Department of Human Services
Health Services
Addictions and Mental Health Division
Family Friends, Inc.
Site Review Report
March 20 & 21, 2008

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 Family Friends, Inc. as authorized by Oregon Revised Statute 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
- Rita McMillan, children's mental health specialist, AMH
- Dan Strasser, peer reviewer, Oregon Association of Treatment Centers
- Michael Franz, MD, child psychiatrist consultant to AMH

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 psychiatric day treatment program at Family Friends, Inc. included a review of clinical records, program policies, and documents. The review team interviewed Family Friends, Inc. 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 two areas of non-compliance with applicable OARs requiring corrective action and two recommendations. 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. The Family Friends, Inc. Day Treatment Program is located in an area of Grants Pass that is accessible to the community. The facility is a space that offers multiple options for the children, staff members, and families to play, meet, and work.

2. The treatment assessment and treatment documentation is complete and thoughtful. The Individual Plan of Care format and the progress note formats are complete.

3. The staffing make-up in the Family Friends, Inc. Day Treatment Program includes clinical leadership with Qualified Mental Health Professionals and Qualified Mental Health Associates that are caring, thoughtful, engaging and cohesive. The kids appear engaged and responsive to the treatment team.

4. The clinical record is orderly with professional documentation. The face sheets have up-to-date emergency and other pertinent information for staff members to access.

5. Teachers and treatment team members are engaging with other treatment professionals such as occupational therapists for treatment modalities.

6. The membership on the Board of Directors is diverse and includes education, medical, business, and family representatives.

7. Personnel records are orderly and organized. All personnel had up-to-date training, and evaluations.

8. Families report that staff members and Family Friends, Inc. resources are accessible to them when needed, including their after-hours response.

9. The consulting psychiatrist, Dr. Patricia Ferguson is engaged with the team and with the community. Dr. Ferguson provides valued and quality psychiatric consultation.

Required Actions.

1. **OAR 309-032-1110 Definitions**

(49) "Manual restraint" means the act of involuntarily restricting a child's movement by holding the whole or a portion of a child's body in order to protect the child or others from injury. The momentary periods of physical restriction by direct contact with the child, without the aid of material or mechanical devices, accomplished with limited force, that prevent the child from completing an act that would result in potential physical harm to the child or others are not considered to be restraint.

OAR 309-032-1180 Behavior Management

(1) Providers shall have a written behavior management policy specifying which behavior management practices and restrictions may be used by staff and the circumstances under which they may be used. The behavior management policy shall:
(a) Establish a framework, which assures consistent behavior management practices throughout the program and articulates a rationale consistent with the provider's philosophy of treatment;
(b) Require the provider to obtain informed consent upon admission from the parent(s) or guardian in the use of behavior management practices and communicate both verbally and in writing the information to the parent(s) or guardian and the child in a developmentally appropriate manner;
(c) Establish thresholds and tracking mechanisms of behavior management interventions that will activate clinical review and which shall be relevant to the acuity and severity of symptoms, and developmental functioning of the population served by the provider;
(d) Require that when thresholds established in the policy are exceeded that the child's individual plan of care be reviewed and revised if necessary within no more than 24 hours and specifies the individual(s) in the program with designated clinical leadership responsibilities who must participate in the review, and specify that the review be documented in the child's clinical record;
(e) Describe the manner and regime in which all staff will be trained to manage aggressive, assaultive, maladaptive, or problem behavior and de-escalate volatile

situations through a Division approved crisis intervention training program, and require that such training shall occur annually; and
(f) Require that the provider review and update behavior management policies, procedures, and practices, minimally annually.
(2) Individual behavior management interventions will be developed, implemented, and reviewed for each child, review shall occur minimally at each individual plan of care review.
(3) Each staff directed behavior management intervention that isolates a child for more than 15 minutes shall be noted in the child's clinical record:
(a) The cumulative data shall be reviewed by the child's interdisciplinary team and be reported in the next required individual plan of care review summary;
(b) The individual plan of care shall outline use of this procedure, therapeutic alternatives, and methods to reduce its use; and
(c) Assure that when incidents of isolation for more than five hours in five days or a single episode of two hours the psychiatrist or designee shall within 24 working hours convene by phone or in person individual(s) in the program with designated clinical leadership responsibilities to review the child's individual plan of care and behavior management interventions and make necessary adjustments. This information shall be documented in the child's clinical record and referred to the Special Treatment Procedures Committee.
Stat. Auth.: ORS 430.041, 430.640(1)(h) & ORS 743.556
Stats. Implemented: ORS 430.630
Hist.: MHD 6-2000, f. & cert. ef. 2-15-00

309-032-1190 Special Treatment Procedures
(1) Providers shall have policies and procedures and a quality management system to:
(a) Monitor the use of special treatment procedures to assure that children are safeguarded and their rights are always protected
(6) General Conditions of Manual Restraint and Seclusion.
(a) There shall be a systematic approach, documented in written policies and procedures to the treatment of children which employs individualized, preplanned alternatives to manual restraint and seclusion;
(b) Manual restraint and seclusion shall only be used in an emergency to prevent immediate injury to a child who is in danger of physically harming him or her self or others in situations such as the occurrence of, or serious threat of violence, personal injury or attempted suicide;
(c) Any use of manual restraint and seclusion shall respect the dignity and civil rights of the child;

(d) A child shall be manually restrained or secluded only when clinically indicated and alternatives are not sufficient to protect the child or others as determined by the interdisciplinary team responsible for the child's individual care plan;
(e) The use of manual restraint and seclusion shall be directly related to the child's individual symptoms and behaviors and the acuity of the symptoms and behaviors. Manual restraint and seclusion shall not be used as punishment, discipline, or for the convenience of staff;
(f) Manual restraint and seclusion shall only be used for the length of time necessary for the child to resume self-control and prevent harm to the child or others;
(g) If manual restraint and seclusion are considered as part of the child's individualized safety needs, then alternatives to manual restraint and seclusion shall be identified and made a part of the child's individual plan of care. The individual plan of care shall outline use of this procedure, and goals addressing therapeutic alternatives and interventions to reduce its use; and
(h) Each incident of manual restraint and seclusion shall be referred to the Special Treatment Procedures Committee.
(A) Manual Restraint:
(i) Each incident of manual restraint shall be documented in the clinical record. The documentation shall specify less restrictive methods attempted prior to the manual restraint, the required authorization, length of time the manual restraint was used, the events precipitating the manual restraint, assessment of appropriateness of the manual restraint based on threat of harm to self or others, assessment of physical injury, and the child's response to the intervention;
(ii) A minimum of two staff shall implement a manual restraint. If in the event of an emergency a single staff manual restraint has occurred, the provider's on-call administrator shall immediately review the intervention;
(iii) A manual restraint intervention that exceeds 30 minutes shall require a documented review and authorization by a QMHP, interventions which exceed one hour shall require a documented review and authorization by a psychiatrist or designee; and
(iv) A designated individual with clinical leadership responsibilities shall review the manual restraint documentation prior to the end of the shift in which the intervention occurred.
(v) If incidents of manual restraint used with an individual child cumulatively exceed five hours in five days or a single episode of one hour, the psychiatrist or designee shall within 24 hours convene by phone or in person individual(s) in the program with designated clinical leadership responsibilities to review the child's individual plan of care and/or behavior management interventions and make

necessary adjustments. This information shall be documented in the child's clinical record and referred to the Special Treatment Procedures Committee.

Finding #1: Reviewers were unable to determine if the Special Treatment Procedures and the Behavior Management Policies are reviewed and, if needed, revised annually. Through review of the clinical records and through observation, the use of the quiet rooms are concerning because they appear to be unintentional seclusions. For example, one child was not allowed to leave the quiet room until s/he cleaned the quiet room window, another child was told that he could not have the door open while he was in the quiet room and that the door must be closed while he was in the quiet room. The use of the time-outs and the quiet rooms appear to be used coercively; time-outs also appear to be employed for everyone and is not tied to individualized plans. For example, it is documented that children are told that they must go to the quiet room on their own or be taken there by staff members; the use of physical assists or escorts are not documented as being used consistently, and are possibly restraints.

Required Action #1: Family Friends, Inc. shall provide AMH with evidence that the Behavior Management Policies and the Special Treatment Procedures meet the standards of the rule. These policies are to be reviewed and if needed revised, on an annual basis. Family Friends, Inc. shall provide AMH with evidence that the child's behavior support options are tied to their individualized plans and that options are not coerced. Family Friends, Inc. shall provide AMH with evidence that restraints (including escorts and physical assists that involuntarily restrict a child's movement) are documented appropriately. **Due Date: July 28, 2008**

Recommendation #1: It is recommended that Family Friends, Inc. conduct an audit of incident report documentation in the clinical records to review for coercive language and escorts that are restraints. It is further recommended that Family Friends, Inc. involve an external consultant who can provide professional advice on the program's behavior support system and to involve family members and adolescents in the policy and procedure reviews.

2. **OAR 309-032-1110 Definitions**
(53) "Medication service record" means the documentation of written or verbal orders for medication, laboratory and other medical procedures issued by a Licensed Medical Practitioner employed by, or under contract with, the provider and acting within the scope of his or her license. The provision of medication

services is documented in written progress notes and/or medication administration records and placed in the client's record.

309-032-1160 Establishing and Maintaining Clinical Records

(6) Providers shall insure that each clinical record includes the following documentation:
(f) Completed medical history including current prescribed medications and allergies;

309-032-1140 General Staffing and Personnel Requirements

(1) Providers of children's intensive mental health treatment services shall have the clinical leadership and sufficient QMHP, QMHA and other staff to meet the 24-hour, seven days per week treatment needs of admitted children and shall establish policies, contracts and practices to assure:
(a) Availability of psychiatric services to meet the following requirements:
(A) Provide medical oversight of the clinical aspects of care in nationally accredited sub-acute, assessment and evaluation programs and residential psychiatric treatment programs and provide 24-hour, seven days per week psychiatric on-call coverage; or consult on clinical care and treatment in psychiatric day treatment, partial hospitalization, therapeutic group homes and treatment foster care programs;
(B) Assess each child's medication and treatment needs, prescribe medicine or otherwise assure that case management and consultation services are provided to obtain prescriptions, and prescribe therapeutic modalities to achieve the child's individual plan of care goals;

309-032-1150 System of Care

(1) General Requirements. All ITS providers described in this section shall meet the following general requirements:
(a) Active psychiatric treatment and education services shall be functionally integrated in a therapeutic milieu designed to promote achievement of goals and treatment objectives developed in each child's individual plan of care.
(c) ITS providers shall maintain linkages with primary care physicians, CMHPs and MHOs and the child's parent(s) or guardian to plan for necessary continuing care resources for the child.
(f) ITS providers shall ensure that the following services be available and accessible through direct service, contract or by referral:
(A) Psychiatric and psychological assessment and treatment;
(C) Medication evaluation, management and/or monitoring;

Finding #2: The reviewers were unable to locate documentation that the program's consulting psychiatrist assessed each child's medications or that the program maintained documentation of the children's current medications. For example, one child's medication was noted as discontinued in February 2008 after the child had not received the medication for several days. A reason for the prolonged medication omission was not documented in the child's progress notes or medication service record. Though the physician order and the administration of the medication was not the responsibility of Family Friends, Inc. or the program's consulting psychiatrist, the program is responsible to maintain documentation of medication services, medical histories, current medications, and linkages with prescribing physicians.

Required Action #2: Family Friends, Inc. shall provide AMH with evidence that medication services, medical histories, current medications, and linkages with prescribing physicians are documented in the clinical records. **Due Date: July 28, 2008**

Recommendation #2: The medication service record and any medication that is to be dispensed at the program is located in a locked closet and behind another locked door. Medications are in the locked closet in a locked box. However, the three keys needed to access the medications are located in an unlocked staff office that is accessible to all staff. Two sets of the keys are located in this office. It is recommended that Family Friends, Inc. provide a means to monitor and control the access to the medications.

Summary.

The Family Friends, Inc. was found to be in "Substantial Compliance" with applicable OARs as defined by OAR 309-012-0130 through 309-012-0220. A total of two areas of non-compliance were identified which require corrective action. As specified by OAR 309-12-0200(1), the department may place conditions on approval of a provider because of failure to substantially comply with applicable rules as described in OAR 309-012-0210(2). The Certificate of Approval issued to Family Friends, Inc. is contingent upon completion and proven compliance of the corrective action requirements described in this report.