, 2008 3. Urgent work order list for November 07—April 08 4. Environment of Care Grid <p><u>Toured:</u></p> <ol style="list-style-type: none"> 1. Unit 21 2. Unit 32 3. Unit 35 4. Unit 36 5. Unit U05 6. Unit EB11 7. Unit EB12
I.3.a	<p>Potential suicide hazards are identified and prioritized for systematic corrective action, and such action is implemented on a priority basis as promptly as feasible;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Implement the plan described above (in prior report) and monitor results, including asking for feedback during Council meetings.</p> <p>Findings: The facility has identified environmental modifications to address</p>

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		<p>suicide and other safety hazards and assigned each a priority status. Some measures are underway, such as the exchange of shower valves for push-button valves, the removal of grates on the outside of the windows and the repositioning of lockers against the wall, so as not to obstruct the view.</p> <p>The Environment of Care Grid tracks progress on each of the work projects. Individuals attending Council meetings are provided the opportunity to put environmental concerns in writing and these are forwarded to Plant Operations.</p> <p>Other findings: The facility has revised the form used by Unit Supervisors in conducting monthly environmental rounds to include a review of the cleanliness of the unit and a review of suicide hazards. The facility's data shows that in monitoring the monthly inspections of 25 units (compiled on May 7, 2008), seven units had not turned in the April inspections and two units of these had not turned in inspections for March as well. Furthermore, three of the seven units were not using the new form when they did complete environmental rounds and two other units that completed their rounds in a timely manner were not using the revised form. Training on the use of the revised form was provided in November and again in March.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Work to ensure the timely and accurate completion of unit monthly environmental inspection reports.2. Continue efforts to involve individuals in addressing the problem.3. Engage individuals who require assistance/encouragement to care for their person and personal space with appropriate training and
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		other measures.
I.3.b	All areas of the hospital that are occupied by individuals being served have adequate temperature control and deviations shall be promptly corrected;	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Proceed with plans to enhance cleanliness in individuals' personal space and common areas.</p> <p>Findings: Steps have been taken to address the issue of cleanliness in personal and common areas, but it is clear that problems remain as discussed in Other Findings below. Bathrooms are cleaned twice daily and large overhead fans have been installed in 12 bathrooms. The issue of choice versus responsibility as related to personal hygiene and care of environment has been discussed at Council meetings, and representatives from Standards Compliance and Health and Safety Department have attended Council meetings to address the issue. Individuals are provided the opportunity at Council meetings to put their environmental concerns in writing.</p> <p>Other findings: Documentation of 11 random spot checks completed by Health and Safety personnel in January, March and April indicated problems with bathrooms during five of the 11 spot checks. These were reported and immediately addressed.</p> <p>Between November 2007 and April 2008, 97% of the 130 work orders related to hot ambient temperatures were addressed within one workday, according to the facility data. Similarly, 95% of the 134 work orders in the same time period related to cold temperatures were resolved within one workday.</p> <p>The temperature on the units toured over two days was comfortable.</p>

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		<p>Tour of seven units revealed the following problems:</p> <table border="1" data-bbox="993 305 1879 755"> <tr> <td data-bbox="993 305 1178 378">Unit 32</td> <td data-bbox="1178 305 1879 378">Food and juice container smashed between the head of the mattress and frame in two beds.</td> </tr> <tr> <td data-bbox="993 378 1178 565">Unit 35</td> <td data-bbox="1178 378 1879 565">One bathroom in extraordinarily bad condition with very poor lighting. Work is scheduled to begin on this bathroom in August. Water damage in several areas of the unit.</td> </tr> <tr> <td data-bbox="993 565 1178 638">Unit EB 11</td> <td data-bbox="1178 565 1879 638">Urine odor in one bathroom. Large fan working well in second bathroom.</td> </tr> <tr> <td data-bbox="993 638 1178 711">Unit EB 12</td> <td data-bbox="1178 638 1879 711">Dirt trapped inside plexiglass in one bedroom with four individuals.</td> </tr> <tr> <td data-bbox="993 711 1178 755">Unit 05</td> <td data-bbox="1178 711 1879 755">Water bottle stored next to urinals in one bedroom.</td> </tr> </table> <p>Compliance: Substantial compliance on temperature control. Cleanliness still needs improvement.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Engage individuals who require assistance/encouragement to care for their person and personal space with appropriate training and other measures. 2. Continue efforts to involve the Councils in addressing the cleanliness problem. 	Unit 32	Food and juice container smashed between the head of the mattress and frame in two beds.	Unit 35	One bathroom in extraordinarily bad condition with very poor lighting. Work is scheduled to begin on this bathroom in August. Water damage in several areas of the unit.	Unit EB 11	Urine odor in one bathroom. Large fan working well in second bathroom.	Unit EB 12	Dirt trapped inside plexiglass in one bedroom with four individuals.	Unit 05	Water bottle stored next to urinals in one bedroom.
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I.3.c	Each State hospital reviews, revises, as appropriate, and implements procedures and practices so that individuals who are incontinent are assisted to change in a timely manner;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Continue to produce both reports and cross-check them until the hospital is satisfied that the Medical Conditions Report is accurate and reliable as the sole source of this information.</p>										

		<p>Findings: The facility has developed a database identifying individuals with the problem of incontinence. Standards Compliance staff review the Health Services Specialists' reports to identify persons with episodes of incontinence and enter them into the database, which is used to produce the monthly trigger report on incontinence. When there is a question about whether an episode of incontinence is an isolated instance, B. DePalmer, the Standards Compliance nurse who keeps this database, explained that he checks with the team.</p> <p>Recommendation 2, November 2007: Implement the new nursing procedures regarding incontinence care.</p> <p>Findings: The facility reports that 76% of unit staff have been trained on the revised nursing procedures for incontinence care.</p> <p>Review of the hospital's monitoring data indicates that on average in the six-month period November 2007—April 2008, in 92% of the monitoring events the individual was clean, dry and odor-free. Individuals said staff acted quickly to assist them in 96% of the interviews, and nursing staff were able to describe how they assist the individual in 98% of the interviews. These positive outcome measures are in contrast to poor performance related to addressing incontinence in the present status of the case formulation (34%), in formulating objectives that promote dignity and self-reliance (32%) and in the individuals' ability to verbalize goals and interventions addressing the condition (27%).</p> <p>Other findings: A review of the clinical records of seven individuals identified as having the problem of incontinence who were audited by Standards Compliance</p>
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		<p>between March 24 and May 9, 2008 revealed that problems identified in the audits were corrected in the records of three of the individuals.</p> <table border="1" data-bbox="991 305 1873 760"> <thead> <tr> <th>Individual</th> <th>Problem identified in audit</th> <th>Status at review</th> </tr> </thead> <tbody> <tr> <td>KJ</td> <td>Incontinence not in Focus 6</td> <td>Corrected</td> </tr> <tr> <td>MK</td> <td>Incontinence not in Focus 6</td> <td>Not corrected</td> </tr> <tr> <td>_S</td> <td>Incontinence not in Focus 6</td> <td>Not corrected</td> </tr> <tr> <td>RW</td> <td>Incontinence not in Focus 6</td> <td>Corrected</td> </tr> <tr> <td>MB</td> <td>Incontinence not in Focus 6</td> <td>Corrected</td> </tr> <tr> <td>AT</td> <td>Incontinence not in present status</td> <td>Not corrected</td> </tr> <tr> <td></td> <td>WRP does not addresses nursing assistance</td> <td>Not corrected</td> </tr> <tr> <td>JC</td> <td>Incontinence not in present status</td> <td>Not corrected</td> </tr> <tr> <td></td> <td>WRP does not address nursing assistance</td> <td>Not corrected</td> </tr> </tbody> </table> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that WRPTs understand the responsibility to correct deficiencies in planning and care identified by the audit team. 2. Monitor for corrections on a sample basis. 3. Share with nursing staff the hospital's monitoring data, pointing out the need for their advocacy in including appropriate goals and objectives in the WRP and in teaching individuals the outcomes they hope to achieve. 	Individual	Problem identified in audit	Status at review	KJ	Incontinence not in Focus 6	Corrected	MK	Incontinence not in Focus 6	Not corrected	_S	Incontinence not in Focus 6	Not corrected	RW	Incontinence not in Focus 6	Corrected	MB	Incontinence not in Focus 6	Corrected	AT	Incontinence not in present status	Not corrected		WRP does not addresses nursing assistance	Not corrected	JC	Incontinence not in present status	Not corrected		WRP does not address nursing assistance	Not corrected
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I.3.d	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	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Monitor compliance with the new Administrative Directives #15.29 and #15.20.</p>																														

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	<p>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: PSH reports that effective March 2008 the IRC began to review "unacceptable sexual behavior" incidents. It further reports that in its monitoring of the clinical records of 37 individuals involved in 33 incidents, only one record did not have documentation of the sexual contact. This was immediately addressed.</p> <p>Other findings: Review of four sexual incidents yielded mixed compliance with expectations for nursing and physician attention to these incidents.</p> <p><u>Incident 1:</u> Peer to peer sexual contact on 4/9/08</p> <ul style="list-style-type: none"> • No note written about the incident on the date of the incident. • Note on 5/13 states STDs and high-risk behaviors reviewed. • Sexual activity is not addressed in WRP. • No mention of the incident in 5/6 WRPC. <p><u>Incident 2:</u> Individual and staff contact (touching outside of clothing) on 4/15/08</p> <ul style="list-style-type: none"> • Nursing note written. • Psychology note written. <p><u>Incident 3:</u> Peer to peer sexual contact on 4/20/08</p> <ul style="list-style-type: none"> • For male: No counseling note and no physician note. • 6/8 nursing note states individual was educated on safe sex and STDs. • For female: Late entry note on 4/21/08 includes a nursing assessment and describes attempts to talk to individual about the incident. • 4/22 monthly psychiatry note makes no mention of the incident. <p><u>Incident #4:</u> Peer to peer sexual contact on 4/27/08</p>
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		<ul style="list-style-type: none"> • For male: Nursing note written; no physicians note. • For female: Excellent nursing note describing immediate care and follow-up one hour later. <p>Compliance: Partial.</p> <p>Current recommendation: Continue to monitor compliance with expectations around the treatment provided to individuals in sexual incidents. Ensure this information reaches physicians and psychiatrists.</p>									
I.3.e	<p>Each State hospital develops and implements clear guidelines stating the circumstances under which it is appropriate to utilize staff that is not trained to provide mental health services in addressing incidents involving individuals. Each State hospital ensures that persons who are likely to intervene in incidents are properly trained to work with individuals with mental health concerns.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, November 2007: Share the list of non-clinical staff providing Mall services with Staff Development, so that SD can track training compliance.</p> <p>Findings: This recommendation was implemented and the lists are updated at the beginning of each mall session.</p> <p>Other findings: The facility data over the six month period November-April the number of non-unit staff providing mall groups rose from 54 to 139. This count included many licensed personnel and others with clinical training. Facility data shows improvement in training compliance in five of seven areas.</p> <table border="1" data-bbox="991 1263 1885 1416"> <thead> <tr> <th>Course</th> <th>November 2007 % in compliance</th> <th>April 2008 % in compliance</th> </tr> </thead> <tbody> <tr> <td>PMAB</td> <td>46</td> <td>60</td> </tr> <tr> <td>CPR</td> <td>63</td> <td>73</td> </tr> </tbody> </table>	Course	November 2007 % in compliance	April 2008 % in compliance	PMAB	46	60	CPR	63	73
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		First Aid	70	84
		Recovery (chapter 1)	89	64
		By Choice	89	80
		Patients Rights	48	65
		Neglect and Abuse	46	86
		<p>Compliance: Partial.</p> <p>Current recommendation: Continue efforts to bring all Mall facilitators up-to-date on training.</p>		

Section J: First Amendment and Due Process

J. First Amendment and Due Process		
J		<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. The facility responded to concerns about the way individuals were treated by dining room staff by providing training on abuse and neglect reporting specifically for those staff members. Nearly 85% of these staff have completed the training. 2. The facility continues to include individuals on facility committees. Council members particularly commended the inclusion of individuals on the committee addressing changes needed in Administrative Directives to reflect the recovery model. 3. The April Central Council minutes devoted a section to thanking the facility for responding to concerns regarding the regular delivery of newspapers, the celebration of Black History month, and for participation in the hospital-wide Choices in Recovery Symposium, a training opportunity available to both staff and individuals. These notes of appreciation indicate a commitment to wellness and recovery that goes beyond treatment planning.
J	<p>Each State hospital unconditionally permits individuals to exercise their constitutional rights of free speech, including the right to petition the government for redress of grievances without State monitoring, and provides them due process.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. C. Clark, Individual/Administration Liaison 2. P. Mc Cord, Supervising Advocate Specialist 3. Several attendees at the Council meetings [conversations before and after Council meetings] <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Nutrition Service meeting minutes for April 08 2. Council meeting minutes 3. Central Council Senate 2008 Safety Action Committee minutes 4. Consumer survey reports and analysis

Section J: First Amendment and Due Process

		<p><u>Observed:</u> Council meetings on both sides of the compound</p>
J		<p>Current findings on previous recommendations:</p> <p>Recommendation 1, November 2007: Take actions to improve the relationship between individuals and dining room staff. Provide training on verbal and psychological abuse.</p> <p>Findings: The facility reported that that as of April 10, 2008, 41% of the dining room staff had completed Abuse/Neglect Reporting training. Additional training raised the compliance rate to 83% by May 10. The May Council meeting minutes state that since monitoring began, there have been no allegations of verbal or psychological abuse made against dining room staff.</p> <p>Recommendation 2, November 2007: Continue Neighborhood Watch meetings and encourage participation.</p> <p>Findings: The Neighborhood Watch has been renamed the Safety Action Committee. Meeting notes from January—May report discussion on the use of drugs, particularly in the outdoor portable toilets; searches and shakedowns; and the pros and cons of establishing units for individuals who make a pledge of non-violence.</p> <p>Recommendation 3, November 2007: Identify where the SIR process is breaking down when individuals write to the Executive Director and fix it.</p> <p>Findings: The Supervising Senior Special Investigator developed a process to</p>

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		<p>address this problem. There was not evidence of this problem on this visit.</p> <p>Other findings: When questioned about improvement in the relationship between individuals and the dining room staff, while the answers were mixed, the majority seemed to be indicating improvement or approval of the way they are treated. Some individuals said that dining room staff act appropriately when supervisors are present.</p> <p>Review of the results of the 20-question survey completed, in part or in whole, by approximately 160 individuals in February 2008 reveals that six of the 20 items received a positive response by 70% or more of the respondents. These items were:</p> <table border="1" data-bbox="991 743 1885 1123"> <tr> <td>Staff believe I can get better.</td> <td>81%</td> </tr> <tr> <td>Staff tell me when I do something well.</td> <td>66%</td> </tr> <tr> <td>Staff make sure rules are followed.</td> <td>78%</td> </tr> <tr> <td>When staff talk to me, they also listen.</td> <td>70%</td> </tr> <tr> <td>Staff are respectful of race and culture. [A Spanish-language version of the survey was available and the narrative comments of individuals replying in Spanish were presented in both Spanish and English.]</td> <td>74%</td> </tr> <tr> <td>Staff talk to me about changes in my medications and of my concerns about medications.</td> <td>74%</td> </tr> </table> <p>Eight other items received scores between 65%--69%.</p> <p>A comparison of the responses received in August 2007 and February 2008 compiled by the facility indicated that seven of the 20 responses either improved or remained the same.</p> <p>The Council meeting minutes indicate that staff in leadership positions</p>	Staff believe I can get better.	81%	Staff tell me when I do something well.	66%	Staff make sure rules are followed.	78%	When staff talk to me, they also listen.	70%	Staff are respectful of race and culture. [A Spanish-language version of the survey was available and the narrative comments of individuals replying in Spanish were presented in both Spanish and English.]	74%	Staff talk to me about changes in my medications and of my concerns about medications.	74%
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		<p>are attending the meetings and answering questions.</p> <p>During the June meeting attended by this monitor, several issues were raised:</p> <ol style="list-style-type: none"> 1. A rights issue surfaced: A number of individuals complained about procedures for gaining access to their records and writing a statement in it. They said that in many instances, the response was circular. When the request made its way up the administrative review process, the staff member making the decision would refer it back to the team where the request started. No decision was ever reached and no rationale provided. 2. Council members commended the inclusion of individuals as the facility undertakes the review of Administrative Directives to reflect the recovery model. 3. A request was made for educational software for the computers. These might include language instruction, history and art materials and tutorials in using word processing and Excel programs. 4. Some discussion suggested that on one or more female units, women are lining up naked waiting to shower. <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Address the issue of access to records, not only with the individuals but also with the staff members handling the requests. 2. Take measures to ensure that no individuals are waiting naked to shower. 3. Continue the practice of including individuals on facility committees as appropriate. 4. Train the remaining dining room staff on Abuse and Neglect Reporting.
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Section J: First Amendment and Due Process

		5. As planned, share the survey data and analysis with the individuals and with staff.
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