P2316

QUALITY ASSURANCE PLAN

for State Facilities

MINNESOTA DEPARTMENT OF PUBLIC WELFARE
MENTAL HEALTH BUREAU
658 CEDAR STREET, ST. PAUL, MINNESOTA 55155

"... this administration expects to give a special emphasis to the protection of the rights and dignity of every client. It is my firm position that violation of rights, including abuse, is not acceptable, and that any inadvertent violations which occur must be immediately corrected."

Commissioner Leonard W. Levine
Memo to facility Chief Executive Officers
March 11, 1983

It is the policy of the Department of Public Welfare that its institutions provide effective, humane care and that they are used for those persons whose clinical needs can be most appropriately met in public facilities. The right of vulnerable persons to be free from abuse and neglect within the state institution and community service systems is absolute. They are entitled to decent physical facilities, the caring - even loving - attention of sensitive, well-trained staff, and effective programs designed to enhance their ability to live in the least restrictive, most normal environment. This is a statement of both intent and commitment, which exemplifies this administration's policy on the rights and dignity of every person it serves. Because this Plan was developed in a very short time frame, it may be modified as additional issues and information become available. This Quality Assurance Plan is applicable to all state facilities, but will be modified in certain instances to address the special requirements of the two state nursing homes. Its applicability to community service systems will be implemented at every opportunity through DPW rules and guidelines.

Leonard W. Levine, Commissioner
Department of Public Welfare

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September 1983

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Many individuals and organizations assisted in the development of this Quality Assurance Plan for State Facilities. The contributions of AFSME Council 6, Minnesota Department of Employee Relations, the Welsch v. Levine Court Monitor, community agencies, and interested individuals are gratefully acknowledged. The efforts of many individuals within the Department of Public Welfare are also acknowledged.

Executive Summary

The purpose of this Quality Assurance Plan is to identify the Department of Public Welfare's approach for assuring that high quality treatment and habilitation programs are provided at state facilities in an abuse-free atmosphere while serving a more seriously disordered and vulnerable client population. The protection of clients' rights and the prevention of abuse and neglect constitute two elements in a total quality assurance program which relates effective treatment/habilitation program development qualified and optimally-trained employees, effective supervision and administration, and coordinated and effective monitoring and accountability for all aspects of the program. This document presents a plan for action which will be modified and built upon based on experience and results. Responsibility and resources requirements for each step of the plan have been

PROGRAM DEVELOPMENT

1. The mental health program divisions will conduct comprehensive program reviews at *each* facility at least biennially, using both central office staff and, if resources permit, outside experts.

2. The state institutions and program divisions will complete a multi-phase review and organizational adjustment which will include:

    a. Designating a facility Quality Assurance Officer.

    b. Updating care standards for each disability program (admission, discharge, and length of stay criteria; evaluation, treatment, and staffing standards; outcome

    c. Organizational realignment to support new program standards.

    d. Training to achieve new standards, and in new treatment technologies.

e. Development of specific quality assurance measures (priorities for quality assurance audits; data from clients, staff and outside persons).

3. Program experts in each disability will consult regularly with staff at each facility; experts working with the Mental Health Bureau will meet with facility management staff to explore new or improved treatment methods.

4. Facility program directors will meet regularly for the purpose of improving and updating programs; facility staff members will have access to current professional literature and seminars relating to quality assurance.

5. Student placement training programs with professional training institutions will be expanded whenever possible.

6. Ongoing institution efforts to involve all levels of employees in the definition and solution of problems and the improvement of facility function will be evaluated (including the Oak Terrace Quality Circle project and Cambridge task forces process). If found positive, similar projects will be established at all facilities.

7. Effectiveness of program development and management of Quality Assurance Plans by Chief Executive Officers and their management staffs will be one performance indicator in annual effectiveness evaluations.

PERSONNEL MANAGEMENT

1. The DPW Personnel Director, in consultation with other appropriate persons, will implement the newly-developed Human Services Classification Study which redefines existing classifications or establishes new ones for paraprofessional direct care staff in accordance with the skills needed for that work. Appropriate examinations will be developed for those classifications.

2. The DPW Personnel Director, in consultation with other appropriate persons, will examine the feasibility of an applicant screening process to identify persons whose employment history or personal characteristics make them unsuitable for patient/resident care positions.

3. A review of the adequacy of supervision of direct care staff will be completed (numbers; skills; training; supervisory practices; federal, state, and judicial standards) and recommendations made for improvements.

4. There will be continuing review of present training practices. Activities and items for which recommendations for improvements will be sought include:

   a. An updated and/or revised training plan for all state hospital employees, with priority for direct care and supervisory employees (subjects including treatment planning, intervention and contain-

ment methods, abuse and neglect policies and procedures, clients' rights, normalized living conditions, communications and human relations skills, stress management, policies and procedures in effect to protect clients, case management and supervision, human sexuality, supervision and managerial training).

b. A status report on impact and cost of existing pre-service training programs (training before working with clients) for paraprofessional direct care personnel.

c. A plan for providing system-wide, a mandatory core of training as pre-service training, if appropriate, and/or as on-the-job in-service training.

d. Identification of additional mandatory training which will include training about the individual treatment plan, abuse and neglect, clients' rights, specific protective procedures, and therapeutic intervention methods. A schedule of retraining will be established for mandatory subjects.

e. Development of a training program for all institution advocates.

f. A plan for ongoing review, evaluation, and update of training materials.

g. Procedures to monitor compliance with the training program and for assessing the quality of training.

h. Evaluation and recommendations of available therapeutic intervention and aggression management curricula, considering effectiveness and cost.

5. A standardized protocol will be prepared to meet legal and collective bargaining agreement requirements for conducting investigations of abuse and neglect, including:

a. Protection of the rights of clients and employees during an investigation.

b. Preparation of guidelines for consistent disciplinary actions in cases of substantiated abuse or neglect.

c. Identification of legal and data privacy issues related to investigation of abuse or neglect.

d. Development and initiation of training courses for employees responsible for investigations.

WELSCH V. LEVINE CONSENT DECREE MONITORING

1. Mental Retardation Division will develop a compliance plan to strengthen the internal capacity of the Mental Health Bureau to monitor implementation of the Welsch v. Levine Consent Decree. This decree established

standards for rehabilitation, staffing, and environment in state facilities serving mentally retarded persons.

CLIENT PROTECTION/ADVOCACY

1. The Commissioner will continue to affirm his commitment to a high departmental priority for clients' rights and prevention of abuse and neglect.

2. Requirements of the Vulnerable Adults Act will be the foundation on which a coordinated system for reporting and investigating abuse and neglect will be constructed. It will clarify definitions, reduce duplication, specify responsibilities, establish avenues of communication, provide for analysis of findings and recommendations for appropriate action, and identify barriers or problems which must be dealt with.

3. There will be a standby investigation team incorporating central office personnel and/or outside experts. It will be used for unusual instances where a special investigation of abuse/neglect is deemed necessary by the DPW Commissioner or the Assistant Commissioner in charge of the Mental Health Bureau.

4. A system will be developed for reporting, analyzing, and developing corrective action plans for incidents where clients allegedly abuse other clients or cause physical harm to employees.

5. The Mental Health Bureau will take over supervision of hospital advocates. Their job descriptions will be revised, if necessary, to emphasize a strong proactive role in protecting clients' rights and preventing abuse. CEOs will continue providing structural support and problem solving skills to assist the supervision of an effective advocacy program.

6. The Medical Policy Committee and the hospital review boards will take more active roles in the prevention of abuse and neglect.

7. Guidelines governing use of aversive/deprivation procedures will be developed for the protection of clients who are mentally ill or chemically dependent, and interim procedures for monitoring aversive/deprivation procedures will be reviewed for compliance with present policies and standards. A task force has prepared a draft of a rule to govern the use of aversive/deprivation procedures with mentally retarded clients. This draft includes specific monitoring and follow-up requirements with special attention to prevention of abuse and misuse of the procedures.

8. Program review teams will consider in their reviews the effectiveness of facility efforts on behalf of clients' rights; the effectiveness of facility abuse prevention, reporting, and corrective action; and identification of conditions (environmental, procedural, attitudinal) which may lead to abuse or other violations of rights.

FINANCIAL MANAGEMENT

1. Fiscal audits are underway by the Legislative Auditor for the three facilities for which audits have not yet been completed. Resulting recommendations will be incorporated into the plan.

2. A biennial fiscal audit of each facility will be requested.

QUALITY ASSURANCE AND PROGRAM MANAGEMENT

1. A simple checklist will be developed for persons having contact with clients, such as family, visitors, volunteers, and county workers. On this checklist they will record their observations about the presence of a treatment plan, its implementation, the client's progress, adequacy of physical care, employees' attitudes and knowledge about the client, living conditions and atmosphere in the ward, and indications of abuse or neglect. The checklist will be designed to help pinpoint strong and weak elements of the service delivery system, and will be incorporated into the department quality assurance monitoring system.

2. Each facility will establish an Incident Control Committee (or assign its functions to an existing committee) which will collect and analyze reports of accidents, abuse, neglect, and suicide attempts in order to identify situations posing a hazard to clients. The committee will make recommendations to correct those situations, and will provide quarterly reports to the Commissioner. It will consider incidents of abuse of residents by staff, of staff by residents, and of residents by residents.

3. All facilities will be required to meet applicable national and state standards for residential mental illness, mental retardation, and chemical dependency programs.

4. The Mental Health Bureau will establish the position of Quality Assurance Director to monitor the facility quality assurance program and to provide technical assistance.

5. A DPW task force will develop a position paper on mental health re search which will describe research and program evaluation activities currently in progress and recommend additional steps and future activities in research and program evaluation.

6. The Mental Health Bureau will review and update the Institutions Manual (a manual of procedures and guidelines for state facilities) in all areas related to quality assurance and program management.

QUALITY ASSURANCE PLAN

for State Facilities

Introduction

This plan was prepared at the request of Department of Public Welfare Commissioner Leonard W. Levine, under the direction of Margaret Sandberg, Assistant Commissioner in charge of the Mental Health Bureau. Its purpose is to identify the Department's management plan for assuring that high quality treatment and habilitation programs are provided at state facilities in an abuse-free atmosphere.

The plan contains six interdependent components: Program Development, Personnel Management, Welsch v. Levine Consent Decree Monitoring, Client Protection and Advocacy, Financial Management, and Quality Assurance Monitoring. The goal of the Department of Public Welfare is to ensure that the state institutions are models of excellence in all these areas.

It is important to articulate the assumptions upon which this plan is based:

Residents of state and community-based facilities have an absolute right to be free of abuse and neglect.

Residents of state and community-based facilities have a right to active, high quality treatment and habilitation programs.

State facilities must be models of programming excellence.

Cost-effectiveness is an essential component of planning and implementing the range of programs and services available in state facilities.

Management and labor have a joint commitment to create and maintain an abuse-free atmosphere in state and community-based facilities.

All programs, whether in an institution or in the community, should be provided in the least restrictive, most appropriate and most normal environment.

There must be a high priority in resource allocation for program development, protection of rights, and prevention of abuse and neglect.

This plan is prepared in the context of a gradually changing institutional population. The past decade's emphasis on deinstitutionalization and the development of community resources have reduced the numbers of those clients who are most likely to respond quickly and favorably to treatment, who require less supervision, and who can most consistently participate in their own care and treatment. More stringent commitment laws and court decisions diverting clients to less restrictive alternatives have resulted in commitment of clients having more seriously debilitating disorders.

Consequently, institutional populations have continuously included higher proportions of persons presenting serious treatment and management problems—more with major mental disorders, multiple handicaps, aggressive behavioral problems, and inability to care for themselves, their environment, and others. These trends are likely to continue and perhaps even accelerate.

Findings

I - Abuse and Deaths in State Facilities

ABUSE

Abuse/neglect unfortunately occurs in all settings. It occurs in private homes as well as in care-giving facilities, regardless of size, population, public or private operation. Direct comparisons are difficult because of variations in reporting requirements and reporting compliance. Facility reports, especially those from state facilities, are generally accurate and complete, while incidents within the community tend to be under-reported. The available data indicates that throughout Minnesota there were 4,388 substantiated cases of child or adult maltreatment reported in 1982. In state facilities there were 42 incidents of substantiated abuse to clients by staff in that same period. It does not excuse the problem, but statistically less abuse occurs in state facilities when population figures are considered.

Reports of abuse/neglect are made primarily through the Vulnerable Adults or Child Abuse reporting systems, through the Health Facilities Complaints Office, and for state facilities, also in accordance with their internal . abuse reporting system. A few reports are made through other channels. To better understand the extent and nature of substantiated staff to client abuse in the eight state hospitals and the two state nursing homes, information from these sources was compiled from January 1, 1978 through February 15, 1983. It would be desirable to include comparable information about neglect, accidents, and injuries, but such data is not readily available. It would require a special study of a number of local data sources, including client records. This Plan does provide for such information as part of the future reporting process.

The average annual reported incidence of substantiated staff to client abuse during the 5.2 years was 35.8 for the ten institutions, or an average of 3.6 per institution per year. The frequency during those years remained fairly constant, with perhaps a slight rise in the past two years, which may reflect an increase in reporting under the Vulnerable Adults Act. (These

lumbers have been adjusted to account for change in the number of institutions with the 1982 closing of Rochester State Hospital.)

Most incidents (63 percent) were reported in facilities dealing primarily or exclusively with the mentally retarded. It is difficult at this time to interpret differences between individual hospitals in their ability to prevent abuse because of differences in numbers of clients, severity and nature of the disorders, and differences in reporting criteria at different periods. Nevertheless, it appears that there may be a relationship between the nature and difficulty of the patient population and the amount of reported abuse.

Most substantiated abuse of clients by staff (59 percent) was physical, ranging in severity from a light slap or pushing, to a broken jaw, with most falling somewhere in between, as with the use of excessive force in controlling an assaultive patient.

Verbal abuse, ranging from the use of profanity to the use of demeaning language, accounted for 18 percent of the incidents. Ten percent were combinations of physical and verbal abuse.

Four percent of the incidents were sexual in nature, ranging in severity from the use of suggestive language to fondling or attempted intercourse. The remaining nine percent were miscellaneous incidents, such as discussing a client's private life, giving beer to a client at the employee's home, taking food from a client's tray, or unauthorized or improper use of time out, holding, or restraint.

Since 1978, of the offending employees, 31 percent either were dismissed, resigned, or retired as a result of the situation. Thirty-three percent received suspensions ranging from one to 30 days. Twenty percent were reprimanded, 5 percent were transferred to non-patient areas, and 4.5 percent received counseling. As a result of further investigation, grievances or arbitration, 4.5 percent were reinstated or no action was taken. In 1.5 percent action is still pending.

DEATHS

Information regarding deaths is routinely collected and summarized by the Residential Facilities Division of the Mental Health Bureau.

The average number of deaths per year for all ten state facilities over the past five fiscal years was 173; the eight hospitals averaged 13 per hospital per year, and the two nursing homes each averaged 34 per year. The general trend over five years is not stable, though there appears to be a decreasing number of deaths, as would be expected because of the decline of the average daily population in state facilities.

As would be predicted, a greater proportion of deaths occurred in the nursing homes. Sixty-five percent of the deaths were to clients 61 years old or older.

Facilities reported 29 suicides during the five-year period, or an average of 5.8 per year. Fourteen of these (about 2.8 per year) occurred on facility grounds and 15 (about 3 per year) occurred while the client was away from the facility (on home visit, pass, or unauthorized absence).

II - Background - Existing Monitoring Processes and Structures

A number of existing guides, statutes, standards, and mechanisms have varying degrees of relevance to quality assurance, programs, rights, advocacy, and prevention of abuse and neglect for clients of state facilities. These mechanisms are listed here for reference:

1. The Vulnerable Adults Act (Minnesota Statute 626.557, 1981, amended 1983) established a reporting and investigating system for licensed facilities and for professionals and their delegates who serve defined vulnerable clients. It requires the reporting of suspected abuse or neglect to county welfare departments, which conduct investigations and must involve, as required by law, county attorneys, law enforcement, state program or health licensing bodies, or state boards for licensing health professions. It also requires an individual abuse prevention plan for each vulnerable client, and an abuse prevention plan for each facility or relevant area. Positions were allocated to the Social Services Bureau and licensing divisions for coordinating this process.

2. The Minnesota Commitment Act of 1982 as amended (Minnesota Statute 253.B) includes a list of rights and procedures to which clients are entitled. In addition, MCA establishes a review board for each hospital (and Veterans Administration hospitals requesting one). The mini mum of three members must include at least one mental health expert and one attorney. These review boards interview any client requesting to be heard, and may involve themselves in any matter related to admission or retention of clients, or anything related to conditions of hospitalization or rights. Further, MCA establishes the county welfare department or its designated agency as the case manager for persons admitted under MCA and for those who are discharged from commitment.

3. The Patients Bill of Rights (Minnesota Statute 144.651 as amended) also establishes a list of rights of persons in residential health facilities, including state hospitals, and requires such facilities to post the list for patients and their relatives. Violations constitute grounds for the issuance of correction orders by the Minnesota Department of Health (Minn. Stat. 144.652, as amended).

4. Mental Retardation Protection Act (Minnesota Statute 252. A) describes the responsibilities of the Commissioner toward mentally retarded per sons for whom the Commissioner is guardian. Matters related to this Act, including authorization for various treatment procedures, are administered by the Mental Retardation Division of the Mental Health Bureau.

5. State Hospital Abuse Policies detailing procedures for preventing, reporting, and correcting actual or alleged abuse are required by the Residential Facilities Division for each state hospital and nursing home; the advent of the Vulnerable Adults Act has modified the individual hospital procedures.

6. The Health Facilities Complaints Office in the Minnesota Department of Health receives and investigates complaints about care of persons in health care facilities, and may institute penalties. Some of these complaints may allege abuse or neglect.

7. The Program Licensing Division of the Support Services Bureau, using program licensing rules as its standard, reviews programs of licensed facilities. To maintain licenses, facilities must prepare a plan of action to correct deficiencies noted in the program review.

8. Each state hospital chief executive officer appoints at least one full-time Advocate; the two nursing homes each have part-time advocates. Advocates serve as resource persons for hospital review boards, and act on behalf of clients in regard to complaints, admission, discharge, and treatment/habilitation programs. They assist clients with appeals and other procedures and matters pertaining to the Minnesota Commitment Act and clients' rights. They are responsible for informing clients of their rights and assisting them in exercising those rights, including help with hospital grievance procedures or referring clients to legal or other agencies outside the hospital. Advocates also assist hospital committees in seeing that local procedures take clients' rights into account.

9. The Client Protection Office of the Mental Health Bureau serves as a patients' rights resource for hospital review boards, advocates, the Mental Health Bureau, and others. It reviews legislation, rules, and procedures for potential adverse impact on clients' rights. It receives complaints or questions about specific cases of alleged or potential rights violations (from clients, relatives, Commissioner, Governor, legislators, and other agencies) and sees that they are investigated and a response prepared. Where the system's response is ineffective or at loggerheads, the CPO resolves the situation when possible, but normally refers it to appropriate persons for resolution. The CPO has limited authority to intervene directly in programmatic or administrative matters.

10. Mental Health Bureau Institutions Manual material (Part XII-0000 through XII-4120, "Involuntary Administration of a Major Tranquillizer in State Hospitals", effective October 1981), establishes standards, conditions, and safeguards for the involuntary administration of major tranquillizers. While this mechanism does not directly relate to abuse, most persons would agree that indiscriminate administration or arbitrary forcing of medications would constitute a form of abuse. These procedures establish criteria and standards and provide for an internal interdisciplinary review panel as well as further review by hospital review boards.

11. Other hospital committees having as part of their function the protection of clients' rights in specific ways are hospital Aversive/Depriva tion and Research Committees, sometimes combined into a review group with broader functions and other titles. Both protect the rights and safety of clients according to specified standards. The Aversive/Deprivation Committee reviews and approves all instances where aversive stimuli or the withholding of ordinarily entitled conditions or materials is proposed as part of a client's individual treatment plan. The Research Committee not only considers the relevance and scientific adequacy of research proposals, but also the adequacy of informed consent, the minimization of risk to the client, and confidentiality of any personal data to be used in the study or incorporated into reported results.

12. The Medical Policy Directional Committee on Mental Health is established by statute and consists of seven members of the major health professions appointed by the Commissioner. The DPW Medical Director serves as liaison to this committee. It is advisory in nature and is concerned with matters related to treatment, health, and research, and makes recommendations on actions, policies, or difficult cases referred to it.

13. The Welsch v. Levine consent decree established a Court Monitor to investigate conditions or actions which may represent inconsistency with the consent decree. After investigation, the Court Monitor reports to the Department and the appropriate Chief Executive Officer about those matters which he finds to be in non-compliance.

14. Deaths and Accidents:

    a. Each institution has established formal procedures for reviewing all deaths.

        If the death was due to suicide, accident, suspected illegal activity or was otherwise unexpected, the local coroner is notified and assumes responsibility for an outside investigation. An autopsy can be ordered by the coroner whenever circumstances warrant, with or without permission of the family. Depending upon the coroner's findings, the case may be closed or referred to other community agencies for further investigation and action.

        All deaths are reviewed individually by the hospitals themselves. Special efforts are made to obtain next-of-kin permission for autopsies if the medical diagnosis is not fully clear before death.

        In seven hospitals, post-mortem reviews are conducted by medical staff committees. Their recommendations are either transmitted to the Chief Executive Officer for implementation or directly instituted by the medical staff organization. In one hospital, the quality assurance coordinator reviews deaths and reports findings to the Medical Director and/or the CEO

for review and action. In the two nursing homes, deaths are reviewed by staff physicians and by a quality assurance committee or a facility committee assigned for that purpose.

As with any other hospital facility reviewed by the Joint Commission on Accreditation of Hospitals, or the Accreditation Council for Mentally Retarded and Developmentally Disabled, the state hospitals which are accredited must meet standards established by those bodies for review of deaths.

b. Suicides. The Department requires a "psychological autopsy" report on each suicide. This report summarizes the hospital's investigation of circumstances surrounding the death, including the deceased's prior mental status and any other relevant observations which might help explain why and how the death occurred and what could have been done to intervene and prevent it. Typically these investigations and reviews involve most of the staff who had contact with the patient and the review serves as the basis for corrective action. A copy of the report is sent to the DPW Medical Director for further investigation and action as indicated.

c. Accidental deaths are reviewed as noted above. In addition, major incidents of this type are reported and investigated according to the hospital's formal incident reporting systems. All incidents, whether or not injuries occur, are handled through these procedures. In the event of an accidental death, the CEO or administrative officer on duty is notified immediately in order to assure their direct involvement in the process. A written report is prepared by the unit staff and checked by supervisory personnel. Depending on the particular hospital organization, the report then goes to the Medical Director, program director, CEO and/or other executive staff members for review and action. For an accidental death, the CEO personally reviews the incident and decides what further steps need to be taken.

d. Each hospital has a safety committee which reviews accidents, investigates hazardous conditions, and identifies potentially dangerous situations. They routinely receive reports on injuries and accidental deaths. Their recommendations for correcting hazardous conditions are forwarded to the hospital administration for implementation. Most institution safety committees prepare summary reports of their work each year.

e. The DPW Medical Director reviews reports on institution deaths and psychological autopsy reports on suicides and accidental deaths, and initiates further investigations where indicated. The Medical Policy Directional Committee schedules a detailed annual review of all institutional deaths.

15. The Minnesota Department of Health licenses various aspects of DPW facilities according to type of facility or program and applicable federal or state requirements. For example, facilities serving food must meet MDH standards, and residential facilities must meet sanitary, space, and similar physical standards, as well as requirements for medication systems. Facilities receiving Title XIX funding are certified by MDH according to federal standards.

16. The JCAH and ACMRDD review and accredit state institutions based on all aspects of hospital management, program development and quality assurance. These reviews are done every two to three years by teams of professional staff from each respective organization. All state institutions are required to seek either or both of these accreditations, as applicable.

Table - Existing Monitoring Processes *and Structures*

	DPW-MHB	DPW (OTHER)	STATE HOSPITAL	CWD	DEPARTMENT OF HEALTH	LOCAL LAW ENFORCEMENT OFFICES	COURTS	PROFESSIONAL LICENSING BODIES	LOCAL CORONER	ACMRDD	JCAH	MEDICAL POLICY COMMITTEE
Vulnerable Adults Act	X	X	X	X	X	X		X		X		
Minnesota Commitment Act	X	X	X	X		X	X			X		
Review Boards	X		X									
County Case Management	X	X	X	X		X	X					
Patients Bill of Rights	X	X	X	X	X					X		
Mental Retardation Protection Act	X	X	X	X			X			X		
Guardianship Statute	X		X	X			X			X		
Facility Abuse Policies	X	X	X							X		
Health Facilities Complaints Office	X	X	X	X	X	X		X				
Dept. of Health Licensing	X	X	X		X					X		
Program Licensing Division	X	X	X							X		
Facility Advocates	X		X	X	X		X					
Client Protection Office	X		X	X	X							
Involuntary Med. Manual Material	X		X									
Aversive/Deprivation Committee	X		X									
Research Committee	X		X								X	
Medical Policy Directional Committee on Mental Health	X		X									X
Court Monitor	X	X	X	X			X					
Reviews Regarding Deaths,	X	X	X			X			X		X	X
Suicides,	X	X	X			X			X		X	X
Accidental	X	X	X			X			X		X	X
Safety Committees	X		X		X			X			X	

Program Development

The primary purpose of state institutions is to provide programs which work and which answer the individual needs of clients. Effective programs increase clients' self-sufficiency, emotional stability, self-respect, and general adjustment, and reduce those internal and external stresses which might otherwise generate emotional disturbance. Effective programs also provide a climate in which frustration for both clients and staff is reduced, disturbances are less likely, and the potential for abuse or neglect is minimized.

Programs and internal structures to carry them out are designed by each institution in the context of the needs and services present in its community and region and the requirements of the various policy and standard setting agencies.

A. PROGRAM REVIEW; CONSULTATION IN STATE OF THE ART PROGRAM DEVELOPMENT; TRAINING

ISSUES AND DISCUSSION

Institutions such as state hospitals and nursing homes exist to provide programs and services for their communities. These programs must be' developed from an assessment of each client's needs and worked out from an array of possible treatment methods. They must be developed whenever possible with the collaboration and acceptance of the client and must stress the use of positive, constructive methods and the least restrictive and intrusive techniques possible in each case.

To do this requires knowledge and skills in program development, new treatment techniques, evaluation and treatment standards, and regular reviews to maintain standards and assure change and growth as new technologies and techniques become available.

In the mental health field, both professional expertise and public expectations have risen rapidly in the past three decades. Hundreds of new techniques have been introduced to improve the effectiveness and

humaneness of therapeutic programs. The general public has also become better educated about mental health treatment issues and expects continuing improvement in professional performance.

In a number of areas the treatment expertise of state institution staffs exceeds that of other programs. Because their traditional role has been to provide care and treatment for some of the state's most difficult and refractory cases, state institutions continue to be called upon to provide consultation and technical assistance to other facilities which have some of the same types of problem cases.

In view of this special role, and despite limited resources, it is incumbent upon the state system to continue to strive for excellence and to assume a leadership role in developing and utilizing advanced treatment technologies.

ACTION PLAN

The Mental Health Bureau program divisions will lead state hospital program development by significantly expanding program review and technical assistance activities. They will:

1. Conduct comprehensive program reviews (mental illness, mental retardation, chemical dependency, geriatric) at each institution periodically but not less than biennially, using central office staff, outside experts if resources permit, and shared hospital staff if appropriate and feasible. These program reviews will include specified areas related to rights and prevention of abuse and neglect (pages 28-29).

2. Continue regular meetings of the institution Mental Illness, Mental Retardation and Chemical Dependency program directors.

3. Identify program experts in each field and arrange consultant visits to the institutions.

4. Assure that institution staffs have ready access to current professional literature and opportunities to attend seminars relating to quality assurance.

5. Expand student placement training programs with colleges and professional training institutions.

6. Maintain compliance with current program rules and standards.

In conjunction with the Mental Health Bureau and the DPW Medical Director, expert consultants will meet with the state institution Chief Executive Officers, Medical Directors, program directors and other relevant treatment staff to provide leadership in exploring and developing new treatment programs.

Program development and maintenance, and management of quality assurance plans will be one performance indicator for annually evaluating the work of CEOs and their management staffs.

B. IN-DEPTH ADMINISTRATIVE AND ORGANIZATIONAL REVIEW OF STANDARDS AND OUTCOME

ISSUES AND DISCUSSION

It is beneficial for any organization to periodically undertake in-depth reviews of its policies, standards and procedures. It is also desirable that there be some consistency between similar programs in the system. Some institutions have not done this type of review for several years.

ACTION PLAN

The state institutions, working with Mental Health Bureau program divisions, will complete a multi-phase review and organizational readjustment. Successive phases will proceed to the fullest extent possible even if unavoidable delays should occur in completing a previous phase.

Phase I: Designation of a facility Quality Assurance Officer to assure utilization of quality assurance findings.

Phase II: Using program rules as a basis, development or revision of care standards for each disability program:

Admission criteria.
Client evaluation and treatment standards. Discharge criteria.
Outcome measures and length of stay standards.
Staffing standards for each unit based on needs of the clients and relevant requirements.

Phase III: Organizational realignment:

Staff changes necessary to support new program standards. Staff recruitment.

Phase IV: Training:

Training to achieve new or existing standards. Training in new or existing treatment techniques.

Phase V: Quality assurance:

Identification of high priority areas for quality assurance audits. Implementation of a quality assurance program that utilizes data from patient/residents, staff and outside persons. Consultation by Quality Assurance Officer (who will have access to all employees and records) with the Mental Health Bureau Quality Assurance Director. Coordination of activities by local Quality Assurance Officer in accordance with standards and procedures established by the Mental Health Bureau Quality Assurance Director.

C. EMPLOYEE INVOLVEMENT

ISSUES AND DISCUSSION

To achieve goals, an organization's structure must reflect and support its basic mission. The mission or "product" of state institutions is a successful treatment/habilitation/rehabilitation outcome for individuals in those programs.

Numerous studies have shown that organizational structures which encourage employee comment, input and feelings of pride toward the final product result in better products, more efficiently produced and higher employee satisfaction. Application of this concept to the provision of facility services is worth evaluation.

ACTION PLAN

The DPW Residential Facility Division will complete an evaluation of ongoing institution efforts to involve all levels of employees in the definition and solution of problems and the improvement of facility function, such as with the Oak Terrace quality circle project and the Cambridge task force process. Similar projects based on the findings will be established in other facilities if the results show they are indicated.

Personnel Management

Personnel and staffing are crucial to the performance of any function within the state institutions. Therefore, it is important that a quality assurance plan involve the selection, management, development and training of human resources in order that employees can develop and carry out effective treatment programs and respond appropriately in difficult situations.

A. PERSONNEL SELECTION

ISSUES AND DISCUSSION

Procedures used to select and promote employees, and qualifications essential to perform direct care duties need to be constantly scrutinized. A study of the Human Service Technician and Human Service Specialist classes has been underway and is being implemented. A review of the selection procedures and qualifications remains.

ACTION PLAN

Coordinated by the DPW Personnel Director, the department will work with staff from the Department of Employee Relations and, when appropriate, incorporate discussions with employees, exclusive representatives of employees and other organizations, in order to complete:

1. Implementation of the Human Services Classification Study which redefines existing classifications and establishes new classifications which clearly describe the types and levels of work performed by paraprofessional direct care staff and the skills, knowledge and abilities necessary to perform that work.

2. Development of examinations for paraprofessional direct care classifications redefined or established as a result of the Human Services Classification Study. Examination content will be based on those skills, knowledges, and abilities identified as necessary for satisfactory job performance.

3. A study of the feasibility of developing an applicant screening process to identify persons whose employment history and/or personal characteristics make them unsuitable for patient/resident direct care positions. The process will conform to all validity standards and legal requirements.

B. STAFF SUPERVISION

ISSUES AND DISCUSSION

Type and amount of supervision is an essential consideration. Supervision of staff providing direct care to patients/residents in the institutions varies in practice. It is timely to initiate a review of institution supervisory practices focused on supervision of direct care staff.

ACTION PLAN

The Personnel Director will coordinate a department review of the adequacy of supervision of direct care staff and make recommendations to • the Assistant Commissioner of the Mental Health Bureau and Commissioner of Public Welfare. Assistance will be requested, as needed, from institution and central office program staff, staff from the Department of Employee Relations and from outside consultants. The study will include:

1. Analysis of the ratio of supervisors to paraprofessional direct care staff to determine whether the span of control is appropriate.

2. Assessment of supervisory knowledge, skills and abilities needed to provide quality direction and training to paraprofessional direct care staff.

3. Review and assessment of current supervisory practices and methods to discern problem areas needing a plan of corrective action developed.

4. In consultation with the Mental Health Bureau, review of federal, state and judicial standards and guidelines which establish staffing requirements for state institutions. The review will include such documents as Joint Commission on Accreditation of Hospitals and Accreditation Council for Mentally Retarded and Developmentally Disabled standards, the Welsch vs. Levine Consent Decree, Minnesota Health Department and Public Welfare Department licensing standards and other pertinent rules and regulations.

C. PERSONNEL DEVELOPMENT/TRAINING ISSUES AND DISCUSSION

Employees must develop and carry out effective treatment programs, respond appropriately in difficult situations and perform their jobs

skillfully and humanely. A Quality Assurance Plan must provide for training and retraining staff in basic skills, and to develop increased skill in the performance of assigned job responsibilities. While institutions and employees currently have training programs and individual training plans, and some excellent curricula and courses exist, the application of training policy, delivery of training and commitment to training is inconsistent between facilities and between units of a facility.

ACTION PLAN

The DPW Personnel Director, with input as appropriate from employees, exclusive representatives of employees and other organizations, and in consultation with training staff from the Department of Employee Relations, will continue a review of present training practices and recommend revisions and improvements. The recommendations will include:

1. If necessary, an updated and revised training plan covering all state institution employees, with special attention to direct service and supervisory employees, and consideration for the training needs of volunteers having direct contact with patients/residents. This curriculum will consider content areas of:

    a. Treatment planning and techniques; the individual treatment plan and the interdisciplinary team process.

    b. Intervention and containment techniques (for dealing with assaultive, uncooperative persons; suicidal persons; confused, disoriented persons; physically handicapped persons).

    c. Abuse and neglect (policies, definitions, reporting, penalties; Vulnerable Adults Act, individual and facility abuse prevention plans; Health Facilities Complaints Office; local and state procedures and resources).

    d. Rights of clients (Minnesota Commitment Act; Patients Bill of Rights; resources available such as advocates, review boards, Client Protection Office, etc.).

    e. Living conditions and the "normalization" principle.

    f. Communication and human relations skills.

    g. Stress management.

    h. Specific procedures to ensure protection of patients who are subject to aversive/deprivation therapy, research and involuntary administration of major tranquillizers.

    i. Case management and supervision.

    Human sexuality.

k. Managerial and supervisor training including prevention of abuse/neglect and dealing with suspected or alleged situations, including complete investigation and reporting procedures.

2. A status report on existing pre-service training programs for institution paraprofessional direct care personnel. The report will include an evaluation of each training program in terms of cost and impact on quality of care provided to residents and patients.

3. An assessment of the feasibility of requiring specific pre-service training and education for paraprofessional direct service personnel prior to regular employment (utilizing the resources of colleges, community colleges, AVTI's and/or the hiring of this staff in the institutions and providing them with a core training program before permitting them to have any direct patient/resident contact), taking into consideration costs, staff coverage and available positions designated by the Legislature. Included in any training, among other subjects, will be clients' rights, abuse prevention, therapeutic intervention, and the characteristics and behavior associated with the various disabilities.

4. Following the assessment, a report on the feasibility of the Commissioner of Public Welfare establishing a policy mandating a core training program for direct care staff prior to their being permitted direct patient/resident contact. Core mandatory training will be required system-wide as pre-service training, if appropriate, and/or as on-the-job in-service training with additional mandatory training tailored to the different disabilities. The minimum employee training program will cover:

   Individual treatment plan
   Abuse and neglect policy
   Rights of clients
   Specific protective mechanisms (aversive/deprivation, research; involuntary treatment)
   Therapeutic intervention

5. The establishment of a schedule of periodic retraining on mandatory subjects.

6. The development of a training program for all resident advocates in the state institutions.

7. A plan to review, evaluate and update training materials on an ongoing basis in consultation with appropriate DPW Bureaus, divisions and offices.

8. The development of procedures to monitor compliance with the training program and to assess the quality of training.

9. An evaluation of available therapeutic intervention and aggression management curricula, including the Illinois Aggression Management Training series and the DPW Therapeutic Intervention and Containment course. A report will be prepared assessing quality, effectiveness and cost of each training program and recommending revision of in-house training and/or contracting for services.

D. INVESTIGATION PROCESS

ISSUES AND DISCUSSION

It is management's responsibility to investigate alleged infractions. At present, there are no consistent procedures for institution managers and supervisors to follow in making their investigations, nor are there guidelines regarding the amount or type of discipline for a particular infraction if investigation substantiates an infraction. In particular, there are needs for an investigation process for alleged abuse/ neglect of patients/residents utilizing trained investigators, and for guidelines regarding discipline applied for infractions the investigation substantiates. Management actions in disciplining employees must be fair, consistently applied, and in conformance with discipline procedures appearing in collective bargaining agreements, and plans developed by the Department of Employee Relations pursuant to Minnesota Statutes §43A.18. Under the provisions of these contracts and plans, employees have due process through the grievance procedures.

ACTION PLAN

The DPW Personnel Director, in consultation with appropriate Mental Health Bureau staff and others, will prepare the following:

1. A standardized protocol meeting legal and collective bargaining agreement requirements for conducting investigations and protecting the rights of clients and employees during the process.

2. A training course on investigations developed with the assistance of the labor relations and training staff of the Department of Employee Relations. This course will be given to those employees responsible for investigations.

3. Guidelines establishing consistent disciplinary actions in cases of substantiated abuse or neglect.

4. In consultation with staff from the Attorney General's Office, identification of data privacy issues and other legal issues as they relate to investigations and the availability of the resulting data to interested parties.

E. RESIDENT ACTIONS VS. EMPLOYEE AND VS. OTHER RESIDENTS

ISSUES AND DISCUSSION

It is management's responsibility to provide a safe environment that protects patients/residents from each other. It is also management's responsibility to provide as safe a work environment as is possible considering the circumstances under which employees work with patients/residents in the institutions, many of whom may exhibit aggressive behavior towards institution staff.

ACTION PLAN

The Chief Executive Officers in coordination with the DPW Personnel Director, the Mental Health Bureau divisions and other appropriate persons and bureaus, will recommend to the Assistant Commissioner of Mental Health:

1. A system for reporting, analyzing and developing possible corrective action plans regarding client actions towards employees if such action results in physical harm to the employee.

2. A system for reporting, analyzing and developing possible corrective action plans regarding alleged client actions toward other clients.

Welsch v. Levine Consent Decree Monitoring

ISSUES AND DISCUSSION

The Welsch v. Levine Consent Decree developed from a 1972 class action suit brought by Richard Welsch in the name of his daughter, Patricia, then a resident at Cambridge State Hospital, on behalf of all persons who are mentally retarded and who reside in Minnesota state institutions. This action culminated in a Consent Decree entered into by the plaintiffs and the State of Minnesota on September 15, 1980. The Decree specifies individual rehabilitation programs, minimization of certain aversive procedures, minimum staffing levels, and certain physical plant changes at each of the state institutions that provide services to mentally retarded persons.

The Consent Decree incorporates a process whereby any one of a number of individuals (plaintiffs, plaintiffs' counsel, family members, staff, or interested parties) may identify to the court monitor items or actions that may represent non-compliance with this agreement. The court monitor investigates each such item and advises the Department and the appropriate Chief Executive Officer of those items deemed by the monitor to constitute non-compliance. The CEO then establishes a plan of correction and notifies the court monitor once the plan has been put into effect. The monitor then determines if the plan of correction has resolved the issue.

As of December 1982 the court monitor identified a total of 955 items of possible non-compliance involving state hospitals and excluding statewide issues. Of that number 564 have been resolved or corrected, 391 are outstanding. The state hospitals believe that most of the outstanding issues have been corrected but await concurrence of the court monitor before counting them resolved.

Compliance issues are drawn from paragraphs 16 to 104 of the Consent Decree. The greatest number of issues cluster around those paragraphs related to individual resident programs of habilitation and behavior management. A second major group of issues deals with admissions, discharge and post placement factors. The third major group of issues is related to staffing and the way staff members are listed and counted toward the staff-to-resident ratio requirements.

When the court monitor is notified of an allegation of non-compliance, copies of that allegation or issue are sent to the Department's counsel, the Commissioner (Mental Retardation Program Division) and the appropriate CEO. Currently, this serves as an alert to the facility to review the issue and either correct the problem, prepare a response, collect appropriate data and documentation or prepare a plan of corrective action, and to respond to the allegation directly to the court monitor within two weeks. Copies of the responses are sent to the initiator of the allegation and central office staff. The initiator then responds to the correspondence from the state hospital, again directing the response to the court monitor with copies to the Chief Executive Officer and the central office staff. If the monitor determines by his review and/or investigation that the facility is out of compliance as alleged, notification of such is sent by him to the Chief Executive Officer who is requested to respond. No response is made until requested by the court monitor.

The court monitor reviews those issues identified by the hospitals as having been corrected and those requiring resolution at the central office level. The latter issues are resolved on a statewide level by central office staff.

ACTION PLAN

On receipt of the court monitor's listing of presently unresolved compliance issues, the Residential Facilities Division will instruct each facility to prepare and send to the division office, within fifteen working days, a plan of corrective action, including a timetable, related to any issues for which corrective action is not already in progress.

The Bureau of Mental Health, Department of Public Welfare, will create the internal capacity to monitor Welsch v. Levine Consent Decree implementation. A compliance plan will be developed under the direction of the Mental Retardation Division. This plan will be monitored closely through regular progress reviews to assure proactive identification and resolution of non-compliance issues with a view toward strengthening program accountability both while the Consent Decree is in effect and after it expires. This program accountability will be integral to the individual service planning process of assessing, planning, implementing, and evaluating programs to meet individual needs.

Client Protection / Advocacy

An advocacy program which includes the protection of clients' rights and the prevention of abuse and neglect is a part of a more complex quality control program. Such a program combines and integrates effective, modern treatment/habilitation program development, suitably qualified and optimally-trained employees, effective supervision and administration, coordinated and efficient monitoring and accountability for all aspects of the total program. As in the case of the other components, however, advocacy and prevention of abuse require specific attention and independent support to maximize effectiveness.

A. AFFIRMATION OF POLICY; SUPPORT

ISSUES AND DISCUSSION

Department, Bureau, and institution policies, reinforced by statutes, define patients' rights as essential, and abuse, neglect, and abnormal living conditions as undesirable and intolerable. Priorities in resources and official attention have largely gone to other areas, a trend unintentionally encouraged by preoccupations with recurring budget and staffing reductions, deteriorating physical plants, and • judicial actions. As attention focused on other concerns, the official priority given to patients' rights, abuse, neglect, and related matters seemed to fall—not by intent or policy, but by implication or inference—from the greater attention given to other things.

ACTION PLAN

The Commissioner has affirmed his and the Department's commitment to patients' rights, including the prevention of abuse and neglect and the development of an effective, fair process of investigation and correction when abuse or neglect occurs or rights are violated. Such statements have been made in legislative hearings and public forums, and will now be conveyed in writing to state hospitals, nursing homes, county welfare departments and all facilities licensed by the Department.

Statements of intent, no matter how sincere, ultimately lead to cynicism and resistance if not validated by allocation of tangible resources and actions consistent with those statements. Therefore resources and support will be assigned toward the goal of protecting clients.

B. REPORTING AND INVESTIGATING ABUSE

DISCUSSION

Although there are several processes for investigating and reporting alleged abuse and neglect, some (such as the Vulnerable Adults Act) are relatively recent and involve many levels of government and agencies. As a result, a need exists for continuing procedural adjustments, definition of agency roles, consistent definitions of abuse/neglect, and solutions to problems of getting consistent information to relevant persons in a timely fashion. These processes have been complicated by legal requirements for confidentiality and privacy at various stages. Further, there are parallel processes for investigating allegations of abuse from the standpoint of the alleged victim, while maintaining due process under appropriate union contracts for employees accused of abuse. Each process has separate steps and requirements for persons involved.

The coordination of these multiple and complex procedures has improved through cooperative efforts by the state hospitals, counties, the vulnerable adults staff, licensing staff and the Health Facilities Complaints Office (aided by DPW rules: 12 MCAR 2.010, Reporting Maltreatment of Vulnerable Adults in Licensed Facilities, effective January 17, 1983, and 12 MCAR 2.221, Protective Services by Local Social Services Agencies to Vulnerable Adults, effective April 26, 1982).

A need remains for further improved coordination and development of reporting, clarification of responsibilities for reviewing and analyzing reports of trends, and for transmittal of analyses to appropriate persons with recommendations for system changes (policies, procedures, administrative action).

ACTION PLAN

The Vulnerable Adults Act (Minnesota Statute 626.557 as amended) provides the structure for reporting and investigating incidents of adult abuse and neglect. In 1983, legislation was passed providing the structure for reporting and investigating incidents of child abuse and neglect. To the extent possible, procedures for reporting and investigating adult and child abuse and neglect in state facilities will be consistent in order to facilitate implementation.

Staff of the Adult and Volunteer Services Section, Division of Social Services, Social Services Bureau is responsible for developing a coordinated system for reporting and investigating reports of alleged abuse or neglect of vulnerable adults. Procedures for reporting and

investigating alleged abuse and neglect of children are the responsibility of the Family and Children's Section, Division of Social Services. (For both adults and children, the Division of Licensing has a major role in investigation.) Since the majority of persons under care in state facilities are adults, the primary leadership role will be placed with Adult and Volunteer Services. Several bureaus are involved in processes related to abuse and neglect. Reporting, investigation and corrective action responsibilities will be appropriate and clearly defined.

A system designed to report, investigate, coordinate and gather information, will be developed and include:

1. The participation and/or approval of DPW's Residential Facilities Division, Quality Assurance Director, Client Protection Office, program divisions, Licensing Division, Medical Director, state hospitals, and Family and Children's Section; Minnesota Department of Health, Health Facilities Complaints Office; and representatives from the county, police, and nursing homes.

2. Folding in or coordinating all other reporting mechanisms, if needed, with the statutory provisions and rules of adult and child protection, with responsibilities designated for each party involved and with duplication of effort minimized or eliminated.

3. A written guideline describing internal state facility investigation and reporting of incidents, which is consistent with the procedures of county social services, Division of Licensing, Office of Health Facility Complaints, and law enforcement.

4. A separate more prescriptive statement of specific responsibilities and actions of state facility administrators that will provide for the protection of patients/clients, and describe the process of reporting, investigation and resolution of alleged incidents taking into account relevant collective bargaining agreements, plans and state personnel rules and procedures.

5. Recommendations to the Commissioner, and Assistant Commissioner of the Mental Health Bureau, for the establishment of and designation of members for a DPW team to serve on a standby basis for unusual instances where an additional investigation of state hospital/ nursing home resident abuse/neglect is requested by the Commissioner or Assistant Commissioner.

6. Statistics related to occurrences of adult and child abuse and neglect in state facilities, extracted from the statewide statistics by the Social Services Monitoring and Reporting Section, forwarded to the Mental Health Bureau Quality Assurance Director who will summarize the aggregated data and distribute the results to the Mental Health Bureau Division Directors and the Client Protection Office. The Quality Assurance Director, Division

Directors, and Client Protection Office will make recommendations for necessary corrective action to the Assistant Commissioner of the Mental Health Bureau.

7. Identification of any problems which might interfere with the development of a single coordinated system (data privacy, inter-agency or inter-bureau jurisdictional issues, legal issues) and recommendations for solutions to those problems (statutory changes, interagency negotiations, policy changes, etc.).

A system for reporting, analyzing, and developing possible corrective action plans regarding client actions against other clients or against employees, will be developed by the Chief Executive Officers and others (Personnel Management, page 20).

C. ASSIGNMENT OF HOSPITAL ADVOCATES
ISSUES AND DISCUSSION

Each employee's job requires that he/she serve as an advocate for the client. However, each employee's background, perspective and training varies, and concentration on the professional/technical skills and tasks of each job does not ordinarily add up to adequate representation of the client's position in all aspects. Therefore, persons knowledgeable about the requirements for clients' rights and assigned exclusively in that area—advocates—are essential to an effective program.

To date, hospital advocates have been appointed by and are responsible to the hospital Chief Executive Officer. This arrangement has had some advantages. In some cases, the advocate is more likely to be perceived by staff as "one of us" rather than "one of them" and is therefore in a better position to negotiate immediate preventive or corrective action. On the other hand, some advocates can be disadvantaged if they are perceived as part of the hospital administration, thus potentially creating some reluctance for lower-echelon employees to be frank about hospital or client problems. Conversely, it is harder for some advocates to vigorously press some issues which are unpopular or difficult or critical of the hospital administration.

The question of "loyalty" or "troublemaking", or even an implied or felt threat against an advocate is not unknown, though most CEOs understand that an effective advocate not only helps individual clients, but prevents problems, keeps the hospital out of trouble, and helps create conditions and a climate in which clients are more likely to respond to treatment. The effectiveness of the advocate is in large measure dependent upon the attitude and support of the CEO, as well as on the advocate's own strengths and skills.

In recent years there has been increasing concern over the potential and actual constraints and conflicts of interest such an arrangement places on the advocate's effectiveness, and the difficult position in which this places both the advocate and the CEO. Therefore, there have been proposals to assign the advocates either outside the Department

(totally external to the system) or outside the hospital but within the Department (external to the hospital but within the system). Preferring an assignment outside the Department, the Mental Health Association of Minnesota, the Minnesota Association for Retarded Citizens, and the Mental Health Advocates Coalition have taken the position that advocates' supervision should be external to the facility itself.

ACTION PLAN

Direct supervision of hospital advocates will be transferred to the Mental Health Bureau and the Client Protection Office will review and revise advocates' job descriptions in order to emphasize a strong proactive role in protecting clients' rights and preventing abuse and neglect. CEOs will continue to provide structural support and problem-solving skills to assist supervising an effective advocacy program.

Effective results from this action will occur only if the Client Protection Office has additional resources to provide the necessary supervision, administrative support, and instruction to advocates, all of which are now provided by the CEOs and various hospital offices through the hospital budgets. The advocates' wide geographic distribution provides some special supervisory difficulties, and some relaxation of travel restrictions will be necessary. The Mental Health Bureau will provide internal and external resources to support this effort.

D. REDIRECTION OF EXISTING MECHANISMS ISSUES AND DISCUSSION

Some bodies are established for a variety of purposes of which clients' rights and abuse prevention are only part. However, it may be possible to increase their attention to clients' rights and abuse prevention and to stimulate a more proactive stance.

ACTION PLAN

1. The Medical Director and the Medical Policy Directional Committee on Mental Health will develop ways in which the Committee can support components of the quality assurance plan related to treatment, standards, professional training, facility environment, clients' rights, and abuse prevention. The Committee will continue to schedule a periodic detailed review of all institutional deaths, and an annual detailed review of advocacy programs, clients' rights, and client abuse and neglect.

2. The Mental Health Bureau will instruct each hospital review board to review how it presently functions and consider ways in which it can contribute more in the areas described above. The Client Protection Office will meet with each review board at an early regular meeting to identify specific areas and training needs.

3. A proposed Rule 40 regulating the use of aversive/deprivation procedures is nearing completion by the Mental Retardation Division assisted by a task force with outside members.

   a. The proposed rule includes specific monitoring and follow-up requirements to assure that no aversive/deprivation techniques are used apart from the provisions of the rule, that the rule's standards are adhered to in all stages of treatment (not just in the initial approval stage), and that abuse or misuse of the procedures are dealt with.

   b. The Mental Illness and Chemical Dependency Divisions will develop the same or similar procedures or guidelines for their clients in state facilities for whom aversive/deprivation procedures are proposed as part of a treatment plan. They will begin this process immediately by reviewing present procedures and the work of the Mental Retardation Division task force on Rule 40.

   c. The Residential Facilities Division will review the adequacy of facility aversive/deprivation procedures and committees according to present policies and standards. In a timely manner, after the program divisions have developed their aversive/deprivation procedures as recommended above, and with the consultation and/or approval of the program divisions and the Client Protection Office, the Residential Facilities Division will see that each facility's written policies and procedures are revised in accordance with the new rules or procedures.

4. The Residential Facilities Division will instruct quality assurance personnel to include in their studies the adequacy of protection of clients' rights and prevention of abuse and neglect.

PROGRAM REVIEWS: CLIENTS' RIGHTS AND ABUSE PREVENTION ISSUES AND DISCUSSION

The best policies and procedures are likely to be weak or useless without inspection and audit capability. This capability has on the whole been reduced over the past years, with increased dependence being placed on mechanisms such as licensing reviews and accreditation surveys by the Joint Commission on Accreditation of Hospitals or the Accreditation Council for Mentally Retarded and Developmentally Disabled. Internal program audits which have been used (for example, Chemical Dependency program audits by a team of members from the Client Protection Office and the Chemical Dependency, Residential Facilities, and Licensing Divisions) have successfully detected problems and improved treatment programs.

ACTION PLAN

It is proposed elsewhere in this report (page 12) that program reviews

be established. The following will be included in the charge of any program review teams which may be established:

1. Determine conditions (environmental, procedural, attitudinal) which may lead to disturbance, abuse or neglect, or other rights violation.

2. Determine effectiveness of facility abuse/neglect prevention, reporting, and corrective action.

3. Determine effectiveness of facility efforts on behalf of clients' rights.

4. Recommend improvements for protecting clients' rights and pre venting abuse and neglect.

F. CONSUMER (PUBLIC) OBSERVATIONS
ISSUES AND DISCUSSION

Consumers and the public (relatives, visitors, clients) are encouraged to discuss hospital conditions and treatment with the hospital and DPW staff. However, there is no systematic record of such observations, and some may find it inconvenient, embarrassing, or intimidating to consult with the staff or the Department.

ACTION PLAN

Elsewhere in this report (pages 33-34) is a description of a concise consumer (public) input form that will be initiated. This form will include items relating to attitudes, living conditions, and handling of clients.

G. STAFF TRAINING: CLIENTS' RIGHTS AND ABUSE PREVENTION
ISSUES AND DISCUSSION

Training about clients' rights and abuse/neglect prevention occurs in state facilities, but timing, consistency, and content varies.

ACTION PLAN

A previous section of this report describes an action plan for training in the areas covered by this report. Included in that section are plans for training that will cover clients' rights and prevention of abuse and neglect (pages 17-18).

Financial Management

It is a basic administrative requirement that all funds and accounts be managed in such a way that they are used for the purposes intended and are fully accounted for at all times. Because the primary purpose of the institution and its money is to provide programs, any inadequate financial management which might occur would likely have an adverse effect on the resources available for treatment programs.

ISSUES AND DISCUSSION

In early 1982, the Accounting Officer at Anoka State Hospital reported to the Chief Executive Officer that he suspected discrepancies in the facility's Social Welfare account. The CEO promptly reported these suspicions to the Legislative Auditor, who immediately ordered a full investigation. This investigation disclosed a cash shortage of at least $29,000. Legal action is pending as a result of this shortage.

The CEOs of the remaining facilities were advised to review their own procedures for handling cash in the various Social Welfare accounts. As a result of this internal review, the CEO at Cambridge State Hospital also reported a suspected cash shortage to the Legislative Auditor. A final report on an . audit there disclosed a cash shortage of at least $24,000. Legal action is pending at this facility also.

Joint Commission on Accreditation of Hospital surveys occurring over the past several months have reported that state hospitals and nursing homes have not been regularly audited, in some cases not since the mid-1970's. The Residential Facilities Division has repeatedly requested of both the Legislative Auditor's Office and the Fiscal Audit Division that a full annual fiscal audit be conducted of each state institution, and audits are now in progress.

ACTION PLAN

During the last quarter of 1982, the Residential Facilities Division assigned the CEO from the former State Hospital at Rochester to visit each state hospital and state nursing home to review all appropriate accounting

procedures and determine if the procedures followed at Anoka and Cambridge in the Social Welfare accounts were in use elsewhere. Faribault State Hospital was also found to have only one person administering portions of the Social Welfare account. Procedures at Faribault were immediately changed to require a minimum of two persons to be involved in any financial process or procedure dealing with cash.

Beginning February 1983, the Legislative Auditor ordered full audits of Social Welfare accounts at Brainerd, Faribault, Fergus Falls, St. Peter and Willmar State Hospitals. Following receipt of the result of these audits, an implementation plan will be submitted to correct any deficiencies noted or recommendations made.

The Department will request that the Legislative Auditor include audits of Moose Lake State Hospital, and the Ah-Gwah-Ching and Oak Terrace Nursing Homes in the present review.

The Department will request that a biennial audit of each state institution be accomplished.

The results of the Legislative Auditor's report and recommendations will be incorporated into this Quality Assurance Plan when available.

Quality Assurance and Program Management

Treatment programs are not static. They evolve and change with changing needs and conditions of clients, with the development of new techniques, and with the skills and resources of treatment and administrative personnel. Change occurs positively under a constantly adjusting, renewing program plan. Detrimental effects can happen if positive program growth does not occur when needed or if there is slippage in the implementation of a good plan.

It is important, therefore, that treatment programs are accompanied by provisions through which the status of each program is known in terms of its current appropriateness for the individual client, the extent to which it represents current professional knowledge and practice, the degree to which it is implemented, and whether it is effective in achieving the client's treatment/habilitation goals and the goals of the facility and the Mental Health Bureau. These elements are necessary in order to make any needed programmatic, administrative or resource adjustments. This process—quality assurance—is a necessary management and treatment tool.

A. SYSTEMATIC CONSUMER INPUT

ISSUES AND DISCUSSION

The state institutions have programs already in place which assure more protections of human rights than are available in most other settings. Sensitive and caring staff members, conscientious advocates and dedicated outside review boards have all contributed toward making state hospitals humane and effective treatment environments.

But it is more difficult to maintain and assure quality services for persons in state operated facilities than in many other types of health care settings. A large percentage of the patients/residents in these institutions are so severely handicapped that they can neither judge whether they are getting quality services nor be in a position to advocate for themselves.

Many state hospital patients/residents are profoundly dependent upon the system in which they live. They suffer from serious mental deficits which impair their ability to cope with the world around them. They often lack a strong network of interested family and friends outside the hospital, and their lack of financial resources deprives them of "consumer clout" that is found elsewhere in a competitive economic system. In the best of circumstances this kind of dependency diminishes their ability to challenge the service being provided. These patients/ residents are not able, by themselves, to provide the usual consumer pressures that motivate continual change and improvement.

Even where there are interested outsiders—relatives or friends who visit often and try to be helpful—it is difficult for these people to judge whether their loved ones are receiving effective treatment, adequate physical care, or are being neglected. These outsiders need assistance in becoming educated observers and effective spokespersons.

They need basic information and a simple, objective instrument for recording their observations and reporting them to central administration.

ACTION PLAN

Fart of the Department's quality assurance program will involve the systematic use of consumer input both from patients/residents and from outsiders such as family, friends, visitors, volunteers and county workers. It will involve the development of simple checklists which can be filled out by persons having direct contact with patients/ residents in state facilities. Items to be considered for inclusion, depending on accessibility of the information to the respondent, may include:

1. Indication of any perceived abuse or neglect.

2. Verification that a written individual program plan is in the client's chart.

3. Evidence that the staff is carrying out the treatment program as written and updating the plan as needed.

4. Observations about the patient/resident's progress toward treatment goals.

5. Comments about the adequacy of physical care.

6. Comments and observations about staff members' attitudes, interests and general knowledge about patients/residents on the unit.

7. Ratings of the attractiveness and general atmosphere in the units.

Implementation of this external quality assurance program will require:

1. Identifying whose observations should be sought and selecting contents appropriate for each type of observer/consumer.

2. Determining how data is to be analyzed and used for identifying strong and weak points in the service system.

3. Developing a form or forms that can be accurately and easily filled out by the individuals whose observations are sought.

4. Developing a procedure by which the checklist is made available or distributed to relevant persons and collected for analysis.

5. Developing an in-service education program for state hospital and central office staffs to acquaint them with this part of the quality assurance program.

6. Developing an instructions package for persons who will be filling out the questionnaires.

B. FACILITY INCIDENT CONTROL COMMITTEE ISSUES

AND DISCUSSION

At the present time, a number of administrative mechanisms exist for reporting, investigating, and taking corrective action when incidents or accidents occur at the institutions. Preventive measures are also initiated through existing campus safety, infection control, pharmacy and therapeutics, and quality assurance committees. Suggestions from many sources, including advocates, review boards, licensing consultants, fire marshals, Health Department officials, and Accreditation Council for Mentally Retarded and Developmentally Disabled and Joint Commission on Accreditation of Hospitals surveyors are also responded to and acted upon through established administrative channels. Minnesota's vulnerable adults and children legislation requires treatment and prevention planning to protect handicapped persons and this has been implemented in the state institutions.

However, a need still exists at most institutions to take stronger proactive measures to anticipate and avoid serious hazards that might affect patients/residents or that might lead to abuse or neglect of patients/residents by employees or abuse of employees by patients/ residents.

ACTION PLAN

Each institution will establish an incident control committee or assign the following incident control committee functions to an existing committee with appropriate membership: to collect and analyze data relating to serious or potentially serious incidents (accidents, suicide attempts, staff and resident abuse, neglect) and identify situations which pose a hazard to patients/residents or to staff.

This committee will make recommendations directly to the Chief Executive Officer and copies of their meeting minutes will be available for inspection by the central office quality assurance staff. The incident control committee will make recommendations about staff training, staffing standards, supervisory and monitoring activities and other relevant preventive measures.

The CEO will submit a quarterly report to the Commissioner summarizing the data, analyses, recommendations of the committee, and actions taken.

C. FEDERAL AND STATE LICENSING, CERTIFICATION AND ACCREDITATION ISSUES AND DISCUSSION

Present DPW policy requires all state operated facilities to meet Minnesota Department of Health and DPW program licensure standards, fire marshal and life safety codes, and federal ICF-MR certification. In addition, most of these facilities are also accredited through JCAH or ACMRDD. Through these licensing, certifying and accrediting programs, state institution standards have been continually improved.

ACTION PLAN

DPW will continue its present policy of requiring that all facilities seek to meet applicable national and state standards for residential mental health, mental retardation, and chemical dependency programs.

D. ONGOING EXTERNAL REVIEW: QUALITY ASSURANCE OFFICER ISSUES AND DISCUSSION

For Mental Illness and Chemical Dependency facilities, quality assurance programs are already part of the institutions' administrative structures and Mental Retardation facilities are now developing such programs. However, the format of these Quality Assurance committees varies from institution to institution and there have been no requirements for standardized procedures or required audit areas. This approach has allowed each institution to address local treatment issues judged to be of highest priority, but at the expense of consistency of procedures used.

There is no routine DPW monitoring of state institution Quality Assurance committees. Current review of Quality Assurance committees occurs through JCAH, ACMRDD, and licensing or certifying agencies during their survey visits.

There is a need for improved capability and specifically designated responsibility to plan, develop, implement, and coordinate quality assurance policies, procedures and activities of the Mental Health Bureau in order to assure high quality treatment and habilitation programs in an abuse-free setting.

ACTION PLAN

The Mental Health Bureau will establish a position of Quality Assurance Director. This person will be responsible for monitoring the quality assurance system and quality assurance functions throughout the state system, and providing technical assistance to state institutions.

E. RESEARCH AND EVALUATION
ISSUES AND DISCUSSION

Research and evaluation activities improve institution treatment programs in two ways. They provide an organized body of scientific knowledge and stimulate an atmosphere of scientific inquiry and disciplined methodology within the staff at large.

Legislative financial support for state institution research programs was terminated several years ago. Consequently, very few mental health research projects have been completed recently. Depending upon the availability of professional staff and other resources, some institutions have developed and carried out program evaluation and research studies. The Mental Health Bureau program offices have also initiated several follow-up and outcome studies.

In order for the Department to have adequate information about treatment effectiveness and outcome, new resources for underwriting research and evaluation will have to be identified, either by reassigning present staff or locating additional funding sources.

ACTION PLAN

The Department, with representatives from the Mental Health Bureau program offices, the state institutions and the Medical Policy Committee, along with the DPW Medical Director and other appropriate persons or units, will form a task force to develop a position paper on mental health research. This paper will be submitted to the Commissioner, will describe research and evaluation activities currently underway in the state system, and will recommend additional steps that should be taken in research and/or evaluation.

F. INSTITUTIONS MANUAL REVIEW
ISSUES AND DISCUSSION

The Institutions Manual provides a formal description of policies and procedures which have been enacted to carry out significant institutional activities. Changes such as those described in this quality assurance plan will require changes or additions to the Manual.

ACTION PLAN

The Mental Health Bureau will review and update the Institutions Manual in all areas related to quality assurance.