

# Office of the Ombudsman for Mental Health and Developmental Disabilities

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## State of Minnesota

In the Review of: MSHS-Cambridge

Replacement program for the former METO program

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**Date:** September 26, 2012

**Review Team Member:** Alicia Donahue, Chris Michel, and Cheryl Turcotte

### **Legal Jurisdiction for the Review:**

Under Minnesota Statutes 245.91-97, the Office of Ombudsman for Mental Health and Developmental Disabilities is created and charged with promoting the highest attainable standards of treatment, competence, efficiency and justice for persons receiving services or treatment for mental illness, mental retardation and related conditions, chemical dependency and emotional disturbance. Concerns and complaints can come from any source. They should involve the actions of an agency, facility, or program and can be client specific or a system wide concern.

### **Reason for the Review:**

In 2008, the Office of Ombudsman for Mental Health and Developmental Disabilities issued a public report entitled "Just Plain Wrong". The purpose of the unannounced visit was to follow-up on our initial report entitled "Just Plain Wrong" regarding the original METO review and to monitor the progress made. This report describes observations made during the unannounced visit by Ombudsman's staff to the MSHS-Cambridge program on 9/13 and 9/14/2012.

### **Details of the Review:**

During the visit the Ombudsman's Office staff toured the facility, reviewed client charts and documentation. We also observed several mental health reviews with the psychiatrist and/or the advanced psychiatric nurse practitioner. We spoke with Stephanie Kuznia, Stuart Hazard, Paula Halverson and various other staff. As opposed to our 2008 review, staff this time were very welcoming and cooperative.

Our observations and key findings can be found under the following categories:

- Households
- Staffing
- Medications
- Restraints
- Records
- Programming and Treatment
- Employment
- Grievance Process

**This visit was not meant to be a complete or comprehensive review but to give an overview of our observations in key areas during a two day period.**

### **HOUSEHOLDS:**

There has been some remodeling since METO. Walls have been reinforced and plexiglass was used in doors and windows. The former seclusion rooms are now medication rooms. Door handles and locks have been replaced; handles are “suicide proof”. A narrow door which opens outward is located adjacent to the door to the bedroom. This narrow door can be opened to check on the client and to enter if the primary door is blocked. Connecting the two living units/households, is a series of “swing doors” which allow the units to be refigured from the usual four beds on each side, to two on one side, six on the other, etc., in response to the needs of the clients.

The four households visited appeared stark. The main areas typically had nothing on the walls, bare floors and some large pieces of furniture. We noticed few, if any, personal items, magazines, newspapers, etc. Clients do have individual rooms which they can lock if desired.

Near each household’s nursing station were some posted items including a packet of grievance forms. All households had “Home & Courtesy Agreements.” These are “house rules” stating how clients are to treat one another and outline rules and restrictions regarding phone privileges, TV, radio, video games, lights out, access to snacks, etc. See sample. We noted one household’s posted Home & Courtesy Agreements/Guidelines was dated 2008 and its content clearly referred to METO and not the successor program.

**Household Kitchens:** Each household has a kitchen area which can be accessed by clients; supervision is determined individually.

During our tour, there were five clients in the households. Of the five, three were sleeping, one was using the client phone located in a separate room, and one was engaged in negative interaction. Records indicate that some clients wake up, do their first mini-core, and then often go back to bed. Staff said they give reminders or prompts to a client who misses a group or lunch; a client overhearing this remark stated: “no they don’t, they don’t do shit here, they say

they do, but they don't."

### **STAFFING:**

MSHS-Cambridge currently has four nurses on staff, plus the Director of Nursing. The RN's work primarily daytime hours, with an RN on-call nights and weekends. When asked what happens when there isn't an RN on call, both Paula Halverson & Stuart Hazard indicated that that has not happened and will not happen at this time. MSHS-Cambridge is, however, moving toward fewer RN's, with the eventual plan of having no nursing coverage nights and weekends. They indicate this would be most similar to community facilities "like most IRTS are" and would be in line with their current licensing. They plan to move towards increased use of community resources such as the local emergency room or transfer to AMRTC. Quote from Paula Halverson: "If there were any symptoms, we would bring them to Cambridge Emergency Room for an evaluation to determine risk of safety. If it was determined that we could not keep them safe, we would have them admitted."

MSHS-Cambridge currently has four individuals with the position title of behavior analysts (BA). They are having a hard time hiring someone who meets the proposed criteria in the settlement agreement. Stuart Hazard said they are looking at offering MSHS-Cambridge as an internship site to the University of Minnesota program, in hopes of eventually attracting BA's with the desired credentials.

#### **Staff Ratios:**

- Current staff to client ratio: 1 to 2
- Night staff ratio: 3 night staff per building, each building covers 2 households (6 staff total)
- 1 MHP on the unit, per awake shift

The program uses Mental Health Practitioners (MHPs) rather than QMRPs. MHPs include LPNs, BAs, Skills Development Specialist, Licensed Psychologist, Recreation Specialist and Social Worker (?), all of whom are assigned to households. Centralized staff include: the Clinic RN, Psychologist, RNP, consulting Psychiatrist and Discharge Specialist. Their regular physician continues to be Dr. David Paulson. They also subcontract for medical services from Nurse Practitioner, Keri Anderson. The program uses Human Services Specialists (HSS staff) as line staff.

### **MEDICATIONS:**

Medications are passed by staff who have had the required training. When asked about "first-dose monitoring," Halverson responded that medication changes of that nature are done during the week when there are medical staff available for monitoring. MSHS-Cambridge staff reported to us that "stat" medications are discouraged due to the limited availability of medical staff. Clients will be referred to the community hospital if needed. See Policy #6370 First-Dose Monitoring. For a client example see the 8/23 to 8/29 MAR (Medication Administration Record) for BR.

There appear to be a number of clients on multiple psychotropic medications. The Justification for Medication form states the physician's justification for using poly-pharmacy or the use of medication exceeding the FDA maximum dosage. In addition, we noted the frequent use of PRN's. It is unclear to us whether the medication is being used for behavioral control or to alleviate acute psychiatric symptoms. It should be noted that the current Documentation for Implementation of Controlled Procedures form does not include whether or not the client was administered a prescribed PRN or an emergency PRN ordered at the time of the controlled procedure.

One client record contained an undated physician's Script for PRN Ativan. The Ativan is documented on one MAR, but not on subsequent MARs. No documentation was found indicating whether the Script and the MAR documentation are related to the same prescription, or if they cover different time periods. The Script is identified as being from "Minnesota Specialty Health System – Cambridge."

Medications are regularly reviewed, at least twice per month, in the mental health reviews conducted by the psychiatrist or the advanced psychiatric nurse practitioner. We were able to sit in on three mental health reviews, all of which included the client as an active participant and appeared to be very thorough.

### **RESTRAINTS:**

We requested a restraint log from 12/13/2011 to 9/13/2012, and were given documentation regarding seven uses of restraints as well as copies of reviews by the Internal Reviewer.

General Comments: Though prone restraint is not to be used, it is evaluated for contraindications in the initial History & Physical and is referred to in other documents. It appears a prone hold is usually used while in transition to another position.

#### **Examples:**

1. JR had a May 4th restraint. We found two completed DHS 3652 Documentations for Implementation of Controlled Procedures forms describing the same incident. One contained detailed information regarding a prone hold; however, the other did not.

2. JL's record contains an initial history and physical assessment which indicated contraindications to a prone hold; however, a unit form indicated that there were no contraindications. This was brought to the attention of Amanda Bartnick, R.N. who immediately made arrangements to correct this.

Restraint usage is reviewed by Internal Reviewer, Dr. Rick Amado. His reviews appear to be thorough and give specific recommendations. Some of these recommendations were "accepted." However, the majority were "accepted with ... modifications". The MSHS-Cambridge response is done by Stuart Hazard, Treatment Director. It is unclear whether anything further happens with these recommendations, i.e. are they shared with the treatment team or acted upon in some other way. It was unclear what the follow-up process is when the Internal Reviewer says one

thing and the MSHS- Cambridge response is “modified.” The real value of an Internal Reviewer is the Reviewer’s expertise in effectively addressing the behavioral issues through treatment planning. We wonder whether this expertise is being truly utilized in a manner that has a meaningful impact on the client’s treatment.

Examples:

- The Internal Reviewer questioned whether JR’s transfer was clinically contraindicated because he appeared stable prior to his move to MSHS-Cambridge; he further questioned whether this might constitute abuse or neglect. The response indicated that this would be formally brought up at the next diversion meeting. We didn’t find documentation that this was done or that it was passed on to the CEP.
- The Internal Reviewer suggested completion of a functional behavior analysis (FBA) regarding a specific behavior for JS. We did not find evidence of follow through.

No medical orders for restraint were found in the records. When asked, Paula Halvorson said that medical orders for emergency/unplanned restraint are not required for facilities covered by their current license.

At least four uses of emergency restraint were reviewed by DHS Licensing as evidenced by Licensing Compliance Reports/Correction Orders issued on 2/15/2012, 7/5/2012, 7/5/2012 and 7/12/2012. These reports can be found on the DHS Licensing website.

## **RECORDS:**

General Comments: Records appear disorganized and confusing and because of this, the records were difficult to review. The documents are very different than those used at the time of the initial review. Many of the documents are lengthy, redundant and scattered making us question how the records can all come together to be actually used in a meaningful way. In contrast, the purple binder that follows the client was concise, well organized and contained helpful information. This binder is described under “PROGRAMMING AND TREATMENT” in more detail.

Several mistakes and filing errors were noted. Perhaps the most significant was the client record that contained two different History & Physical Forms, obviously describing different people, but both identified as being for the same client. NOTE: This was pointed out to Paula Halvorson who immediately removed the incorrect form. This was brought to her attention because of the potential danger to the client if the wrong information were to be used in an emergency situation.

The difficulty in locating items may or may not be related to the fact that each professional does his/her own filing.

## **PROGRAMMING AND TREATMENT:**

Mini-Core meetings: Mini-cores are held twice daily --- this is a meeting between an individual client and at least one staff person. The client is able to identify what he/she wants to work on and how. Communication issues are addressed and clarified and they talk about what is working and what is not. These working forms are included in a purple binder kept on the household. The binder also contains very simple forms, to be used by client and staff in reviewing, setting goals and making daily plans.

This purple binder is a working individual folder which provides the means by which the volumes of information contained in the actual client records is translated into a meaningful working treatment plan. As opposed to the two primary records, which are cumbersome at best, these binders contain a minimum of paper and seem to effectively translate the plan into daily life activities providing a method for data collection. A core piece is the Quick Look. This is a brief two to four page document written by an R.N., which gives a quick view of the client. It contains the necessary identifying information, diagnosis, medications, brief history, current programming, etc. It provides information in a concise manner readily accessible to unit staff.

Per Stuart Hazard, treatment is based on the **“Boys Town”** model, which was also the basic structure of the old METO. The primary treatment technique used is IM&R (Illness Management and Recovery), an approach normally used with people with serious and persistent mental illness (SPMI). Stuart Hazard indicates that it is not difficult to adjust this approach for persons with developmental disabilities (DD) --- one just needs to “repeat, repeat, repeat.”

Clients are assigned Privilege Levels including “on track”, Treatment Interfering Behavior, and Safety Interfering Behavior. We did not, due to time constraints, delve into this further.

MSHS-Cambridge openly described utilizing IM&R as their primary treatment modality. Stuart Hazard provided information pertaining to implementation.

- “Illness Management and Recovery Focus Areas” is a document located within each client chart.
- It outlines each of the ten modules within the IM&R program. Each module includes a handful of bullet points describing the topics covered in that module.
- Mr. Hazard reports the IM&R module “Drug and Alcohol Use” is not used due to “staff not having the necessary training or credentials.”
- Staff are assigned to one of each of the other nine IM&R modules. That staff person is then responsible to learn the curriculum and facilitate the group sessions for that module.
- Mr. Hazard reports that Nicole McMahon (staff person from AMRTC – unknown to us function) helped redesign IM&R to be a more appropriate fit for their clientele. We do not have specific information regarding the redesign.
- When Mr. Hazard was asked, “as the treatment director, how did you decide on this

treatment modality, which is not an evidence based practice for the population you serve?” he answered “because it was a preset curriculum.” When Mr. Hazard was asked, “how has MSHS-Cambridge overcome the IM&R requirement of client’s recognizing and challenging highly cognitive distortions and behaviors?” he responded “while it doesn’t necessarily fit with our population of DD, it does meet some of their needs.” When asked for specific examples of ways in which the programming was modified to fit with their client population, Mr. Hazard replied with “simpler language and more repetition.”

- Mr. Hazard indicated while alcohol and drug abuse is not addressed through IM&R, it is also not addressed with any other treatment method even though a number of clients have chemical dependency issues.

START (“Socialization Training and Anger/Aggression Replacement Treatment”) is another treatment modality utilized at MSHS-Cambridge. Mr. Hazard indicates this treatment is based on the program “Be Cool.” CoolAnger.com reports this treatment model “combines educational, awareness, insight cognitive and real life applications to bring the client into self-empowerment to change” ([www.CoolAnger.com](http://www.CoolAnger.com)) MSHS-Cambridge “Be Cool” programming is done in a group setting. It utilizes worksheets, handouts and videos. Based on our reading we can’t tell whether this is evidenced based practice or is suited to this population.

MSHS-Cambridge subcontracts with Riverwood Center once a week for sex offender treatment and MSHS-Cambridge provides transportation.

Cambridge Isanti School District provides educational services for individual clients at MSHS-Cambridge. Clients do not go off campus to attend public school.

Sensory Room: Though not visited at this time, several OMHDD staff recall seeing this room at the time of the original review. It continues to be overseen by the Skills Development Specialist and continues to be located in the Vocational Building. The room provides a calm peaceful environment. It contains a variety of swings, brushes and other sensory items. Clients can, and do, request to use this room.

Recreation Center: While touring, we observed several clients and staff interacting in a positive manner while engaged in a number of wellness activities.

## **VOCATIONAL:**

Assessments include identification of clients’ strengths and needs in the vocational area and may include a determination of potential benefit from work opportunity. There is also documentation that at least some clients want to work. This is a very important part of day to day living; however, it does not appear to be addressed. There are no employment or job training opportunities available to clients at MSHS- Cambridge. Example: In the former METO program, NK consistently attended work, was considered a good worker and found the job interesting. Although NK continues to state “I want a job, I need to make money,” employment is not



available under the MSHS-Cambridge redesigned program. We noted during the initial METO review that the vocational program was robust and we were disappointed to see this absence in vocational opportunities.

### **GRIEVANCE PROCESS:**

See Grievance Policy and sample form. A packet of forms is posted outside the nursing station on each living unit. The hospital review board is no longer utilized by MSHS-Cambridge.

### **OMBUDSMAN'S COMMENTS/CONCERNS:**

I have reviewed the observations made by the staff of this agency and provide the following comments.

The Ombudsman remains concerned about the following issues reviewed in this visit report. These may be in addition to other areas previously expressed by this agency in the original report and over the course of various meetings the Ombudsman has had with the leadership of DHS since the original report was issued.

- There is a general concern that the programing provided for the clients deviates from the original purpose of the program as outlined in the empowering legislation for METO or the subsequent Settlement Agreement that described the conditions of any successor program. This was and is to be primarily a program for individuals with a developmental disability with serious behavioral and legal issues, regardless of what other co-occurring conditions these clients may have.
- There is concern that there is a lack of vocational/habilitation programing that has clearly has always been a hallmark policy of this state for persons with developmental disabilities.
- There is a concern that chemical restraints appear to be used based on the PRN use of psychotropic medications and other medications used to deal with agitation.
- There is concern regarding the lack of medical staffing and the use of HSS staff for medication monitoring including first dose or PRN medication, given the number of complex medications that many clients are prescribed. There is concern as to whether HSS staff members are trained on monitoring for the very serious side effects that can accompany use of PRN antipsychotics.
- Also arising out of concern for the medical coverage is the issue of using the local Cambridge Medical Center when a client is out of behavioral control. While on first look this might appear to be logical, however the Cambridge Medical Center's Director of Behavioral Health is the same person who was the Clinical Director at METO during the time of excessive restraints and the person who would decide what protocols the Medical Center will use when the MSHS clients are at the medical center. In addition, it was the understanding of the Ombudsman that the special unit at AMRTC was supposed to



provide those services needed when the MSHS – Cambridge clients were in need of acute behavioral stabilization.

- There is a concern that the Internal Reviewer is not being utilized as intended in the Jensen Settlement Agreement. We question why the facility under federal monitoring is allowed to reject or modify recommendations.
- Charting continues to remain a significant concern.
- Our office remains concerned that despite the agreement that this program would not be developed as an IRTS, all indications point to the program operating as if they are. Just because the DHS Licensing laws, rules and variances for persons with developmental disabilities under 245B are silent on medical staffing, day habilitation by the program and other issues does not mean that this is the right approach for the population that is to be served in this program.

Issued under the authority of



**Roberta Opheim**

Minnesota Ombudsman for Mental Health and Developmental Disabilities