Department of Human Services
Addictions and Mental Health Division
The Child Center
Site Review Report
May 3 & 4, and June 18, 2007

Background.

The Addictions and Mental Health Division (AMH) of the Department of Human Services conducted a site review of the psychiatric day treatment program at The Child Center as authorized by Oregon Revised Statute (ORS) 430.640. The AMH review was conducted to assess compliance with applicable Oregon Administrative Rules (OAR). The AMH site review team consisted of the following individuals:

- Jeannine Beatrice, Children's Quality Improvement Coordinator, AMH
- Judy Rinkin, Family Partnership Specialist, AMH
- Rita McMillan, Children's Mental Health Specialist, AMH
- Stan Gilbert, Peer Reviewer, Oregon Association of Treatment Centers
- Robert McKelvey, MD, Child Psychiatrist, Oregon Health and Science University

Applicable Administrative Rules.

OAR 309-012-0130 through 309-012-0220, "Certificates of Approval for Mental Health Services." Effective date: August 14, 1992.

OAR 309-032-1100 through 309-032-1230, "Standards For Children's Intensive Mental Health Treatment Services." Effective date: February 15, 2000.

Findings.

The review of The Child Center included a review of clinical records, program policies, and documents. The review team interviewed The Child Center administrative and treatment staff, community representatives, board members, and

family representatives. The review team also observed treatment review meetings and classroom and milieu activities.

The review team identified four areas of non-compliance with applicable OARs requiring corrective action. For each area of non-compliance, the applicable OAR is referenced in italics, a statement of the Finding is described, and the Required Actions are listed with the due date for the completion of the required corrective action.

Areas of Strength.

1. Education and treatment services are integrated in the classroom and in the documentation. The director and supporting staff members foster relationships between the education and mental health system, which appears to create seamless integration in the classroom.

2. The longevity of treatment staff members and the strong core of clinical supervision maintain a culture that is child and family friendly and progressive.

3. The family members report that they love the success that they experience here with their children.

4. The program uses a strength-based approach that is evident in the classroom as well as in the documentation. The Child Center has a history of progressively and creatively working to keep children in the least restrictive treatment environment.

5. The communication systems, both formal and informal, are set up to allow for feedback between staff members and administrators.

6. The clinical record has quality documentation, providing a clinical story of the family and child.

7. The Child Center benefits from a long-term relationship with their well-respected consulting psychiatrist, Dr. Dennis Reynolds. Dr. Reynolds maintains connections in the community with primary care physicians and with the agency's consulting child psychiatrists, which is documented in the clinical record.

8. The quality of psychiatric care at The Child Center benefits from the contribution of their part-time nurse, Lori Fisher. For example, she documents relevant health information such as lab results, Body-Mass Index, and height and weight. The nurse also acts as a resource to staff members if needed for a child's more common (allergies) or uncommon (diabetes) medical needs.

9. Personnel files are complete and organized.

10. The policy and procedure manual holds policies that are organized numerically and are all in one place. Policies and procedures are easy to locate.

11. The Board of Directors report that they receive quality assessment and quality improvement reports. They are responsive to the needs of the community as well as aware of the limitations of the agency. The members are linked to local community resources and provide good oversight of the workings of the program.

12. The Quality Management Committee represents families, the community, and the agency's treatment approach. The performance indicators listed in the quality management plan are actively monitored.

13. The Center's Executive Director, Bill Wellard, is actively involved in the community. He is very aware of the workings of the children's mental health system and is well respected by his staff.

Required Actions.

1. 309-032-1190 Special Treatment Procedures

(7) Application for the use of seclusion. Any facility or program in which the use of seclusion occurs shall be authorized by the Division for this purpose and shall meet the following requirements:
(a) A facility or program seeking authorization shall submit a written application to the Division;
(b) Application shall include a comprehensive plan for the need for and use of seclusion of admitted children and copies of the facility's policies and procedures for the utilization and monitoring of seclusion including a statistical analysis of the facility's actual use of seclusion, physical space, staff training, staff authorization, record keeping and quality management practices;

(c) The Division shall review the application and, after a determination that the written application is complete and satisfies all applicable requirements, shall provide for a review of the facility by authorized Division staff;
(d) The Division shall have access to the records of the facility's clients, the physical plant of the facility, the employees of the facility, the professional credentials of employees, and shall have the opportunity to observe fully the treatment and seclusion practices employed by the facility;
(e) After the review, the Assistant Administrator or designee shall approve or disapprove the facility's application and if, approved, shall certify the facility based on the determination of the facility's compliance with all applicable requirements for the seclusion of children;
(f) If disapproved the facility shall be provided with specific recommendations and have the right of appeal to the Division; and
(g) Certification of a facility shall be effective for a maximum of three years and may be renewed thereafter upon approval of a renewal application.
(8) Structural and physical requirements for seclusion. Any facility or program in which the use of seclusion occurs shall be certified by the Division for this purpose. A provider seeking this certification under these rules shall have available at least one room that meets the following specifications and requirements:
(a) The room must be of adequate size to permit three adults to move freely and allows for one adult to lie down. Any newly constructed room shall be no less than 64 square feet;
(b) The door must open outward and contain a port of shatterproof glass or plastic through which the entire room may be viewed from outside;
(c) The room shall contain no protruding, exposed, or sharp objects;
(d) The room shall contain no furniture. A fireproof mattress or mat shall be available for comfort;
(e) Any windows shall be made of unbreakable or shatterproof glass, or plastic. Non-shatterproof glass shall be protected by adequate climb-proof screening;
(f) There shall be no exposed pipes or electrical wiring in the room. Electrical outlets shall be permanently capped or covered with a metal shield secured by tamper-proof screws. Ceiling and wall lights shall be recessed and covered with safety glass or unbreakable plastic. Any cover, cap or shield shall be secured by tamper-proof screws;
(g) The room shall meet State Fire Marshal fire, safety, and health standards. If sprinklers are installed, they shall be recessed and covered with fine mesh screening. If pop-down type, sprinklers must have breakaway strength of under 80 pounds. In lieu of sprinklers, combined smoke and heat detector shall be used with similar protective design or installation;

(h) The room shall be ventilated, kept at a temperature no less than 64°F and no more than 85°F. Heating and cooling vents shall be secure and out of reach;
(i) The room shall be designed and equipped in a manner that would not allow a child to climb off the ground;
(j) Walls, floor and ceiling shall be solidly and smoothly constructed, to be cleaned easily, and have no rough or jagged portions; and
(k) Adequate and safe bathrooms shall be available.

309-032-1110 Definitions *(77) "Seclusion" means the involuntary confinement of a child alone in a specifically designed room from which the child is physically prevented from leaving.*

Finding #1: The Child Center has three rooms that are used to seclude children. Two of the rooms do not meet the standards set in the OAR and are not certified as seclusion rooms at this time. One room located in the back classroom (referred to as the newest seclusion room) is useable, however, it is very small and children would need to be transported or escorted to the room. Physically escorting children is an intervention that has a high risk for injury to children. It should also be noted that at any point that the child is not allowed to leave the room, even if the door is technically unlocked, this becomes a seclusion and must be documented as a seclusion.

Required Action #1: The Child Center shall provide AMH with evidence that the rooms used for seclusion interventions meet the standards set forth in the rules. In keeping with The Child Center's Behavior Management policy and the treatment philosophy, it is recommended that the seclusion rooms be renovated to reflect a more comfortable and safe space, and that the doors be removed. **Due Date: October 5, 2007**

2. 309-032-1130 General Treatment Requirements
(5) Individual Plan of Care Review. A written summary of each individual plan of care review shall be filed in the child's clinical record. Revisions shall be implemented as necessary based on each child's individualized response to the treatment interventions.
(40) "Individual plan of care" means the written plan developed by a QMHP for active treatment for each child admitted to an intensive treatment service program. The individual plan of care specifies the DSM diagnosis, goals, measurable objectives, and specific treatment modalities and is based on a completed mental health assessment or comprehensive mental health assessment of the child's functioning and the acuity and severity of psychiatric symptoms.

Finding #2: The Child Center creates an initial plan of care with goals and objectives. The Center then writes a narrative review of the child's progress on a monthly basis. However, the reviewers were unable to determine how or if objectives are revised after those initial plan of care objectives are either met or determined unobtainable as written. The reviewers were also unable to determine how the child is progressing with interventions designed to address a particular diagnosis. For example, at intake, a child is diagnosed with a mixed receptive expressive language disorder, speech and language services are noted as a weekly intervention, but no specifics on what these services were or how the child progressed were located.

Required Action #2: The Child Center shall provide AMH with evidence that objectives are revised as necessary based on the child's individualized response to the treatment interventions. **Due Date: October 5, 2007**

3. OAR 309-032- 309-032-1130 General Treatment Requirements

(3) Assessment.

(b) A comprehensive mental health assessment shall be conducted by the provider's interdisciplinary team and be completed within 30 treatment days after admission.

OAR 309-032-1110 Definitions

(16) "Comprehensive mental health assessment" means the written documentation by a QMHP of the child's presenting mental health problem(s) and mental status; and emotional, cognitive, family, substance use, behavioral, social, physical, nutritional, school or vocational, recreational and cultural functioning; and developmental, medical and legal history. A comprehensive mental health assessment is collected through interview with the child, family and other relevant persons; review of previous treatment records; observation; and psychological and neuropsychological testing when indicated. The comprehensive mental health assessment concludes with a completed DSM five axis diagnosis, clinical formulation, prognosis for treatment, and treatment recommendations. The comprehensive mental health assessment is used to document the need for mental health services and to develop or update the child's individual plan of care.

(54) "Mental health assessment" means the written documentation by a QMHP of the child's presenting mental health problem(s) and relevant child and family history, mental status examination and DSM 5-axis diagnosis or provisional diagnosis.

Finding #3: The Child Center completes an initial mental health assessment prior to the child's first day in the program. This mental health assessment includes most of the domains required in the comprehensive mental health assessment document (which is not due until 30-days after admission). However observation or results from testing is not included. It appears that because of the thorough initial mental health assessment, the program has abandoned the comprehensive mental health assessment requirement.

Required Action #3: The Child Center shall provide AMH with evidence that a comprehensive mental health assessment is completed within 30-days after admission. **Due Date: October 5, 2007**

4. 309-032-1120 General Conditions of Participation for Children's Intensive Mental Health Treatment Services Providers

Providers delivering children's intensive mental health services shall:
(6) Demonstrate family involvement and participation in all phases of assessment, treatment planning and the child's treatment by documentation in the clinical record

Finding #4: Reviewers were unable to determine through reviewing the records, how the families were included in all phases of the assessment, treatment planning, and treatment of the children. For example, family members sign a separate signature page for the individual plan of care on dates after the plan is created and after the plan is reviewed by other interdisciplinary team members.

Required Action #4: The Child Center shall provide AMH with evidence that families are involved in all phases of the assessment, treatment planning, and treatment of the children. The Child Center shall provide AMH with evidence that the quality management plan and process is used to assess and monitor family involvement. **Due Date: October 5, 2007**

Summary.

The Child Center was found to be in "Substantial Compliance" with applicable OARs as defined by OAR 309-012-0130 through 309-012-0220. A total of 4 areas of non-compliance were identified which require corrective action. The Certificate of Approval issued to The Child Center is contingent upon completion and proven compliance of the corrective action requirements described in this report.

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