Department of Human Services
Health Services
Office of Mental Health and Addiction Services
Morrison Child and Family Services
Edgefield Children's Services
Site Review Report
October 6 & 7, 2005

Background.

The Department of Human Services, Office of Mental Health and Addiction Services (OMHAS) conducted a site review of the psychiatric day treatment and psychiatric residential treatment programs with Edgefield Children's Services. The OMHAS site review was conducted as authorized by Oregon Revised Statute 430.640 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
- Len R. Peavy, Quality Improvement & Certification Manager, OMHAS
- Ellen Pimental, Children's Mental Health Specialist, OMHAS
- Frank Kennedy, Peer Reviewer, Children's Array of Psychiatric Programs
- Tom Gunderson, Peer Reviewer, Oregon Association of Treatment Centers
- Kerry Blum, Peer Reviewer, Children's Array of Psychiatric Centers
- Kyle Johnson, MD, Child Psychiatrist, Oregon Health and Science University

Applicable Administrative Rules and Regulations.

OAR 309-012-0130 through 309-012-0220, "Certificate 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.

OAR 309-034-0150 through 309-034-0320, "Medicaid Payment for Child/Adolescent Residential Psychiatric Treatment Services." Effective date July 5, 2001.

Code of Federal Regulations (CFR), Title 42, Volume 3, Chapter IV Centers for Medicare and Medicaid Services, Department of Health and Human Services, Part 441, Subpart D Inpatient Psychiatric Services for Individuals Under Age 21 in Psychiatric Facilities or Programs. Revised as of October 1, 2004

Findings.

The review of Edgefield Children's Services included a review of clinical records, program policies, and documents. The review team interviewed Edgefield Children's Services 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 5 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 educational services through the school district is designed to promote achievement of academic and social success in the child's home school.

2. The treatment coordinators appear to like the children, are hungry for knowledge about good child-caring skills, are embracing the cultural changes of the agency, and interact respectfully with the children.

3. The psychiatrist pays attention to both medical detail and the children's mental health system in Oregon. Dr. Ajit Jetmalani is well respected in his field.

4. The Quality Assessment and Improvement process is well detailed; data are made into information that is available to staff to use. Administrators described several examples of how the agency used their Quality Management system to improve services.

5. The core group of leaders at Edgefield Children's Services has a clear concept of "team," and are seen as approachable.

6. The agency has a system to integrate families in both individual treatment decisions and program decisions.

7. The agency has made visible facility improvements to the residential building.

8. Staff members shared a sense of "team" and camaraderie, and believe that they have a voice in the process, have access to their administrators, and are supported by the agency.

Required Actions.

1. **OAR 309-032-1110 Definitions** As used in these rules: *(35) "Formal complaint" means the expression in a manner appropriate to the child or family/guardian of dissatisfaction or concern about the provision or denial of services that is the responsibility of the provider under these rules. The formal complaint can be expressed by a child or by the child's representative.*

OAR 309-032-1170 Child and Family Rights

(20) Right of formal complaint. The child, parent or guardian or child's representative shall have the right to assert formal complaints concerning denial of any rights contained in this section in a fair, timely and impartial formal complaint procedure. There shall be no retaliation or punishment for exercise of any rights contained in this section.

OAR 309-032-1210 Formal Complaints

(1) The child, or the person consenting to the child's treatment, has the right to file an oral or written formal complaint with the entity providing services and receive a timely response. All providers will:

(b) Designate a staff person to coordinate formal complaint information, receive formal complaint information, assist any person who needs assistance with the process, and enter the information into a log. The log will identify, at a minimum, the person lodging the formal complaint, the date of the formal complaint, the nature of the formal complaint, the resolution and the date of the resolution.
(c) Have written procedures for informing children and their legal guardian orally and in writing about the provider's formal complaint procedures.

Finding #1: Edgefield Children's Services has policies and procedures for children and their families to file complaints; however, by interview, staff members were not aware of a way for children to file a complaint other than speaking to a staff member.

Required Action #1: Edgefield Children's Services shall provide OMHAS with evidence that children have a means to file complaints unencumbered by staff members. Evidence needs to be reflected in both policy and procedure, staff training and orientation, and in the areas where the children live and go to school.

2. **OAR 309-032-1190 Special Treatment Procedures**
(4) The provider shall establish a Special Treatment Procedures Committee or designate this function to an already established Quality Management Committee. Committee membership shall minimally include a staff person with designated clinical leadership responsibilities, the person responsible for staff training in crisis intervention procedures, and other clinical personnel not directly responsible for authorizing the use of special treatment procedures with individual children. The committee shall:
(b) Conduct individual and aggregate review of incidents of seclusion and manual restraint;
(c) Conduct individual and aggregate review of incidents of isolation for more than five hours in five days or a single episode of two hours;

Finding #2: Edgefield Children's Services employs their Special Treatment Procedures (STP) committee for the purpose of reviewing STPs (namely restraint and seclusion use). However, the meeting that the review team attended and a history of STP Committee meeting minutes reflect that individual incidents are reviewed.

Required Action #2: The program's STP Committee shall conduct individual reviews of all seclusions and manual restraints. Edgefield Children's Services shall

provide OMHAS with meeting minutes from their STP committee meetings on a monthly basis.

3. **OAR 309-032-1110 Definitions** As used in these rules: *(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.*

(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.

OAR 309-032-1130 General Treatment Requirements

(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;
(B) Be based on a mental health assessment of the child's functioning, the acuity and severity of the child's psychiatric symptoms, diagnosis, and the biological, medical, psychological and sociocultural factors that influence the child's development and functioning;
(C) State treatment goals and measurable and observable objectives;
(D) Prescribe an integrated program of therapies, activities, interventions and experiences designed to meet the goals;

OAR 309-032-1160 Establishing and Maintaining Clinical Records

(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 #3: The progress notes, Individual Plans of Care (IPOC), and mental health assessments in the clinical records were not connected to one another. For example, the progress notes did not reflect goals of the child and family or the interventions of the staff as stated in the IPOC. The IPOC goals and interventions did not appear to be based on the mental health assessments. Most of the assessments (mental health assessment, educational, medical, psychiatric) were written by several different people, but then not coordinated or put together into the comprehensive mental health assessment.

Required Action # 3: Edgefield Children's Services shall provide OMHAS with evidence that a) the IPOC is developed by an interdisciplinary team based on the child's mental health assessment, b) the progress notes are related to the IPOC, and c) the Qualified Mental Health Professionals are organizing information from the interdisciplinary team into all of the required domains of the comprehensive mental health assessment.

4.**OAR 309-032-1130 General Treatment Requirements**
(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:
(E) Include a discharge plan to ensure continuity of care with the child's family, school, and community upon discharge;
(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:
(A) Integrate discharge planning into ongoing treatment planning and documentation from the time of admission, and specify the discharge criteria that will indicate resolution of the symptoms and behaviors that justified the admission;
(B) Review and, if needed, modify the discharge plan every 30 days;
(c) Providers shall notify the child's parent(s) or guardian and the provider to which the child will be discharged of the anticipated discharge dates at the time of admission and when the discharge plan is changed.

Finding #4: The review team found that the IPOCs in the clinical records are missing discharge-planning documentation.

Required Action # 4: Edgefield Children's Services shall provide OMHAS with evidence that the IPOCs include discharge plans that are comprehensive and are updated by the treatment team.

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;
(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;
(B) Seclusion:
(vi) Each incident of seclusion shall be documented in the child's clinical record. The documentation shall include the clinical justification for use, the written order by the authorized individual, the less restrictive methods attempted, length of time the seclusion was used, the precipitating events, assessment of appropriateness of the intervention based on threat of harm to self or others, assessment of physical injury, and the child's response to the intervention;

42CFR483.370 Post intervention debriefings.

(a) Within 24 hours after the use of restraint or seclusion, staff involved in an emergency safety intervention and the resident must have a face-to-face discussion. This discussion must include all staff involved in the intervention except when the presence of a particular staff person may jeopardize the well being of the resident. Other staff and the resident's parent(s) or legal guardian(s) may participate in the discussion when it is deemed appropriate by the facility. The facility must conduct

such discussion in a language that is understood by the resident's parent(s) or legal
guardian(s). The discussion must provide both the resident and staff the opportunity to discuss the circumstances resulting in the use of restraint or seclusion and strategies to be used by the staff, the resident, or others that could prevent the future use of restraint or seclusion.
(b) Within 24 hours after the use of restraint or seclusion, all staff involved in the emergency safety intervention, and appropriate supervisory and administrative staff, must conduct a debriefing session that includes, at a minimum, a review and discussion of--
(1) The emergency safety situation that required the intervention, including a discussion of the precipitating factors that led up to the intervention;
(2) Alternative techniques that might have prevented the use of the restraint or seclusion;
(3) The procedures, if any, that staff are to implement to prevent any recurrence of the use of restraint or seclusion; and
(4) The outcome of the intervention, including any injuries that may have resulted from the use of restraint or seclusion.
(c) Staff must document in the resident's record that both debriefing sessions took place and must include in that documentation the names of staff who were present for the debriefing, names of staff that were excused from the debriefing, and any changes to the resident's treatment plan that result from the debriefings.

Finding #5: The check boxes available for staff to use to document clinical justification and the events precipitating the use of restraint and seclusion includes behavior descriptors such as "swearing" and "threatening to others". The incident report documentation is missing what is occurring at the debriefing. The debriefing documentation does not include alternative techniques that might have prevented the use of the restraint or seclusion or the procedures that staff are to attempt to prevent the recurrence of the use of restraint or seclusion. The documentation does not include the names of all of the staff that were present for the debriefing, or any changes to the child's treatment plan that resulted from the debriefing. The comment reviewers found most often in the "Debrief of Incident" section of the incident report read "no new information at this time."

Required Action # 5: Edgefield Children's Services shall provide OMHAS with evidence that each occurrence of 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. Edgefield shall

provide OMHAS with evidence that documentation of the "debrief" sessions includes topics as outlined in the CFRs and OARs.

Summary.

The psychiatric day treatment and psychiatric residential treatment programs with Edgefield Children's Services was found to be in "Substantial Compliance" with applicable OARs as defined by OAR 309-012-0130 through 309-012-0220 "Certificate of Approval for Mental Health Services." A total of 5 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 Edgefield Children's Services is contingent upon completion and proven compliance of the corrective action requirements described in this report.