Department of Human Services
Health Services
Office of Mental Health and Addiction Services
Cascade Child Center, Inc.
Site Review Report
February 3 & 4, 2005

Background.

The Department of Human Services, Office of Mental Health and Addiction Services (OMHAS) conducted a site review of the Cascade Child Center, Inc. as authorized by Oregon Revised Statute 430.640. The OMHAS review was conducted to assess compliance with applicable Oregon Administrative Rules (OAR). The OMHAS site review team consisted of the following individuals:

- Jeannine Beatrice, Children's Quality Improvement Coordinator, OMHAS
- Ellen Pimental, Children's Mental Health Specialist, OMHAS
- Ivan Frasier, Peer Reviewer, Oregon Association of Treatment Centers
- Larry Marx, MD, Child Psychiatrist, Oregon Health and Sciences 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 psychiatric day treatment program at the Cascade Child Center, Inc. included a review of clinical records, program policies, and documents. The review team interviewed Cascade Child Center, 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 five 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. The direct-care staff members are clearly dedicated to their work and demonstrate a high level of skill in their interactions with the children and other members of the treatment team. They follow policy and leadership direction and perform their documentation duties effectively.

2. Participating school district representatives provided positive feedback regarding the referral process and transition process for children returning back into the community.

3. The clinical records made available to reviewers were well organized.

4. The program has maintained stability in service delivery despite recent budget fluctuations relating to state level cuts.

5. The members of the governing board are linked to local community resources and provide good oversight of the workings of the program. A mechanism to annually evaluate the Executive Director is established.

6. Weekly debriefing of youth progress is built into the program's schedule to discuss medication changes, behaviors, treatment ideas, and the schedule of staff. The staff members are knowledgeable of the youth and families.

7. The program has maintained a long-standing relationship with Dr. Godbey. This relationship has provided long-term stability to the program and has contributed to quality services for enrolled youth.

8. The psychiatrist is well integrated into the treatment planning and interventions, is connected with clients, and the staff. Dr. Godbey is

approachable to the team and documents youth progress and interventions in the clinical record. He attends the 30-day reviews and makes himself available to staff.

Findings and Required Actions.

1. **OAR 309-032-1160 Establishing and Maintaining Clinical Records**
(4) Signature of authors. All documentation required in this rule must be signed by the person providing the service and making the entry. Signature must include the person's academic degree or professional credential and the date signed. Documentation that is dictated shall also include the date of dictation and date signed.
(6) Providers shall insure that each clinical record includes the following documentation:
(j) Progress notes documenting specific treatments, interventions, and activities related to the individual plan of care or have treatment planning implications, and the child's response to the specific treatment or activities;

Finding #1: Progress notes in the clinical records pertaining to family therapy progress were unsigned by the authors.

Required Action #1: The Cascade Child Center, Inc. must provide OMHAS with evidence that staff members are signing all documentation required in this rule.
DUE DATE: April 29, 2005

2. **OAR 309-032-1130 General Treatment Requirements**
(3) Assessment. (a) On admission the child shall have an initial plan of care based on a mental health assessment completed by a QMHP.

309-032-1110 Definitions As used in these rules:
(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.
(57) "Mental status examination" means the face-to-face assessment by a QMHP of a child's mental functioning within a developmental and cultural context that includes descriptions of appearance, behavior, speech, language, mood and affect, suicidal or homicidal ideation, thought processes and content, and perceptual

difficulties including hallucinations and delusions. Cognitive abilities are also assessed and include orientation, concentration, general knowledge, intellectual ability, abstraction abilities, judgment, and insight appropriate to the age of the child.

Finding #2: The reviewers found that not all clinical records contained a completed mental health assessment at the time of admission. In particular, the mental status examinations were either not found in some records or were not complete.

Required Action #2: The program shall provide OMHAS with evidence that mental health assessments are being completed at admission. The program shall also provide evidence that internal clinical record audits are a quality assurance task that is conducted and monitored regularly. **DUE DATE: April 29, 2005**

3. **309-032-1110 Definitions** As used in these rules
(73) "Quality Management" means a continuous process to simultaneously promote consistency of performance and to promote meaningful change in measurable objectives. The process is used to improve a provider's performance and adjust measurable objectives and benchmarks.

309-032-1200 Quality Management
(2) The overall scope of the Quality Management process is described in a written plan which identifies mechanisms, committees or other means of assigning responsibility for carrying out and coordinating the Quality Management process activities, and which includes:
(d) Follow-up mechanisms.
(3) The written Quality Management Plan shall describe the implementation and ongoing operation of the functions performed by the Quality Management Committee.
(a) The plan shall be reviewed and revised annually; and
(b) The provider's board shall review the annual Quality Management report and approve the annual Quality Management plan.
(5) The provider shall have a Quality Management Committee that meets at least quarterly. The Quality Management Committee shall be composed of:
(b) A representative or representatives of the children and families served;
(7) The Quality Management process is conducted with input from children, families, and community stakeholders.

Finding #3: A continuous cycle of quality assessment is occurring at the Cascade Child Center, Inc. However, there are components of the quality management system that do not meet the ITS standards. The quality management plan has not been revised since February 2002. It is unclear as to how the gathered data is used to improve quality. The quality management plan does not include provisions or activities to evaluate services between the center and other entities associated with the child and family. The quality management plan does not include how the quality assurance activities will be followed-up with to improve quality. The quality management committee does not have a representative of the children or families served; the process is conducted without input from families.

Required Action #3: The Cascade Child Center, Inc. must provide OMHAS with a revised quality management plan that complies with the relevant OARs. **DUE DATE: April 29, 2005**

4. **309-032-1100 Purpose and Statutory Authority**
(1) Purpose. These rules prescribe standards and procedures for intensive mental health treatment services for children within a comprehensive system of care. The goal of these services is to maintain the child in the community in the least restrictive treatment setting appropriate to the acuity of the child's disorder. The system of care shall be child and family-centered and community-based with the needs of the child and family determining the types and mix of services provided. These services may be as intensive, frequent and individualized as is medically appropriate to sustain the child in treatment in the community.

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;

309-032-1130 General Treatment Requirements
(1) Admission. Providers shall plan admissions, help the child and family understand the reason for admission, give admission consideration to children that realistically allows the child's family to participate in treatment, and advise the family on transportation arrangements when needed.
(4) Active Treatment and Individual Plans of Care.

(b) The individual plan of care shall clinically support the level of care to be provided and shall:
(A) Be developed and implemented no later than 14 treatment days after admission by an interdisciplinary team in consultation with the child, the parent(s) or guardian and the provider to which the child will be discharged;
(6) Discharge Planning and Coordination.
(a) Providers shall establish written policies and practices for identifying, planning and coordinating discharge to after-care resources. At a minimum, the provider's interdisciplinary team shall:
(C) Include the parent, guardian and provider to which the child will be discharged in discharge planning and reflect their needs and desires to the extent clinically indicated;

Finding #4: Family involvement was very difficult to monitor in this review. Evidence that families were involved in a child's treatment was limited to therapist progress notes on family therapy participation, signed consent forms, and signatures of family members demonstrating that they reviewed or attended an individual plan of care review. Family involvement in all phases of assessment, treatment planning and the child's treatment was not demonstrated in the clinical records.

Required Action #4: The Cascade Child Center, Inc. must provide OMHAS with evidence that their services are child and family-centered with the needs of the child and family determining the types of services provided. The evidence must demonstrate family involvement and participation in all phases of assessment, treatment planning and the child's treatment. **DUE DATE: April 29, 2005**

5. OAR 309-032-1190 Special Treatment Procedures
(6) General Conditions of 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;
(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;
(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;

Finding #5: Reviewers found that the documentation in the clinical record did not specify the events precipitating the manual restraints, the assessment of the appropriateness of the manual restraints, or the child's response to the intervention. Mainly, the documentation only covered the student's behavior. Less restrictive methods attempted prior to the manual restraint were documented, but were limited to only five choices. Reviewers also found that manual restraints were documented as being used when there was not an emergency to prevent immediate injury to a child or others. For example, one child was restrained for behaviors documented as yelling, swearing, climbing a door jam, making animal noises, kicking the wall with intent to destroy property, tearing up books, and name calling. The Cascade Child Center, Inc. policy on intervention techniques documents that a child can be transported to the "quiet room" for a time out if the child is unable to "do a time out without disrupting the group." Also, the Protective Hold Log form includes "G3-protect child from harming property" as a reason or goal of using a manual restraint intervention.

Required Action #5: The Cascade Child Center, Inc. must provide OMHAS with evidence that factors precipitating a manual restraint are being documented, that the child's response to the manual restraint intervention is being documented, and that the intervention is assessed for appropriateness. The program must provide OMHAS with evidence that their policies reflect that manual restraints must 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. **DUE DATE: April 29, 2005**

Summary.

The Cascade Child Center, 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 five 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 Cascade Child Center, Inc. is contingent upon completion and proven compliance of the corrective action requirements described in this report.