UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA

James and Lorie Jensen, as parents, Guardians and next friends of Bradley J. Jensen, *et al.*,

Plaintiffs,

v.

Minnesota Department of Human Services, an agency of the State of Minnesota, *et al.*,

Defendants.

Civil No. 09-1775 (DWF/FLN)

MEMORANDUM TO THE COURT: HAZARDS AND POSSIBILITIES DURING MSHS-CAMBRIDGE'S FINAL MONTHS

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April 22, 2014

MEMORANDUM TO THE COURT:
HAZARDS AND POSSIBILITIES DURING MSHS-CAMBRIDGE'S FINAL MONTHS

This Memorandum to the Court expresses serious concern that, in the closing months of MSHS-Cambridge's existence, the remaining clients not be "orphaned" and denied the safety, protection and treatment to which they are entitled under the Court's orders. This is the first state operated institution in Minnesota to close pursuant to a court order.[1] This is a liminal moment, one with both hazards and possibilities. The Cambridge closure requires vigilance.

This Memorandum to the Court:

- Finds deficiencies in staff training, fidelity to a behavioral program, and other factors which contributed to the use of a manual restraint on a client by two staff who were not competent or trained to implement her program and behavioral plan.
- Notes the existence of a nearly blank Transition Plan for the client, although her placement from MSHS-Cambridge is to take place in the immediate future.
- Urges action to ensure that clients' have meaningful lives during Cambridge's final months.
- Points out DHS's failure to provide to the Court Monitor documentation of analysis of restraint use; as to why this is so, DHS responds, "we are not able to answer."

INTRODUCTION

Earlier this month, the Court Monitor posed questions to the Department of Human Services regarding the restraint of a current client at MSHS-Cambridge who had been restrained numerous times in recent months.

The Court Monitor first commends DHS for its forthright response to the Monitor's inquiry, including its agreement that there are deficiencies to be addressed. Such candor is essential to progress. Effective corrective action must follow as well and DHS has committed to take specific steps.[2] Also, the prompt response by Dr. Richard Amado, the DHS Internal Reviewer, to the Court Monitor's request for inquiry is also appreciated. The Court Monitor expects DHS to implement his recommendations.

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[1] Minnesota's closure of the Fergus Falls institution in the earlier 2000s was not under a court order. The court orders in the 1970s and 1980s in the *Welsch v. Likins* case did not require institutional closures.

[2] The corrective actions to be taken are stated by DHS in Exhibit B to this report. Each action would contribute to progress if implemented. This report's focus is compliance and what has already occurred and thus perforce identifies a number of deficiencies.

The clients remaining at MSHS-Cambridge must not be orphaned during the closure process. The Court Monitor is concerned about the safety of clients and staff at MSHS-Cambridge and implementation of their programs, as he has stated to the parties in recent weeks. Cambridge was set to close March 27, 2014, a "hard date," the Monitor was informed a few months ago. Five clients continue to live at Cambridge. Cambridge admissions stopped March 4, 2014. The DHS *Semi-Monthly Update on the Comprehensive Plan of Action* (Dkt. 289) states that current residents will move to the community by June 30, 2014 (EC 95) and also that Cambridge will be "closed" August 31, 2014 (EC 88).

In response to the Monitor's inquiry here, DHS states that it is seeking to address staff competence, training and safety issues. It separately and disturbingly has acknowledged that "for some employees," safety is equated with "a show of force, power and control. It is a legacy of the old institutional way and not the direction we are headed."

This acknowledgement by DHS suggests that there is reason to believe that the circumstances faced by AM, described below, may be common to those affecting the other Cambridge residents.

DHS would be well advised to vigorously address the situation at MSHS-Cambridge because it is the right thing to do and it is required by the Court's orders. Doing so is in the interest of preventing possibly tragic harm to clients or staff.

CLIENT AM: THE CONTEXT AND IMPLICATIONS OF THE APRIL 6, 2014 RESTRAINT INCIDENT

MSHS-Cambridge client AM was manually restrained on April 6, 2014. This was the most recent of multiple restraints of AM at Cambridge. On April 8, 2014, the Court Monitor requested DHS to provide responses to questions arising from that restraint, and also requested the Internal Reviewer to examine the situation. [3] DHS responded April 17, 2014.[4] The Internal Reviewer's report is dated April 11, 2014.[5] The findings below are based on the above documents and on other referenced material.

[3] Exhibit A below (April 8, 2014 Court Monitor Memorandum to DHS).

[4] Exhibit B below (April 17, 2014 DHS Response).

[5] Exhibit C below (April 11, 2014 Internal Reviewer Report).

A. MSHS-Cambridge Inappropriately Failed to Communicate a Clinical Decision to Direct Care Staff

The April 6, 2014 incident began when AM "was upset and wanted to go for an independent walk. The direct care staff "was not aware if AM's team had approved independent walk/s."[6] Staff did not let her take that walk. She became upset, and slapped another client. A minute-long restraint immediately ensued. AM was forcibly taken down to the ground by the direct care staff.

Had the direct care and professional clinical staff communicated properly, and staff been trained as required (see below), the incident would not likely have happened in the way it did.

Supervision and permissions for walks/travel must be documented in clients' charts, and summarized in a formal document on the unit. DHS' response to the Monitor's inquiry states that there was a March 28, 2014 email sent to staff stating that AM "can come to the op/center without staff (by herself).

In addition, DHS' response states that there was conversation between clinical staff and AM on April 4 (Friday) about extending AM's independent walking time and that this would be discussed April 7 (Monday). DHS states, "This conversation was not adequately communicated to Home 8 staff." DHS' letter to the Monitor does not state whether that conversation was communicated at all to Home 8 staff.

Inadequate communication among staff caring for AM is nothing new. During the prior six months, the Internal Reviewer repeatedly had recommended that staff communications with AM be improved to avoid misunderstanding, and that staff be trained to implement her behavior support plan "with fidelity."[7]

B. The Direct Care Staff Did Not Follow AM's Behavior Support Plan

The staff did not follow AM's Behavior Support Plan. AM's Behavior Support Plan includes multiple detailed actions to be taken when circumstances begin to escalate, and, in addition, more than a half dozen steps to be followed when there is an aggressive behavior.

The staff's official narrative on the form for Emergency Use of Mechanical Restraint states in the description that only "negotiation" was employed; in the check-off box portion of the form, "one-to-one" and "listening and talking in a supportive way" are checked. The check-off box portion also states that "Contact with Behavioral Staff"

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[6] Incident Report, April 6, 2014.

[7] Internal Reviewer, *MSHS-Cambridge Use of Emergency Procedures Monthly Follow-up,*

was tried. However, this is not true. There is no indication in the report that this occurred.

The staffs' description of their response does not show any awareness of the depth and flexibility of AM's behavior plan.

C. The Direct Care Staff Were Not Competent or Trained to Implement AM's Program and Behavior Plan

The direct care staff were not competent or trained to implement AM's program and behavior plan.

There were two staff involved in the failure to respond appropriately to AM on April 6, 2014. The Internal Reviewer examined training records and concluded: "The available data support the conclusion that neither staff person was sufficiently competent and aware of AM's current program plan."[8]

After restraints, there is often a Consultation with Expanded Interdisciplinary Team EIDT) Following Emergency Use of Manual Restraint.[9] The EIDT reports of the January 16, 2014, January 20, 2014, January 24, 2014 restraints of AM, each recommended additional staff training and/or behavioral rehearsal to reduce the need for use of manual restraint. The Settlement Agreement requires that the recommendations be incorporated into the person's individual plan and thus must be implemented. The Internal Reviewer "did not find evidence of correlated training activities in the training records that were provided."

On March 30, 2014, one week prior to the April 6, 2014 incident, the EIDT recommended "Scheduling Behavioral practices twice a shift during awake hours." There is no indication that that occurred.

DHS' response states that it has "identified the need to enhance the efficiency and effectiveness of staff training." This is insufficient. It appears that, at least for AM, the results of the mandated EIDT process are being ignored.

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[8] The Internal Reviewer also found that there were "no items listed in the training records" for either staff person for program training specific to AM in 2014." In addition, the Internal Reviewer found no evidence or documentation that "any other HSSS [direct care] staff were trained in the current version of AM's program plan or prepared to implement the program procedures as prescribed."

[9] *See* Appendix A to the Settlement Agreement. The form for the EIDT review is DHS-3653.

D. AM's Transition Plan Was Essentially Blank

The Court Monitor requested AM's Transition Plan, "exactly as it existed on April 7, 2014," the day after the incident. The provided *Transition Plan and Summary*, an 18-page document, has 11 pages blank, including blanks for all support needs, a blank signature page, and blanks for any meeting date or plan author. DHS' April 17 response letter states that "[m]uch work has been done in the last two weeks" on this Plan.

E. Adoption of the Positive Support Transition Plan Is Confusing

There are three Positive Support Transition Plans. Two are not signed or dated. One of the three is signed, with a signature date of February 14, 2014. The "Projected Implementation Date" is January 1, 2014, a month and a half before the Plan was signed. Page 1 of the Plan states it was completed January 30, 2014.

F. DHS Failed to Provide the Court Monitor with the MSHS-Cambridge Emergency Intervention Reviews

DHS failed to provide the Court Monitor with the Internal Reviewer reviews of each incident report, as requested by the Monitor, and agreed to by DHS, in January 2014.[10] DHS is "not able to answer" why that failure occurred.

DHS states that "some [of these reviews] are signed and some are not" due to a "kink in this process," but that Dr. Amado, the Internal Reviewer, has reviewed each.

DHS states: "As to the question of why you are not receiving copies of each review, we are not able to answer – it was assumed that you received copies – we will need to work with the Internal Reviewer and the Jensen Implementation Team to correct the process."

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[10] On January 28, 2014, the Court Monitor requested DHS to provide him with the documentation of the Internal Reviewer's review of each restraint use at MSHS-Cambridge under a system developed in the prior months. On January 31, 2014, the Court Monitor confirmed: "I am expecting to receive, for each emergency intervention, the Cambridge leadership's review of the situation, the communication of that to the Internal Reviewer, and the Internal Reviewer's response, and the associated documentation."

G. Meaningful Lives

Apart from the findings above, the Court Monitor observes that there appears to be a need for the daily lives of current MSHS-Cambridge clients for meaningful activity. During his visit to Cambridge last month, one staff person described staff's current responsibility as "keeping clients entertained." Therapeutic group sessions seem to have ended. After a morning visit to the public library, one client had nothing scheduled for the entire day until a 3:00 PM departure to visit a group home. Another client sleeps until noon virtually every day. As MSHS-Cambridge enters its last months, DHS is encouraged to work with its clients to achieve a sense of vibrancy, activity and optimism.

CONCLUSION

AM requested her direct care staff in her living unit to permit her to take a walk on her own. Although AM's clinical staff eight days earlier had OK'd her taking a walk on her own, the direct care staff said "no" because they were unaware of that prior approval. A forced manual takedown ensued.

Deep reviews by the Court Monitor, DHS and the Internal Reviewer exposed a number of deficiencies which contributed to the restraint. Staff were untrained for the situation and communications failed. The results of the settlement-mandated post-restraint review procedure for prior incidents were ignored. DHS did not follow through on providing certain information to the Monitor.

There is no reason to believe that the deficiencies identified for AM do not extend to the remaining several other clients served at Cambridge. MSHS-Cambridge will close in the coming months. As stated at the beginning of this memorandum, this liminal moment poses a great challenge to DHS and the Cambridge leadership; that leadership is experiencing the complexity of this closure process. There are potential hazards and opportunities.

Respectfully, the Court Monitor provides these final comments and recommendations:

- It is extraordinarily important that DHS implement measures to ensure that direct care staff are fully trained and their competence monitored with regard to each client's program plans.

- No staff should be caring for a client without such training and confirmation of competence generally and crucially in that client's individual behavior and other plans.

- The recommendations resulting from post-restraint reviews must be implemented.

- Should manual restraint be implemented, meaningful review should take place, as contemplated by the Court's orders.

- Clinical and administrative staff, it is suggested, should demonstrate their commitment and leadership by active presence on the living units.

- Further steps to protect client and staff safety should be considered.

- As MSHS-Cambridge enters its last months, DHS is encouraged to work with its clients to achieve a sense of vibrancy, activity and optimism through meaningful activity.

Respectfully submitted,

/s David Ferleger

April 22, 2014

April 8, 2014

TO: Anne Barry, Deputy Commissioner
Peg Booth, Christina Baltes, Jensen Implementation Team
Richard Amado, Internal Reviewer

FROM: David Ferleger

SUBJECT: a. Questions Arising from Manual Restraint of A.M., April 6, 2014, and
b. Requests for Information on MSHS-Cambridge Restraint Reviews & Analysis

I have reviewed the *Documentation for Emergency Use of Manual Restraint* in this event, and other records regarding restraint use at MSHS-Cambridge, and have several observations and comments. Also I set forth below several requests for documentation, and for further action.

1. Awareness of Status of IDT

The incident began after an apparently uneventful visit with staff to the Humane Society and Best Buy. The report continues:

> Upon returning to Home 8, she was upset and wanted to go for an independent walk. *The staff was not aware if A's team had approved independent walk/s.* (emphasis added).

The situation then deteriorated.

Two employees are listed, a female, Christabel Pendie, as "initiator," and Seiku Sombai, as "assisting." Mr. Sombai is a formidable gentleman and I assume it was he who was the major actor in administering the "arm-bar come-along" and the "side-lying hold."

Mr. Sombai reported that he is a new employee, having worked at Cambridge for about a year.

What causes concern here is that "*The staff was not aware if A's team had approved independent walk/s.*"

Ex. A

Staff working with clients are required to be aware of such things as levels of supervision, and related safety issues. Each chart is to feature the bi-monthly summary of the client's program and supervision needs.

I believe it was Home 8 which I visited last month (March) and found that, for a male client there, the most recent bi-monthly summary in the office chart was August 2013. Mr. Sombai could not explain why that was the case.

There is no reason for staff to be unaware of what the IDT has or has not approved with regard to movement and supervision. Here, the staff said "no" because they did not know what was or was not permitted. In addition, the report does not indicate that any effort was made (or could have been made) to immediately contact someone who knew the answer to that question.

2. Duration of Restraint

The report states:

> "Staff implemented a manual restraint for one minute when A attempted to continue to agress. Staff implemented arm-bar holds, but needed to initiate a side-line hold due to intensity of the behavior."

The duration of the manual restraint is reported to have been one minute, from 6:50 to 6:51 PM. The narrative report of multiple arm-bar holds, followed by initiation of a side-lying hold, at least implies that the duration may have been longer.

3. Consultation with Medical Officer

The report states that Dr. Pratt was consulted and that his "Advice was for staff to continue to follow procedure/s."

Respectfully, I question the usefulness of this advice. Follow which procedures? What support or re-evaluation of the situation would be helpful to staff or to the client? Dr. Pratt is not reported as advising that staff should learn what is or is not permitted by the treatment team, for example.

4. New Process for *Use of Emergency Intervention Review*

From January 21 to 23, 2014, Dr. Stacy Danov and Dr. Timothy Moore, both staff at Cambridge, conducted a *Use of Emergency Intervention Review* of an incident involving A. This was to be an implementation of an evolving method for reviews in which the Internal Reviewer, Dr. Richard Amado,

reviewed the work of Cambridge professionals who examined their own staff's implementation.

If there have been other such reviews, for A. or other Cambridge clients, I believe I have not received them.

Their review resulted in a number of recommendations including:

> "It is recommended to complete the previous recommendation from 12/16/13: 'Therefore it is recommended that the staff be trained to implement the Behavior Support Plan with fidelity. In order to determine if the Behavior Support Plan is effective, we need to ensure that the plan is implemented as intended."

The copy which I received was blank in the portions of the format which require Program Responses to the recommendations (this was not an issue; I received the review at an early stage in the process).

Please provide me with any *Use of Emergency Intervention Reviews* by Dr. Stacy Danov and/or Dr. Timothy Moore, both staff at Cambridge, for any client since January 1, 2014, exactly as it existed on April 7, 2014, yesterday, without revision, correction, expansion or completion.

5. Address of A's Frequent Behavioral Challenges

As you know, there have been numerous, often intense, situations in which restraint has been used for A. Please provide me with all functional behavior assessments, and functional behavior analyses, which have been developed for her in the last 12 months. Also provide me with all related underlying data, including but not limited to graphs. All this material will be exactly as it existed on April 7, 2014, yesterday, without revision, correction, expansion or completion.

In addition, please provide me with the following:

- The notes of the consultation with the Expanded IDT after each restraint of A over the past year.

- Any revisions in A.'s program plan or behavior support plan following each of the consultations with the Expanded IDT after each restraint of A over the past year (including the one yesterday).

6. Transition Plan

Please provide me with A's Transition Plan exactly as it existed on April 7, 2014, yesterday, without revision, correction, expansion or completion.

7. Training Records

Please send me the training records for Christabel Pendie and for Seiku Sombai, exactly as they existed on April 7, 2014, yesterday, without revision, correction, expansion or completion.

8. Request to Internal Reviewer for Review

I request Dr. Amado to promptly review all the material I request above, along with any other material he deems relevant. Dr. Amado is requested to inform me by return email when he will review and when he will complete an analysis and recommendations for delivery directly to me.

* * *

Please provide the requested material to me by noon, **April 18, 2014**. By that date and time, comments from the parties and consultants on the matters stated above are welcomed.

Thank you for your consideration.

Cc: All Counsel

Minnesota Department of **Human Services**

Minnesota Specialty Health System – Cambridge/ Minnesota Life Bridge

April 17, 2014

Mr. David Ferleger
Archways Professional Building
413 Johnson Street, Suite 203
Jenkintown, PA 19046

Re: Response to Your Request dated April 8, 2014

Dear Mr. Ferleger

This letter and accompanying materials are in response to your request dated April 8, 2014. We hope this response sufficiently answers your questions and provides assurance that we are continually taking steps to address our clinical and implementation challenges. Below is an itemized response using the numbered items in your April 8, 2014 letter.

1. Awareness of IDT

At the time of the 4/6/14 restraint with AM, she had been begun training in the use of a keycard to leave her home independently. As of the day of the incident, the approval status was as indicated in the 3/28/14 email here:

From: Maki, Amber L (DHS)
Sent: Friday, March 28, 2014 2:16 PM
To: Bell, Richard P (DHS); Campion, Clayton R (DHS); Carda, Judy A (DHS); Corpuz, Mariah (DHS); Flaherty, Ronald D (DHS); Harris, Betty D (DHS); Lawrence, Mike E (DHS); Nordlum, Maridy A (DHS); Pendle, Christabel N (DHS); Reitmeier, Jennifer M (DHS); Sjostedt, Stacey A (DHS); Sombai, Sekou R (DHS); Stradal, Dustin L (DHS); Thomas, Dawn R (DHS)
Cc: Peterson, Jeamse S (DHS); Sjostedt, Stacey A (DHS)
Subject: AM Update

I thought I had sent this out already but couldn't find it in my sent box. To summarize [redacted] has some changes to her program. She can now go outside of Cambridge with 1 staff. She should go to the Brooklyn Park area to explore that community and begin to get to know the area. If staff are comfortable she can sit in the front seat. Her community planning worksheet is also changing and will be completed by staff with [redacted] providing the input. She also has her keycard activated from 8:15am-8:30am and can come to the op center without staff (by herself). If you have any questions let Stacey or myself know. Thank you.

Amber Maki M.S., BCBA
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Office: 763-689-7298
Amber.l.maki@state.mn.us

During this week, AM walked up to the 'op center' (the administrative office building) from her home to visit with people for 15 minutes. Given success at this stage of training, AM's independence would be increased during the week of 3/31/14 and the following week. In our review of communications about AM's independence after the 4/6/14 incident, it was noted that on 4/4/14 AM spoke with the clinical team about extending her independent walking time. It was agreed that they would discuss it on Monday 4/7/14 (after the weekend). This conversation was not adequately communicated to Home 8 staff. As of 4/7/14 the clinical team created a chart detailing AM's

Ex. B

independence status (included in this packet of materials), posted this document in the home, and will update the status on this form as needed.

Also referenced in your April 8, 2014 letter was the gentleman who lives in Home 8 whose bi-monthly summary entries in the office chart were out of date. The bi-monthly meetings with this gentleman were indeed performed, and their summaries written. Their absence from the chart is unacceptable. Monthly chart audits (weekly) will be required and documented for all homes beginning in May 2014.

2. Duration of Restraint
With respect to the importance of the question, a great deal can occur in the span of 60 seconds when hands are put on a person to restrain their movement. Arm-bar holds were implemented briefly as lesser-restrictive alternatives to the side-lying hold; they were unsuccessful in achieving safety, ultimately leading the staff to choose the side-lying hold. Consistent with our recent practice, we will be reviewing this incident with training staff from the Effective and Safe Engagement (EASE) team who provide our training in manual restraint techniques. Scheduling for this review is in progress.

3. Consultation with Medical Officer
It occurs to us that two action steps are warranted: reminders for staff to indicate with more detail what the medical officer may have recommended, and a conversation with the medical officer (Dr. Pratt) to discuss what materials/information about individuals served at MSHS-C and Minnesota Life Bridge may help him to have on hand to enhance the robustness of his consultations during emergencies. These steps will be complete by 5/1/14.

4. New Process for Use of Emergency Intervention Review
The requested reviews are attached. Please note that some are signed and some are not – we are working out our kink in this process, but be assured the Internal Reviewer (Dr. Amado) has reviewed each one. You may note progress toward completion of recommendations in the attached table. As to the question of why you are not receiving copies of each review, we are not able to answer – it was assumed that you received copies – we will need to work with the Internal Reviewer and the Jensen Implementation Team to correct the process.

5. Address of A's Frequent Behavioral Challenges
The requested documents are attached. The Clinical Director is available at your request to discuss any questions you may have.

6. Transition Plan
The requested document is attached. Much work has been done in the last two weeks on this document, not reflected in the requested version.

7. Training Records
The requested documents are attached.
In the context of our review of recent incidents we have identified the need to enhance the efficiency and effectiveness of staff training. A discussion with the AFSCME Union Steward on 4/9/14 resulted in agreement that enhancements were needed and would be supported by this Union. Effective 5/1/14, the following specific practices will be in place:

A. When Positive Behavior Support plans (referred to now at Positive Support Transition Plans - PSTP) or methodologies to address formal outcomes in the Comprehensive Service and Support Plan – Addendum (CSSP-A) are newly developed or substantially changed, staff will receive training on the following timelines, which exceed current standards under Minnesota Rule 245D:

1. **Within 48 hours, read PSTP or methodology, discuss it with a member of the clinical team until they indicate understanding, and complete a written demonstration of competency with 100% accuracy.**
2. **Within 10 days, demonstrate competency in the demonstration of the PSTP or methodology**

B. Staff who fail to meet these requirements will be unable to work with the individual until they complete the requirements.

8. Request to Internal Reviewer for Review
We shared the requested information with the Internal Reviewer on 4/11/14.

Respectfully submitted,

Steve Jensen, Director
MSHS-Cambridge/MN Life Bridge

To:	David Ferleger,Attorney, Jensen Settlement Court Appointed Monitor
From:	Amado, Richard S
CC:	Anne Barry, Deputy Commissioner Peg Booth, PhD, Jensen Compliance Officer Christina Baltes, Jensen Compliance Office Amy Akbay, DHS Attorney
Date:	4/11/2014
Re:	Ferleger Memo of 4/6/14, Questions Arising from Manual Restraint of AM, April 6, 2014

At your request I have reviewed the 4/6/14 use of manual restraint with AM as well as all the documents identified in your memo:

1) Emergency use of restraint reviews completed by Dr. Moore or Dr. Danov for any client since January 1, 2014...
2) The notes of the consultation with the Expanded IDT after each restraint of A over the past year
3) Any revisions in A's program plan or behavior support plan following each of the consultations with the Expanded IDT...
4) A's Transition Plan...
5) Training records for Christabel Pendie and Seiku Sombai exactly as they existed on 4/7/2014
6) Progress Report and Recommendations, dated 3/15/2014

I also had conversations with Tim Moore, PhD, LP, BCBA-D, Clinical Director, Mark Brostrom, Program Supervisor, Amber Maki, BA 3, Jeamse Peterson, Community Residential Supervisor. Steve Jensen, Program Director was not available the day I was on campus.

Findings

1) I was provided a data sheet for AM specific methodology training that was to have been completed on or before March 16, 2014. The data sheet listed two staff who had participated in the training for the version of AM's program plan that was in effect at that time; both staff appear to have read the program but neither passed the competency demonstration with regard to the methodology. According to the incident report, the staff reported they did not know the procedure. Dr. Moore explained a breakdown resulting from a change in the way information is conveyed from the IDT to the direct support staff and that breakdown added to the staff's lack of critical information on April 6. The available data support the conclusion that neither staff person was sufficiently competent and aware of AM's current program plan.

2) I found no data or other information to resolve the question of the duration of restraint.

3) Consultation with the Medical Officer: Dr. Pratt was consulted and he advised the staff to follow the existing program plan.

4) New Process for Use of Emergency Intervention Review: the reporting form for the review needs to be updated. The Court Monitor commented that in a recent review, the section for the Program's (MSHS) responses to the recommendations was not filled in. That is because the Life Bridge staff are now making the recommendations. This form needs to be updated to be consistent with the current process.

5) Notes of Expanded IDT reviews following the use of an emergency manual restraint were provided to me for meetings on these dates in 2014: Jan 16, Jan 20, Jan 24, March 5, and March 30. (I did not take copies of these EIDT meeting minutes, however, in my notes identified there was a review for 3/5/14. That review was not in the packet sent to the monitor this afternoon.) I was also provided three treatment plans, titled "Positive Support Transition Plan." The dates on the plans are a little difficult to follow. They all have the same Projected Implementation Date: Jan 1, 2014; they all have the same Plan Completed Date: Jan 30, 2014; they all have the

Ex C

same Projected Ending Date: December 31, 2014. The document that appears to be the original plan has no date in the space for "date plan updated," the other two plans have update dates of February 3, 2014 and February 25, 2014. On March 28 an email was sent to staff to update them on IDT decisions.

6) I was provided a partially completed Transition Plan (relocation) and a simple one page graphic that appears to be from a person centered planning process.

7) I found no items listed in the training records for either Christabel Pendie (CP) or Seiku Sombai (SS) for program training specific to AM in 2014. Both staff had Individual Support/program plan training for one-half hour on 12/12/13. SS also had one half hour of individual orientation that included AM on 12/19/13.

Conclusions and Recommendations

1) Awareness of IDT Status

The staff reported they did not know whether or not [redacted] could take a walk; they told [redacted] they did not know; and they acted on their lack of knowledge rather than taking immediate steps to find out what they did not know. The procedural review completed by Dr. Tim Moore for the internal reviewer, identifies an email sent to the staff on 3/28/14 to make them aware of the current expectations of the IDT. Email, while quick and efficient, is not normally accepted as the way to make staff aware of support changes and continuations. It is not clear how staff are provided training, or held accountable for knowing those changes, when changes happen by email.

Recommendation: It might work to identify some communications from the IDT as "to inform" only. This information, such as 'no changes this week', can probably be sent by email with no loss of integrity. Of course, there should be a "read receipt" for each message sent by email. Otherwise, a written memo with a sign off would do. Messages that carry information about procedure or program changes should probably be conveyed to staff in a way that allows evaluation of understanding and competence rather than by email. Staff position descriptions should include a specific performance indicator for updating themselves at the beginning of each shift and demonstrating competence, when there is a program change, within the first shift after the change is made.

2) Length of Time of Restraint

At this time I do not recommend changing anything about measuring the length of time a manual restraint is used.

3) Role of the Medical Officer

The Medical Officer recommended the staff continue to follow the procedure. The problem is the staff were not aware of the procedure and were not following it; had the medical officer asked questions about what the staff were doing, he would not know if they were following the designated procedures because he did not have the program plan, or sufficient benchmark information to provide a correction. It is also possible that providing direction regarding the implementation of a behavior support plan is outside the competency of a physician, even one with psychiatric certification, who would be better off to offer no suggestions rather than risk medical malpractice. It might be worth clarifying the expectations of the Medical Officer during these notification calls.

Recommendation: Representatives of the Medical Director, Court Monitor, Life Bridge, etc. meet to clarify the role and expectations of the Medical Officer taking the call for consultation during the use of manual restraint. I have some ideas to share with that group that might make the consultation activity more useful.

4) New Process for Conducting Look Behind Reviews

There is clearly a breakdown related to the review process regarding how reviews get to the Court Monitor and the form is out of date.

Recommendation: The Jensen Compliance Officer, an executive from Life Bridge, the internal reviewer, and the Court Monitor identify how the information will flow and the responsibilities of each party. The internal reviewer and the Life Bridge representative need to update the review reporting form.

5) IDT Meetings and Notes and Positive Support Transition Plans

There appears to have been a timely meeting of the EIDT following the use of each emergency intervention. Section 5 in the minutes is for describing the changes to the individual program plan that will reduce the need to use manual restraint in the future. For example, from some of the reports by date:

1/16/14: Further staff training and implementation of individual's Positive Behavior Support Plan and assistance in staff idenfifying stressors with individual. Staff and individual to begin Behavioral Rehersals that will be developed and trained. Transportation procedure will be updated and trained, including guidelines for action when seat belt removed (*sic*)."

1/20/14: [redacted] is referred to Riverwood Centers for relationship counseling and she is to identify a list of preferred go-to people to provide support for forming and maintaining healthy relationships with peers, and recognizing the importance of protecting emotional health. Additional staff training via behavioral rehearsal to improve response to emotionally-laden conversational content, including concrete answers, and identification and validation of her emotions. *(sic)*

Both of these EIDT decisions, in fact all but one of the decisions of the EIDT, mention training staff to better..." However, I did not find evidence of correlated training activities in the training records that were provided.

The three Positive Support Transition Plans (PSTP) that were reviewed were very well done. Each document fills ten pages. The material appears to be consistent with the requirements of MN 245D. The PSTP's are dense with information and include some technical language. They are probably beyond the capacity of direct support staff to absorb and use. A bridging document would be helpful that provides the direct support staff a summary or script of the prompts, questions, feedback, etc. they are to deliver according to the PSTP. These less-than-a-page summaries can be created in sufficient quantity that every staff can carry it around until the identified procedure is readily executed by each of them when appropriate.

Recommendation: It is also recommended that Life Bridge create little staff prompt "cheat sheets", or other memory joggers that staff can use to remind themselves of the components of complex programs.

6) Transition Plan

The Transition Summary and Plan (Relocation Document) is off to a good start. There is a one page Picture of a Life and while most of the Transition Plan is still blank, the sections on where [redacted] would like to live have useful information in them One observation about the Picture of a Life and the Transition Plan, instead of using broad, subjective words like "nice" when referring to the characteristics of the people who would best support the person who uses services ([redacted] in this case), use language that describes what "nice" is to the person who uses services.

Recommendation: Continue to develop the Picture of a Life one page document. Make every attempt to add information to it weekly. It would be advantageous to establish a protocol for filling in additional sections of the Transition Plan earlier in the planning process.

7) Training Records

There was no evidence or documentation that either Christabel or Seiku or any other HSSS staff were trained in the current version of AM's program plan or prepared to implement the program procedures as prescribed. The data sheet for tracking staff reading and demonstrating competence with procedures showed only two staff had read the March 16 material and no staff had completed the competency evaluation. Before any set of procedures can be evaluated they must be implemented or conducted with a high degree of fidelity. The most artful Functional Behavior Assessment is meaningless if the resulting function based intervention is not conducted as prescribed. Likewise, a review of incidents cannot lead to an improved prescription if the previous prescription(s) was/were not followed. The issue of program fidelity is reviewed in detail because all else hinges on that fidelity.

Cambridge has adopted a procedure to train staff to conduct programs that are developed for the people using services on campus. That procedure includes two different documents, DHS-6810, the Positive Support Transition Plan (PSTP) and DHS-6835, referred to as the Methodology. When either of these documents is completed and

made available to staff in the homes, there is a requirement that the staff read the document and demonstrate competency in the procedure within ten days.

The data sheet for [redacted] Methodology One with a demonstration deadline of March 16, 2014, had only two staff listed, and they were not competent. The data sheet showed the two staff had read the Methodology, but not that they had demonstrated competence. My review was done on 4/11/14, almost a month after the competency was due. One of the supervisory staff explained to me that there had been instances of staff evading training to conduct programs and, on at least one occasion in the past, the training sign in sheet has disappeared.

Recommendations: 1) develop a protocol for staff training on individual program plans and incorporate the elements of the protocol into staff position descriptions. Staff who perform below the specified criteria can be assisted with performance improvement plans or whatever supervisory tool is appropriate. I have already discussed this idea with some of the Leadership at Life Bridge and the proposal was well received. I would appreciate the opportunity to work with Life Bridge to create the details of the protocol and put this recommendation into practice.

2) All training should be documented in PathLore to create a reliable record. All staff who refuse, avoid, or miss training should be moved to desk duty to learn the program before they can be with the people who depend on Life Bridge for effective support. Desk duty should be limited to the time it takes to complete the training, typically less than one shift.

3) Staff preparedness contributes to, or detracts from, the safety of the environment. Staff who refuse, evade, avoid, or otherwise do not obtain all the minimally necessary training to be effective with prescribed procedures are detracting from the safety of the environment. They put their coworkers as well as the people who are depending on them for services at risk. Therefore, it is recommended that staff training include information about their responsibility to themselves and one another to learn the clinically prescribed procedures as part of safety training.

4) The disappearance of data sheets might not be a persisting problem. However, that it has happened suggests staff might not have a sense of the importance of data sheets. These sheets are state property and could be necessary evidence, as in the immediate situation, that the State is fulfilling its obligation to people in its programs. If the Life Bridge administration believes there is a problem relative to data sheets used to document training or the efficacy of programs, or for any other core responsibility, it is recommended that staff receive training in the importance of these data sheets and the potential consequences to the State and its employees if the data sheets are lost, discarded, or otherwise missing.

The Progress Report of 3/5/2014 has graphs that show [redacted]'s presenting challenging behaviors and symptoms have abated some since she arrived at MSHS Life Bridge. The data graphed in these reports are for physical aggression, verbal aggression, property destruction, self-harm, anxiety, suicidality, and hostility. In the narrative sections, the Report also describes acquisition of socially acceptable alternative behaviors.

Recommendation: Graphing these behaviors and symptoms underscores the attention and importance placed on resolving them. In a Positive Behavior Supports approach, it is equally, if not more important, to expand the skill set and quality of life of the program participant. Therefore, it is recommended that the importance of acquiring these alternate skills be acknowledged by graphing the progress of acquisition as well.

Respectfully submitted,

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Internal Reviewer