

Mental Disabilities Board of Visitors

SITE REVIEW REPORT

Kids Behavioral Health of Montana

Butte, Montana

- August 25 - 26, 2005
- September 15 - 16, 2005
- October 7, 2005
- November 10, 2005
- December 16, 2005
- January 20 - 21, 2006

Gene Haire, Executive Director

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**Mental Disabilities Board of Visitors
Site Review Report
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OVERVIEW

Mental Health Facility reviewed :

Kids Behavioral Health of Montana(KBH)
Butte, Montana
Pam Broughton - CEO (through October 7, 2005)
Albert Gale - CEO (October 2005 - through present)

Residential Treatment Facility (RTF)

Authority for review :

Montana Code Annotated, 53-21-104

Purpose of reviews :

- 1) To learn about KBH services.
- 2) To assess the degree to which the services provided by KBH are humane, consistent with professional standards, and incorporate BOV standards for mental health services.
- 3) To recognize excellent services.
- 4) To make recommendations to KBH for improvement of services.
- 5) To report to the Governor regarding the status of services provided by KBH .

Review process :

- Interviews with KBH administrative and clinical leaders, line staff
- Observation of treatment activities
- Review of written descriptions of treatment programs
- Formal and informal discussions with children
- Inspection of physical plant
- Review of treatment records

BOV Review Teams

August 25 - 26, 2005		
Staff	Board	Consultants
Gene Haire, Executive Director	Kathleen Driscoll, Vice Chair	Bill Docktor, PharmD, BCPS
	Joan-Nell Macfadden	Irene Walters, RN
		Pat Frawley, LCSW
September 15 - 16, 2005		
Staff	Board	Consultants
Gene Haire, Executive Director	Kathleen Driscoll, Vice Chair	Bill Docktor, PharmD, BCPS
	Joan-Nell Macfadden	Irene Walters, RN
		Pat Frawley, LCSW
October 7, 2005		
Staff	Board	Consultants
Gene Haire, Executive Director		Bill Docktor, PharmD, BCPS
November 10, 2005		
Staff	Board	Consultants
Gene Haire, Executive Director		
December 16, 2005		
Staff	Board	Consultants
Gene Haire, Executive Director		
January 20 - 21, 2006		
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Gene Haire, Executive Director	Kathleen Driscoll, Vice Chair	Bill Docktor, PharmD, BCPS
	Joan-Nell Macfadden	Irene Walters, RN
		Pat Frawley, LCSW
		Sheila Smith, LCPC

ASSESSMENT OF SERVICES

Initial Purpose of August 2005 Site Review

The Mental Disabilities Board of Visitors (BOV) scheduled a site review of KBH services for August 2005. Prior to this scheduled review, BOV received several complaints from parents of children who had been at KBH, and noted an increase in KBH-reported "non-accidental" injuries to children and staff. In addition to its standard plan for interviewing staff and residents, reviewing records, and observing program activities; BOV's planned to focus attention during its August review on these particular concerns.

Halfway through the first day of its August review, the BOV team was shocked by the chaos in the treatment environment, by the negligence of the clinical leaders to address the breakdown in the treatment environment, and by the absence of awareness of the grave problems by administrative leadership. BOV abandoned its usual review procedures and shifted to assessing the scope of the problems, focusing on the safety of the residents.

On August 26, 2005, the BOV Executive Director left a voice mail message with the Chief of the Licensure Bureau noting BOV's extreme concerns. On August 29, 2005, the BOV Executive Director discussed these concerns with the Bureau Chief on the phone. On September 1, 2005, BOV sent a letter to KBH¹ (see Addendum 1) citing its authority under Montana law, and making the following recommendation:

Analyze the causes of and immediately put into place resources, procedures, and interventions to eliminate the occurrence of resident-on-resident assaults.

Admission Moratorium Imposed by the Quality Assurance Division

On September 2, 2005, the Quality Assurance Division placed a moratorium on admissions to KBH (see Addendum 2) - which remained in effect until November 16, 2005.

September 2005 Follow-up Site Review / Preliminary Assessment

BOV returned to KBH with its team next on September 15-16, 2005. On the morning of September 15, 2005, at the beginning of this follow-up review, the KBH CEO presented the BOV Executive Director with its written response to BOV's September 1 recommendation (see Addendum 3)².

BOV's letter to KBH dated October 5, 2005 (see Addendum 4) contained a detailed assessment of conditions at KBH based on BOV's August and September reviews, and responded specifically to the KBH September 15, 2005 memorandum. BOV's October 5, 2005 letter contained the following **Findings, Primary Causes, and Recommendations:**

¹ This letter and recommendation formed the basis, as required by Montana law (53-21-104[7], MCA), for ongoing communication between KBH and BOV as detailed in this report.

² BOV has not included the Exhibits provided by KBH in this and other Addenda. Contact BOV for copies of the Exhibits.

Findings³:

- 1) 53-21-107. Abuse and neglect of persons admitted to mental health facility prohibited -- reporting -- investigations.

BOV finding: KBH does not properly detect, report, or investigate allegations of abuse and neglect.

- 2) 53-21-142(2). Rights of persons admitted to facility. Patients must be accorded the right to appropriate treatment and related services...

BOV finding: The treatment environment at KBH is so dysfunctional that appropriate treatment and related services are severely compromised.

- 3) 53-21-142(13). Rights of persons admitted to facility. Patients have a right to a humane psychological and physical environment within the mental health facilities.

BOV finding: KBH has not established and does not maintain a humane and safe environment for residents.

- 4) 53-21-146. Right to be free from physical restraint and isolation.

BOV finding: KBH direct care staff are too poorly trained and supervised and the treatment environment is too chaotic for engagement with residents to ensure that less restrictive approaches are used before physical interventions, and that when physical interventions are used, that they are used properly.

Primary Causes of Resident-on-Resident Assaults/Aggression, and of the Dysfunctional Treatment Culture:

- 1) The presence and acquiescence of a culture of violence and cynicism and a “corrections” atmosphere that has desensitized both staff and residents precludes the possibility for therapeutic engagement because the environment is not safe; staff are not in control of the treatment environment.
- Residents freely discuss their advantage over staff and how they manipulate the environment to create vulnerabilities.
 - In a group situation with the adolescent girls observed by BOV, girls came and went from the group as they pleased, and were disruptive; staff established no boundaries for this behavior.
 - Adolescent girls spoke of their manipulation of staff and their methods of making the staff vulnerable; of the staff they have injured; of their fear of being assaulted by their peers; of the staff’s inability to prevent or intervene on these situations; of having to get help for staff who were being attacked.
 - One adolescent girl stated, “I have never felt as unsafe as I do here.”
 - Staff talk about not knowing what to do to regain control.
 - Staff could describe no tools at their disposal except physical interventions.
 - No appropriate corrective strategies are identified on injury reports.
 - The Director of Nursing showed BOV the primary tool for communication and safety – a walkie talkie - hers was in a desk drawer with a dead battery.
 - Incidents are not appropriately debriefed. Vicarious trauma identified by staff is not addressed, leaving them incapable of therapeutic engagement.
 - Children and staff describe a culture of being respectful of female staff. i.e.: standing until female staff sits down in the cafeteria. Youth witnessing a peer being held by a female staff person jeered at the held youth, “You better not hurt her”, etc. This culture does not extend to male staff. It puts an unhealthy burden on dysfunctional youth to be the guardians of the female staff and further fosters a

³ Invoking 53-21-104(7), MCA with regard to the provisions of the Mental Commitment and Treatment Act.

culture of acceptance of violence as a provision of safety. Residents report that youth who “aggress” on female staff “get it later”. Staff have no insight into the danger and dysfunction established by allowing this to be the female staff’s tool of protection.

- Categorization of injuries on the injury report goes from a ‘2’ which states...pain with no visible injury...to ‘3’ which is characterized by need for treatment in an ER. The distance between the two is vast. Consequently, most injuries are categorized as being minor at a level ‘2’ even if skin is torn, etc.
- Residents report being denied the ability to file police reports for attacks. Two youth reported having requested this but, “They never came back to take the pictures of my injury or took my statement”, “They kept saying I could and my parents wanted me to but they never followed through”.
- Frequent theme from staff and residents that “promises are broken”, “no one follows through”, “requests for supplies, staff, etc. are denied”.
- Therapists report feeling “disempowered, invisible”.
- One child states, “A girl aggressed on me so I had to go to a different team. Now I will be here longer because I can’t go to my CD group. They bring me the material but I can’t read good enough.”
- Eight incidents in July of resident injuries related to broken bathroom tiles; only two of these were reported to maintenance.
- Outside area for adolescent recreation is a relatively small, foreboding area surrounded by a new, eight foot high chain link fence that looks and feels like a prison exercise yard. Residents and staff refer to it as the “rat cage”.

2) The lack of a coherent, clearly-articulated treatment paradigm.

- Throughout KBH literature and program documents, there are references to “residential treatment”, “quality programming”, “nurturing, healing, and healthy therapeutic environment”, “structured, therapeutic milieu”, “interactive resident community”, and “therapeutic intervention”. However no one BOV has spoken to at KBH can articulate clearly what the approach to treatment is.
- The Clinical Director refers to an ever-changing array of behavior-related approaches that appear to be reactive, not proactive approaches that support and are congruent with an overarching model. As stated above, several treatment modalities such as DBT, Moral Recognition Therapy, Today/Tomorrow, and Second Step are being implemented. However, these discrete treatment components must be parts of a coherent whole within a truly safe, nurturing treatment environment in which all staff approach residents consistently, firmly, skillfully, and compassionately. This kind of treatment environment is not in place.

3) The absence of a clinically-driven referral screening and admission decision-making protocol.

- The referral and admission decision-making process disregards the Medical Director’s and other clinicians’ judgment about residents who should not be admitted because of overriding conduct disorder problems and histories of violence, assault, and disruption of previous treatment environments.

4) As a result of (3) above, the presence in the treatment environment of violent, seriously conduct-disordered youth who terrorize other residents and staff at will.

- In a very real and elemental sense, the resident mix at KBH is a volatile blending of children/adolescents who are either passive and/or victims of abuse and violence and children/adolescents who are perpetrators of abuse and violence against others.

5) Overcrowding - the presence of too many residents in the physical space available.

- The number of licensed beds has increased from 48 under the Rivendell program in the late 1980s to 85 currently without any increase in the space in the physical environment.
- Adolescents are housed three to a room.
- Overcrowding is constant and occurs in every aspect of the facility.
- There is inadequate room for anyone to go to unwind or to get away from a group.

6) Direct care staff are under-prepared, unsupported, inadequately supervised, do not have a treatment role, are unsafe in the treatment environment, and do not stay at KBH very long.

- Initial pre-service orientation does not provide adequate education to prepare Mental Health Associates (MHA) to take a treatment role.
- There is inadequate ongoing education.
- No one adequately monitors the competency, skill, effectiveness, consistency, or compassion with which MHAs interact with residents or conduct skills groups.
- BOV observed MHA staff interacting with residents as if they were commiserating about their common situation having to be at KBH; on these occasions, staff appeared to have no concept of professional boundaries and appeared to share some of the anti-social traits of some of the residents.
- Nurses report inconsistency of MHA training and MHA skill deficits as being a major source of difficulty on the units.
- 132 staff injuries in 2.5 months.
- Staff routinely hold residents for 45 minutes or longer.
- The therapeutic value of holds is very unclear.
- During the multitude of emergencies, available staff go to help, leaving remaining staff vulnerable.
- Staff are not able to describe treatment objectives.
- BOV overheard one staff talking to a youth saying, "At least we don't have to be in DBT class."
- Charting revealed issues of power struggles between staff and residents - even involving senior staff.
- 6 – 12 new MHAs are cycled into the "pool" each month to replace others who have left.

7) Confusion about the chain of command.

Even with new leadership and organizational changes – which, as stated above, are positive and hopeful steps - BOV is concerned that the lines of authority and accountability - from corporate to line staff – are not clear enough, and that there continues to be potential for confusion and compartmentalization regarding the chain of command.

The following authority / accountability lines are not clear:

- disconnect between the Nurse as unit leaders and the Team Leads as unit leaders (BOV observed MHA staff openly criticizing a Team Lead's direction regarding holding a child, the Nurse who was present telling the MHA that she could not override the Team Lead, then the Nurse directing the MHA and the Team Lead to take another course of action).
- disconnect between clinical, nursing, and line staff (with the new Program Director position in place, these three staff groups still follow parallel chains of command that do not connect before the CEO level)
- disconnect between Program Director, Clinical Director, Nursing Director, Medical Director (same situation as stated in the bullet above - in reverse)

8) The absence of anyone in a leadership position at either the Butte or corporate level who has demonstrated awareness or insight into clear evidence of pervasive dysfunction and related safety and treatment issues over a number of months, who has called out for an explanation of this dysfunction, who has demanded solutions and empowered others to seek them, who can see beyond the data and statistical trends, who can be truly present in the milieu and form relationships with the staff in the trenches, and who can rally the staff at all levels.

- Unanalyzed injury reports dating back at least 9 months (January 2005 through September 14, 2005).
- No corporate awareness of the crisis or the need for intervention prior to BOV/QA/MAP direct involvement.
- No interactions with the Butte-level "Governing Board" until very recently.
- Compartmentalization of information and analysis at every organizational level.
- Director of Nursing does not have contact with the nurses on the units.
- Unit staff report no meaningful contact with the Clinical Director.
- The Director of Nursing showed BOV the primary tool for communication and safety – a walkie talkie - hers was in a desk drawer with a dead battery.

- Seriously injured staff given the same unit assignment immediately after an attack by a resident, sent a communication to leadership, administrator made a brief passing comment “I got your note.”, no action taken, no one in a leadership position acknowledged staff person’s experience or inquired about her physical or mental well being.
- One staff person in a mid-level leadership position reports never having been approached by or having had a conversation with a senior leader in three years of employment.
- Approximately 60% of resident and staff non-accidental injuries occur before 5:00pm when ancillary staff and leadership are available (but do not respond to incidents).

Recommendations made on October 5, 2005:

(the following recommendations are made in the context of and invoke the response requirements of 53-21-104(3), MCA and 53-21-104(7), MCA.)

- 1) **Voluntarily continue the moratorium on admissions.**
- 2) **Do not resume admissions until KBH demonstrates competence and stability with a smaller resident population over a meaningful time frame as evidenced by:**
 - appropriate admission decisions and process (verified by outside oversight)
 - discharge of residents who represent an unacceptable risk to other residents and staff
 - adoption of a coherent, overarching treatment paradigm consistent with evidence-based practices in the treatment of children with serious emotional disturbance (established with outside clinical consultation)
 - a monthly root cause analysis report of all ‘adverse patient outcomes’ that includes an ongoing action plan, specific corrective interventions, and a description of the results of corrective interventions (including, but not limited to reduction of adverse patient outcomes – especially non-accidental injuries) submitted to QA and BOV
 - demonstration of 100% MHA competence in all areas relating to resident interactions and related treatment activities, including skills groups
- 3) **Determine the maximum number of children that can be safely and effectively served in the current KBH facility.**
- 4) **Stabilize unit staffing by establishing the optimum number of staff per unit/shift – schedule this number regardless of census; assign the same individuals to the same units/shifts consistently unless an emergency staffing problem exists.**
- 5) **Establish 30 minute shift exchanges between night and AM shift (6:45am – 7:15am) and between AM shift and PM shift (2:45pm – 3:15pm) supervised by Team Leads and Assistant Team Leads or other supervisors as needed.**
- 6) **Adjust the referral screening and acceptance procedure so that referrals with clear diagnostic profiles and/or behavioral histories that include documented violence against others and/or significant disruption in other settings, or other indications of high potential for violence against KBH residents or disruption of the KBH milieu are not admitted to KBH.**
- 7) **Adjust the referral screening and acceptance procedure so that the Medical Director has the final decision-making authority.**
- 8) **Identify and discharge residents who represent an unacceptable risk to other residents and staff.**
- 9) **Begin analyzing every ‘non-accidental injury’ of residents and staff for root cause and submit a monthly root cause analysis report that includes ongoing aggressive action plans and results of corrective interventions to QA and BOV.**
 - adopt a ‘rapid cycle’ evaluation and response model

- direct and senior supervisory follow-up in person with each injured resident and staff within 24 hours of each injury
- 10) **Develop a ‘STAT team’ which consists of ancillary staff (CEO, Clinical Director, Director of Nursing, Clinical Nurse Specialist, Medical Director, Program Director, Director of Admissions and Discharges, Resident Advocate, Care Managers), trained to respond to emergency situations to reduce the number of staff who have to be pulled from duty stations.**
 - 11) **Begin immediately to report incidents as required under 53-21-107, MCA.**
 - 12) **Arrange for outside, independent investigation of all allegations of resident abuse/neglect that meet a severity threshold to be determined by KBH/QA/BOV or in which any kind of conflict exists.**
 - 13) **Tear down the “rat cage”; involve MHA staff, residents, and Governing Board in the design of a new, larger, comfortably landscaped, non-correctional, outdoor recreation area.**
 - 14) **No later than November 1, 2005, send a letter to each parent or guardian and referral source of each child currently residing at KBH and of each child admitted to KBH into the indefinite future (until competence and stability are demonstrated per recommendation #2). In this letter, explain the problems that KBH has been experiencing, the oversight activities that are taking place (QA and BOV), and KBH plans to address the problems. Compose this letter with the input of BOV.**
 - 15) **Distribute the 9/1/05 BOV letter, the KBH response that letter, this letter, and the KBH response to this letter to all KBH staff and to the Governing Board.**
 - 16) **Distribute the QA Licensing Deficiency Survey Report and the Plan of Correction to all KBH staff and to the Governing Board.**
 - 17) **The CEO, Director of Nursing, and Clinical Director should meet with all KBH employees in small groups no later than November 1, 2005, apologize for and take ownership for the mistakes that led to the current situation, explain the corrective actions that are in place and planned, ask for their support, and ask for their ideas about healing KBH.**

October – November - December 2005 Follow-up

The BOV Executive Director and pharmacology consultant returned to KBH on October 7, 2005 to review in detail the use of emergency and PRN (as needed) medications (see Addendum 5), and to interview the Medical Director. Upon arriving on the morning of October 7, BOV was informed that the CEO and the Nursing Director were no longer employed by KBH, and that the Clinical Director’s duties had been significantly curtailed.

On November 10, 2005, the BOV Executive Director interviewed a number of staff and observed treatment activities to assess changes that KBH had initiated since October 7, visited with the new acting CEO, and reviewed with him the KBH written response to BOV’s October 5 recommendations (see Addendum 6). Following this visit, the BOV Executive Director recommended to the Quality Assurance Division - based on observed significant improvements in the treatment environment - that the admission moratorium be lifted. The moratorium was lifted on November 16, 2005. The BOV Executive Director visited KBH again on December 16, 2005.

January 2006 Follow-up Site Review

On January 20-21, 2006, BOV returned with a full team to review in-depth changes in the treatment environment as well as the status of the administrative and clinical leadership activities. The team addressed the following questions as framed by the **Findings, Primary Causes, and Recommendations** above (similar questions posed in more than one of these area are grouped together to avoid redundancy):

Does KBH properly detect, report, and investigate allegations of abuse and neglect?
(FINDING #1)

Are allegations of abuse/neglect being reported as required under 53-21-107, MCA?
(RECOMMENDATION #9)

How are decisions being made regarding bringing in outside investigators for certain incidents?
(RECOMMENDATION #10)

Overview:

KBH has recognized the deficiencies in its handling of abuse/neglect allegations and has corrected its process. BOV has worked with KBH to clarify requirements and procedures relative to reporting to BOV, and will continue to monitor in this area.

Staff are doing a better job investigating incidents, more quickly completing investigations

Is the KBH treatment environment functional?

Does the treatment environment support appropriate treatment?
(FINDING #2)

Overview:

In contrast to the treatment environment at KBH prior to January 2005, there is evidence of considerable improvement in the treatment environment. The treatment environment has turned the corner from a negative, reactive, and punitive to a positive, supportive milieu.

Changes that have facilitated this improvement are:

- removal of negligent clinical and administrative leaders and the selection of new leaders who are invested in positive outcomes
- reduced resident numbers
- more careful screening process for new admissions
- removal of inappropriately placed kids to other facilities
- clearer treatment approach
- improved training and support for line staff
- improved communication

Other BOV observations:

- Under new leadership, teams are more effective – program managers are now able to function in their roles as intended.
- Supervisory staff are more aware of what is happening on the units.
- Administrative and clinical leaders are spending time on the units and interacting with staff and children.
- The creation of the Assistant Program Lead position has improved supervisory coverage and cross-shift communication.
- Staff:resident ratios are closely monitored and kept to the new levels⁴.
- The new Activities Director (who is a licensed Recreation Therapist) is a needed addition and has greatly increased recreational activities; there are now structured games, crafts, hobby building, after school activities and outings which provide a healthier treatment environment; children are busy in positive ways; the Activities Director is a part of the treatment team.
- The daily resident schedule allows for less unstructured time.
- The 'Today/Tomorrow Program' has reoriented the milieu and interactions between children and line staff toward a positive approach – both staff and children like it; it has facilitated movement away from reacting/responding to negative behaviors with punishment toward recognizing/reinforcing positive behavior.
- MHAs are now aware of treatment objectives and are have a more clear treatment role; they provide input to the treatment planning process.
- Therapists are now on the units more and interact with the line staff; therapy services are more integrated into the milieu.
- A 'point sheet' that tracks resident movement through the level system is designed to parallel the treatment plan; children earn points for behavior that is defined in treatment plans; points can be exchanged in the 'merit store' for desired items – enhancing a positive orientation to daily choices.
- The level system has been revised so that it is more responsive to behavior and choices over shorter time frames (the level can change daily for adolescents and every shift for the younger children).
- Line staff schedules now enhance consistency and match skills with the resident they work with.
- Daily services review meeting captures all relevant issues, ensuring that feedback and follow-up take place; line staff input is brought to this meeting.
- The 'shift dynamic form' is a good tool that has improved communication and cohesion among shifts and across disciplines.
- Communication among service components (direct care, clinical, school, medical, nursing) is improved.

Concerns:

- The improved milieu as described and observed by BOV appears to support treatment; it will be critically important for staff at all levels of KBH to maintain awareness of all variables that affect treatment and work diligently to maintain the improvements over time.
- While KBH appears to be committed to bringing the census up carefully, and within the parameters of good clinical judgment, BOV believes that there should be continuing oversight to ensure that increasing resident numbers do not return to inappropriate and unworkable levels
- Therapists are not assigned to only one "team" of residents; this fact diminishes the coherence of each team, dilutes the effectiveness of the Therapist role, and reduces the integration between the milieu / resident teams and the clinical component.

⁴ 1:3 for the youngest children's team; 1:4.5 for other children; 1:5.5 for adolescents during the 7am – 3pm shift; 1:5 for adolescents during the 3pm – 11pm shift (see Addendum 6, p. 2)

- The two-way radios carried by the MHAs are noisy and disruptive in the classrooms and in the milieu generally, contribute to a 'corrections' feel, and – in the content of communications - compromise the residents privacy.
- Communication protocol between therapists and MHAs is not defined or formalized; communication of relevant clinical information – whether in person, via the team lead, or in writing varies by therapist.

Recommendations:

1. Assign a designated Therapist to each residents team.
2. Reallocate program management structure so that each Program Manager is responsible for one team of 12 residents; creating "mini-programs" within the overall program would lend itself to better, more cohesive treatment and an improved sense of ownership among all staff in each "mini-program".
3. Improve the integration of the educational component and the mental health component by establishing more clearly that each classroom is a treatment environment; ensure that educational goals are consistent with the mental health treatment goals.

Is the KBH treatment environment humane and safe environment for residents?

(FINDING #3)

Has the rate of 'non-accidental injury' of residents and staff been brought to a reasonable level?

(RECOMMENDATION #7)

Are 'non-accidental injuries' of residents and staff being appropriately analyzed?

(RECOMMENDATION #7)

Are appropriate corrective interventions in response to 'non-accidental injuries' taking place?

(RECOMMENDATION #7)

Overview:

Interviews with staff and residents, and an examination of incident reports clearly indicate that the treatment environment is safer than it was prior to January 2006; residents and staff report that they are more comfortable (i.e. feel safer) than last August. The number of emergency medications, seclusions, and restraints has decreased substantially since August. The number of incidents of resident-on-resident aggression has increased, though the number of injuries to residents has decreased. The number of injuries to adolescents has decreased; the number of injuries to children has increased.

Director of Nursing keeps excellent hand-written records of injuries and other "negative outcomes", and can clearly articulate the trends and patterns.

Staff are intervening earlier. Chaos has been greatly diminished. Leadership is looking at incidents daily and implementing appropriate responses to identified issues.

Changes that have facilitated this improvement are:

- Inappropriately placed children with conduct disorders have been discharged.
- The new Resident Advocate and the new Nursing Director are clearly committed to maintaining safety and the integrity of the treatment environment; they are diligent in their efforts to collect, review, and monitor information related to resident safety; the Nursing Director, in particular, has an excellent ability to look at the data and recognize areas that need to become a focus of concern.

Concerns:

- KBH needs more experience with its improving treatment culture to demonstrate the ability for optimum responses to reports of injury and allegations of abuse/neglect.
- The data available demonstrate that a shift has been made, but the evidence does not yet demonstrate if this shift represents a sustainable improvement in safety.

- Incident and other negative outcome data need to be adjusted for census. Simple injury numbers do not necessarily mean the same thing with a census of 85 as they do with a census of 40. (e.g. one injury with a census of 40 is a rate of 2.5%; one injury with a census of 10 is a rate of 10%).
- The current data system is cumbersome and only allows for a quarterly report to be generated at the cooperate office. Nice reports are provided to KBH-Butte, but the information collected needs to be easily and quickly analyzed on site for staff to respond with appropriate interventions. The ability to analyze data and use it for quality improvement is hampered by the lack of appropriate computer program capabilities that would reflect trends or other red flags. Data is not sufficiently analyzed to tell if incidents of resident-on-resident aggression are less critical. Both the Resident Advocate and the Nursing Director have a very good idea of the kind of spreadsheets that would be helpful for them to effectively monitor resident safety, treatment, and outcomes. (see the section **Is the KBH treatment environment humane and safe environment for residents?**)

Recommendations:

4. Improve/simplify the process for analyzing data.
5. CEO and corporate office should consult with Nursing Director and Resident Advocate regarding the kind of software that would meet their needs, provide those resources, and provide training in the use of the software.
6. Research “non-accidental injury” benchmarks for this population in other treatment venues nationally.

Are KBH staff well-trained?

(FINDING #4)

Are KBH staff well-supervised?

(FINDING #4)

Have significant improvements been made in preparing and supervising direct care staff?

(PRIMARY CAUSE #6)

Overview:

Staff are better trained now than prior to October 2005; however, evidence of the results of improved training may not come for another year or two. New leaders appear to have good instincts and insight.

Staff are better supervised than prior to October 2005. BOV observed leaders and supervisors - including senior leadership - out on the floor offering help or direction in the moment.

The creation of Assistant Team lead positions on the second shift is a positive addition to the supervisory structure.

Direct care staff have received more training; job responsibilities and expectations have been reworked and now are more clear; the roles for Program Managers, Team Leads and Assistant Team Leads in support of MHA accountability are now clear; BOV saw evidence of supervision and “teaching moments” taking place on the units; direct care staff appear and describe feeling more confident and competent.. (One indicator that this process is working is evidenced by the lower rate of staff turnover and fewer numbers of staff calling off sick.)

During the BOV visits in August and September, some of the MHA’s were observed to interact inappropriately with children, making sarcastic comments, and sabotaging treatment. Presently, all staff observed appeared to be engaged and knowledgeable about the issues the children are working on.

Concerns:

- New leaders will need more tools to maintain any degree of success.
- Clinical and administrative leadership has had no formal training regarding (1) the issues that led KBH to serious problems, or (2) their role and skills needed to implement culture change and to sustain improvement.

- There is no formal training program developed for MHA's other than the orientation.
- Line staff are always with kids; they don't have opportunity to give and receive peer feedback.
- There is not a regular schedule of full team meetings with all employees from all shifts present.
- There is no regularly-scheduled individual supervision for MHA staff which would encourage staff to more closely examine the transference and counter transference traps associated with this special client population.
- There is no regularly-scheduled individual supervision for supervisory staff which would build skills, confidence, and consistency of supervision across all units.
- Therapists do not receive regularly-scheduled individual supervision from a highly skilled and qualified clinical supervisor with experience in child, adolescent and family therapy.
- It appears that staff go through a fairly thorough orientation but receive little or no formal supervision or training after that. If this is accurate, it is an area of great weakness. Direct care staff must be well supervised on a frequent, regular basis with focus on issues related to professional development-not just "job evaluation".
- Having Team Leads and Program Managers stretched over units of 25-35 residents (based on 1/19/06 census) spreads the supervisory responsibility over the MHAs too thin; if the census grows, the Program Managers and Team Leads will be unable to fulfill their responsibilities in a playful, proactive way - they will be forced to spend the bulk of their time on crisis situations rather than helping the MHAs become skilled, competent members of the treatment team.

Recommendations:

7. Develop a formal agency training plan for all positions. Incorporate training that is not solely provided by KBH.
8. Develop and implement training and support for leaders at all levels, especially people who have significant responsibility for implementation and sustenance of program improvements.
9. Develop and implement formal training program for MHA's in addition to the orientation. This should include training provided by external sources.
10. Build in opportunities for staff to process and debrief outside of milieu responsibilities.
11. Provide therapists with regularly-scheduled individual supervision from a highly skilled and qualified clinical supervisor with experience in child, adolescent and family therapy.
12. Develop and implement a regular schedule of group and individual supervision for MHA and supervisory staff focusing on all areas of professional and personal growth.

Are physical interventions used only as a last resort when danger to a resident or other residents in the immediate area is imminent?

(FINDING #4)

Are physical interventions used properly?

(FINDING #4)

Overview:

Evidence indicates a decrease in the number of physical interventions for KBH overall. There is no evidence that physical interventions are viewed as a first line of response, but are used when there is imminent danger. Discussion of incident reports in morning meeting, review of incident reports by Safety Officer and debriefing of staff and resident by nursing staff have all improved greatly.

The staff are well-trained in Mandt procedures and it appears that physical interventions are being properly used. There are clear requirements for when such interventions can be used.

Concerns:

- It appears that formal debriefing between Program Managers and MHA's and/or Program Leads following each physical intervention does not take place.
- Incident reports do not indicate whether or not verbal de-escalation or other proactive measures were taken prior to physical interventions.
- There was dramatic increase in number of physical restraints with the adolescents from November to December (from 9 to 20); it appears that there may have been a correlation between this increase and the admission of 28 kids in 28 days during that time.
- Documentation does not fully describe the physical holds utilized in order to better assess the proper use of MANDT techniques.

Recommendations:

13. Provide increased training and supervision to MHA's focused on increasing their skills in proactive intervention before kids become dangerous to others. (see **Are KBH staff well-supervised?** above)
14. Enhance incident report documentation format to provide information about pre-incident efforts to deescalate and to prevent physical intervention.
15. Enhance incident report documentation format to provide information about the proper use of MANDT techniques.

Has the violence and “corrections” atmosphere at KBH been eliminated?

(PRIMARY CAUSE #1)

Are staff in control of the treatment environment?

(PRIMARY CAUSE #1)

Overview:

Violence has not been eliminated, but it has been significantly reduced. The corrections atmosphere is almost gone. The lower census and other improvements enables the milieu to be managed rather than controlled. Youth who identified themselves as gang members are no longer at KBH. Rules such as *don't walk on the grass* – which have been “invitations to battles” - have been relaxed or revoked. The environment “feels” more therapeutic.

Children no longer come and go from groups as they see fit; disruptions are handled as they occur; staff appear to feel more confident about themselves and their ability to handle situations that arise; line staff are more clear about their expectations, and they experience better support and supervision from their leaders.

The new confidence of the staff have had a positive and calming effect on the treatment environment.

Concerns:

- The changes made are not yet solid. If the pressure increases by adding more residents too fast, the milieu could fail.
- The physical facility tends to perpetuate the feeling of a correctional facility (one client asked his case manager if he was “in jail because of his probation violation”). The facility is stark and bare and more reflective of a hospital or juvenile detention facility. There appears to be limited ability to “normalize” the environment to reflect a children's treatment program.
- Skills are new. Reinforcement and training will need to be ongoing.
- There is a fine line between staff “being in control of the treatment environment” (which is necessary to ensure safety) and “managing the treatment environment” to create and enhance the process of treatment within a therapeutic milieu. This dynamic dovetails with the next category of a *clearly articulated treatment paradigm*.

Is there now a clearly-articulated treatment paradigm at KBH?

(PRIMARY CAUSE #2)

Overview:

KBH has implemented an “eclectic” model of treatment which incorporates Dialectical Behavioral Therapy within a milieu program called Today/Tomorrow Behavioral Programming. Staff have recently received new training on a variety of clinical topics including behavior modification and reshaping, and Today/Tomorrow milieu development.

Concerns:

- Beyond describing the Today/Tomorrow Behavioral Programming program, no one BOV interviewed - including clinical leaders with the responsibility to set the tone for clinical services - could articulate how KBH works with children in terms of a comprehensive treatment approach that includes the clear *integration* of individual, group, family, and milieu treatment with the educational and psychiatric services.
- Management must be accountable for universal understanding throughout the organization of the treatment approach at KBH. As David Damschen’s report on the KBH redevelopment project stated very clearly that the organizational leaders “must become fluent with regard to the theory, models and techniques in developing a coercive/violence free milieu in order to provide effective leadership and oversight during this process.”

Recommendations:

16. Analyze the current written description of the KBH treatment approach. Refine it so that it clearly describes a comprehensive treatment approach that includes the clear *integration* of individual, group, family, and milieu treatment with the educational and psychiatric services.

Is referral screening and admission decision-making driven by clinical assessment?

(PRIMARY CAUSE #3)

Are referrals for whom KBH does not have appropriate services not admitted?

(PRIMARY CAUSE #3)

What is the current status of the referral and admission process?

(RECOMMENDATION #1)

How is the coherence of the treatment milieu being taken into account when considering new referrals?

(RECOMMENDATION #1)

What is the status of the Medical Director’s decision-making authority in the referral screening and admission process?

(RECOMMENDATION #6)

Overview:

Referral and Admission Process:

- Admission/Discharge Coordinator receives the referral and gathers information regarding the prospective resident.
- Admissions Committee - comprised of the Medical Director, Program Managers, APRN, and Social Services Manager - reviews the data and decides if referral is appropriate - if the admission committee decides that the referral will be

accepted:

- Admission/Discharge Coordinator arranges for transport to KBH
- A therapist is assigned based on who is best suited to address the clients issues, availability, and which unit is assigned.
- On arrival, the resident and his/her parent or guardian complete the paperwork in the admissions coordinators office, meet the therapist, tour the unit with their family, and meet the kids and staff on the unit.
- The nurse completes the nursing assessment
- Mental status examination is completed by the Medical Director, contract MD, or the Clinical Nurse Specialist within 24 hours.
- Full psychiatric evaluation is completed within 72 hours.
- General treatment plan is used which includes observation and some items identified during the preadmission and initial evaluation.
- Psychosocial evaluation is completed prior to the treatment plan.
- Full treatment plan is completed within two weeks.
- Physical examination and laboratory evaluation are completed within one week.

KBH has been diligent in working to assure that admissions are only being considered for youth who can be appropriately treated. BOV did not observe "milieu-disruptive" children at KBH in January that it had observed previously. KBH is evaluating referrals more carefully to see if they are appropriate for its program. KBH is not accepting referrals with a diagnosis of behavioral profiles consistent with "conduct disorder", which posed a major problem in the past.

The CEO, the Medical Director, the Social Services Director (Claudia), and other staff who participate in admission decisions report that the ability of the milieu to receive and support each potential referral is a central determining factor in admission decisions. This process is in contrast to the one in place prior to September 2005, when virtually every child referred to KBH was accepted without consideration of the effect on the milieu or whether the treatment offered by KBH would meet the needs of the referred child.

BOV did not observe an admission decision-making meeting in progress. As consistently described by all participants, the process is careful and deliberate, prioritizing the issues of the referred child's clinical and behavioral needs, KBH's ability to meet those needs, and the dynamics in the milieu that argue for or against a given child entering the milieu. The admission team appears to have control over admissions (as opposed to the corporate office). The CEO clearly describes - and the Medical Director affirms - a process where the Medical Director has the final decision-making authority.

The screening process appears tighter that it was prior to October 2005, with more specific data being required from referral sources in order to consider a potential admission.

Concerns:

- Although there were, purportedly, referrals rejected, the Medical Director stated that there were 28 new admissions in December following the lifting of the admission moratorium on November 16. . There was also an increase from 9 to 21 in the number of physical restraints among adolescents during this time period. This phenomenon left BOV unclear as to what degree – in fact - the coherence of the treatment milieu is being given due consideration in the admission process. Admitting too many new residents too quickly can rapidly undermine the positive resident / treatment culture that is in the early stages of being established. The culture of violence and bullying at KBH was out of control prior to the admission moratorium. Only through a decrease by half in the census, wide-ranging changes in staff – including the removal of the CEO, Nursing Director, and Clinical Director - and significant structural reorganization was this culture impacted. The new resident / treatment culture is very tenuous and it can very easily return to its previous state if intakes occur too quickly, and if serious deliberation on all of the variables affecting the milieu is not ongoing.
- Control over the admission decision-making process seems tentative. Several Admission/Screening Committee members reported that in several instances, they have been asked repeatedly by senior leadership to reconsider after saying no to a referral.
- The process by which each Admission/Screening Committee member reviews the referral information is unclear. When reviewing resident charts, BOV saw only comments by the Medical Director on the "RTF Admission Checklist" form that is utilized in the screening process. This form is generally oriented to validate medical necessity criteria for the RTF level of care and indicates severe intellectual, medical, or chemical dependency issues that may make the child inappropriate for placement in the RTF. The form does not contain categories related to physical aggression, sexual aggression or reactivity, self-harming behaviors or other symptomatology that should be considered in the screening process.
- The therapists are not included in the admissions committee and do not appear to be involved in the admission decisions.

- There are no clearly-defined admission criteria.
- As noted previously in the section titled **Is the KBH treatment environment functional?**, Therapists are not assigned to only one “team” of residents; this fact diminishes the coherence of each team, dilutes the effectiveness of the therapist role, reduces the integration between the milieu and resident teams and the clinical component, and diminishes the Therapist role in decision-making - with the Program Manager - as to the impact of new admissions on the current milieu and group dynamics.
- The KBH staff person who is primarily responsible for ongoing relationships with referral organizations is the Director of Marketing. This critical communications position should be shifted to incorporate clinical expertise, authority, and accountability.

Recommendations:

17. Revise the “RTF Admission Checklist” form to include these categories: (a) physical aggression, (b) sexual aggression or reactivity, (c) self-harming behaviors, (d) other symptomatology that should be considered in the screening process; and to include space for comments and signatures of all members of the Admission/Screening Committee in order to verify that they reviewed the referral information and that any concerns or questions are documented.
18. Include therapists in the referral screening process in order to take advantage of their clinical skills and experience.
19. Develop a comprehensive plan for rebuilding relationships with referral sources that are mutually reciprocal.
20. Involve clinical staff more in liaison work with referral source colleagues. This should not be primarily a “public relations” project.
21. Define, standardize, and maintain firm admission criteria.

Are diagnostic profiles and/or behavioral histories that include documented violence against others and/or significant disruption in other settings, or other indications of high potential for violence against KBH residents or disruption of the KBH milieu being addressed appropriately in the screening and admission process?

(RECOMMENDATION #5)

Have the violent, seriously conduct-disordered residents been discharged to more appropriate settings?

(PRIMARY CAUSE #4)

Overview:

These residents have been removed from the facility; the program managers expressed that, if they felt like a resident needed to be removed due to dangerousness, the Medical Director would support them in that decision. The screening and admission process is now more clinically driven so that violent kids or those kids with histories that indicate a high potential for disruption are not accepted for admission.

Concerns:

- While it appears clear that the number of residents who were assaulting other residents and staff have been discharged, there does not appear to be a clear decision-making process for making discharges. It is not clear what the decision-making process is or who makes the decision that a resident has completed treatment or that a client should be discharged for other reasons (i.e., too violent, not able to make treatment progress, needs acute hospitalization, has a medical condition unable to be treated in this facility, etc.).
- It does not appear that the “Referral Information” form is consistently required by KBH from the referring agent. This form does contain categories of: history of sexual offending or sexual inappropriateness, history of physical/sexual abuse or other trauma, history of homicidal or suicidal behavior and current juvenile justice system involvement.
- There appears to be very little support from external resources to move children who don’t work out to more appropriate venues.

Recommendations:

22. Develop and implement a clear policy and procedure for making discharge decisions with particular emphasis on specific discharge criteria and benchmark behaviors or symptoms that may indicate the need for the resident to be removed from KBH.
23. Develop and implement a system for documenting discharges that includes more precision in articulating reasons for discharge, where the resident was discharged to, and post-discharge treatment recommendations.
24. Add a category of 'history of aggression and/or assaultiveness towards others' to the "Referral Information" form.
25. Require the "Referral Information" form to be completed by the referring agency before the referral will be considered by the admissions committee.

What is KBH's current approach to determining how many children can be effectively and safely treated at KBH?

(PRIMARY CAUSE #5)

How many children do staff think can be safely and effectively served in the current KBH facility?

(RECOMMENDATION #2)

Overview:

The overwhelming consensus of staff interviewed is that the number of children that can be safely and effectively served in the current KBH facility is 65-70. All stated they never wanted to see 85 residents again.

The CEO and other administrative and clinical leaders emphasized the use of a new decision-making process that includes analysis of the current milieu dynamics when considering new referrals. The description of this process, and staff descriptions of how it has operated since October indicate that it is diligently followed. At the same time, the CEO emphasized that KBH holds firm to its belief that it can, under the correct circumstances, serve 85 children (the number of beds KBH is licensed for) in the current facility. All interviewed staff were effusive in their assessment that the significantly reduced numbers of children in the KBH environment since September had been essential to the return of order, and to the staff ability to curb the culture of violence and to establish a culture of treatment.

In addition to the overall number of residents in the building, it is clear that adhering to the new MHA to child ratios has been one of the keys to managing the treatment environment.

Concerns:

- BOV does not believe that KBH should - under any circumstances - serve 85 children in the current facility. This number may be the number that the Quality Assurance Division has licensed KBH for, but BOV believes that the licensing criteria need to be revisited to take into account environmental dynamics that contributed to the chaos of the treatment milieu at KBH prior to September 2005.

Recommendations:

26. Voluntarily cap the census at KBH at a maximum of 70.

Do direct care staff now have a clearly-defined treatment role?

(PRIMARY CAUSE #6)

Overview:

The direct care staff role is now more clearly envisioned by management, articulated by supervisors, and (based upon BOV interviews) understood by the direct care staff. Integration of the point sheets (a responsibility of the MHAs) with the treatment plan appears to have created a tangible link between MHAs and treatment. MHAs provide input into treatment planning via Team Leads.

Concerns:

- MHAs are not directly involved in treatment planning.
- MHAs are not included clinical staffing or treatment review.
- There are no weekly treatment meetings that include the MHAs nor do MHAs have their own weekly meetings to staff cases.
- MHAs do not receive individual or group supervision nor related to their role as valued members of the treatment team.
- BOV believes that - even though there has been improvement in this area - the marginal role MHAs have in the *process* leads them to view themselves, and to be viewed by others, as merely “behavior managers” rather than key providers of treatment.

Recommendations:

27. Actively include and involve MHAs in learning about milieu treatment; actively include MHAs in every aspect of the process of treatment - including direct involvement in treatment planning meetings, and ensure that MHAs are active participants in decision-making about the program’s effectiveness

**Has confusion about the chain of command been eliminated?
(PRIMARY CAUSE #7)**

Overview:

KBH has reworked the chain of command.

Concerns:

There are several chain-of-command and supervisory relationships and one position title that are unclear to BOV and that appear to compromise clinical, education, and direct service integration.

- The school principal and teachers are under the Chief Operating Officer.
- The Manager of Social Services, therapists, and chemical dependency counselor are under the Chief Operating Officer.
- The person who is ostensibly the “clinical director” has the title “Manager of Social Services”. Although it is unclear if it has any detrimental effect on this position’s authority, the fact that this position is not on the same level in the organizational chart as “manager” positions appears to reduce in importance the role of clinical work relative to other parts of the organization.

**Is the leadership of KBH now actively involved in the ongoing treatment and aware of and addressing problems that arise?
(PRIMARY CAUSE #8)**

**Do leaders up to the CEO place themselves regularly in the milieu?
(PRIMARY CAUSE #8)**

**How has KBH leadership interacted with line staff in the program improvement process?
(RECOMMENDATION #13)**

Overview:

Under the leadership of the new CEO, all leadership team members are more involved, are regularly on the units, and are aware of treatment issues. There is an administrative on-call schedule for managers who rotate through evening/weekend duty on the units. Mr. Gale is a regular presence on the units - the children like him- a MHA from the children's unit said he sees him three or four times a week on the unit. This is a significant change in the attitude of management and represents the beginning of a very healthy shift in the treatment culture.

Are staffing decisions being made in a way that ensures unit stability and continuity?

(RECOMMENDATION #3)

Overview:

Staff : Resident ratios have been improved. Program Managers familiar with unit dynamics and needs now do the interviewing, reference checking, and hiring of the MHAs.

Concerns:

- The reality of staffing a 24/7 program like KBH is that ideal staffing is not always possible; 'flexing' staff (reducing individual staff from 40 hours/week to lower levels of employment) has been difficult but is reportedly necessary because of the reduced census and resulting reduced financial resources.
- The Unit Coordinator (primarily an administrative position) does the scheduling; it is unclear how this position interacts with the Program Managers in order to ensure unit stability and team coherence.

Recommendations:

28. The Licensure Bureau and the Children's Mental Health Bureau Review should review financial records with KBH to determine the appropriate parameters of reduction in staffing based on revenue.

Is communication between shifts occurring in an effective way?

(RECOMMENDATION #4)

Overview:

Communication notebooks and shift dynamic forms have improved cross-shift communication; supervisors are taking a more active role in ensuring that this communication takes place.

Has something like a 'STAT team' - trained to respond to emergency situations - been implemented?

(RECOMMENDATION #8)

Overview:

Nothing formal has been implemented, however administrative and clinical leaders are being trained in MANDT and, through their increased presence on the units, function as an additional resource when emergency situations arise.

Concerns:

- There is no clear plan for designated personnel throughout the KBH building to respond when emergency situations arise.

Recommendations:

29. Formulate a plan that designates who on each shift will respond to distress calls; educate these staff and the staff remain on units about the roles and responsibilities for each situation.

What is the status of the 'rat cage'?

(RECOMMENDATION #11)

Overview:

The fence has been removed. To some extent, the attention paid to the inappropriate nature of this fenced-in area has resulted in more recreation outings into the community, and some increased focus on the need for recreational activity generally.

Recommendation :

30. Realistically analyze the elopement risk and develop policies and procedures that appropriately address it, while optimizing all residents' access to the outdoors.

How are children being given the opportunity to get outdoors?

(RECOMMENDATION #11)

Overview:

Some progress has been made in this area. There is "outside time" on the schedules for all resident units. Residents are no longer been penalized for being outdoors but not engaged in group activities; the central courtyard is more effectively used since children are no longer scolded for walking on the grass in the courtyard. The hiring of a Recreation Therapist demonstrates a commitment to recreational activities.

Concerns:

- Residents continue to spend a disproportionate of time indoors, and that does not meet developmental needs of youth.
- Staff noted that there was not a lot of outdoor play equipment available and they would have to wait until the new budget year to purchase items.
- Adolescents appear to have very limited access to the outdoors beyond the enclosed courtyard.

Recommendations:

31. Develop a plan to utilize the ~10 acres of agency-owned land surrounding the KBH facility for enriching the program through landscaping, recreational equipment, and programmed access to the outdoors.
32. Make adequate outdoor play equipment and material be made available; for example, bicycles for the children's unit residents.

How was the issue of informing parents/guardians about program problems and improvements addressed?

(RECOMMENDATION #14)

Overview:

After consulting with legal counsel, KBH decided not to communicate with parents/guardians about it's program problems.

Review of the Use of Medications

William Doctor, PharmD

On site review of medication records and interview with the Medical Director conducted 10/7/05

Because of the endemic dysfunction in the KBH milieu observed in August and September 2005, BOV felt it important to explore the hypothesis that PRN (as needed) or emergency medication use is high due to inadequate milieu management, inadequate training for direct care staff, and/or inadequate leadership.

There were several lines of evidence that this hypothesis was true:

1. There were several hundred emergency medications used from January through September 2005 for up to 85 residents. This appeared to be a much larger number than one would expect.
2. The Medical Director stated that prn medication use was high due to an unskilled staff. She added that direct care staff are not trained to deescalate, are understaffed, and the training provided is ineffectual.
3. In-depth review of three cases revealed a pattern of repeated behaviors with minimal/inadequate documentation of attempts to intervene with these behaviors in ways other than physical intervention and medication. Treatment plans did not change despite repeated need for Emergency Staff Intervention (ESI) and/or medication.

In case 3782-01, the notes document numerous episodes of barricading herself and others in rooms, refusing to leave the courtyard, and attempts to sabotage staff efforts by helping other residents get out of holds. There were several notes that documented acting out and swearing without any consequences. When the behavior escalated to a more severe level, ESI and/or medications were used. There is little documentation of attempts to control these behaviors otherwise. In one case, the resident left in the middle of a therapy session upset, escalated, and "required" an ESI. During the nine months of charting reviewed, no changes were made in the treatment plan.

In case 3847-01, a very similar pattern occurred. One additional observation is noteworthy: on 9/3/05, this resident's bedtime dosage of Seroquel was given at 5:30pm for "acting out". After settling down at the nurse's station, she returned to the team. There is no documentation of consulting the physician about administering this bedtime medication hours earlier than prescribed for behavioral reasons.

Case 3800-01 also indicated a similar pattern, but with fewer emergency medication uses.

Issues reviewed with the Medical Director:

The Medical Director complained about the non-physician former clinical director accepting patients referred to KBH that she had recommended not be admitted. She found and showed us one where the admission screening form has been signed by a PhD on the Medical Director signature line.

The KBH corporation brought in a pharmacist to discuss medication. He apparently suggested chlorpromazine (Thorazine) as a less expensive alternative to the second generation agents. The Medical Director has avoided using first generation agents due to the greater "cognitive dulling" they allegedly cause in comparison to the second generation agents. BOV's pharmacology consultant tends to agree with this assessment, the data supporting this belief is inconclusive. Nevertheless, the Medical Director appeared to feel the need to seriously consider prescribing Thorazine for a few residents, not for the benefit of the residents, but for the benefit other residents and staff that may be achieved by the sedating effects of this medication. It appeared to BOV that the Medical Director felt compelled to compromise her clinical judgment due to pressure from the corporate office, and the chaos generated by residents who should not have been admitted to KBH.

The Medical Director also stated that nurses will not give a medication even in the acute situation and ordered by the physician unless the parent/guardian has approved the use of that medication. She feels this needs to be remedied to allow use of medication for safety reasons even without parental consent.

On site review of medication records and interview with the Medical Director conducted 1/19-20/06

General Description/Impressions:

There appears to have been a significant decrease in the use of emergency medications, although this may be skewed by how this data were reported. There are fewer residents now, and the residents are now less volatile. However, the Clinical Nurse Specialist and the Medical Director both agree that many issues are dealt with before getting to the point where medications are needed.

Four charts of residents who had received emergency medication during January 2006 were selected for in-depth review. All of these residents had a number of ESIs in recent weeks as well. In each of these cases, the medication prescribed appeared to be consistent with diagnoses and signs and symptoms presented. Three of the residents received only one emergency medication in the past two months, while one received an emergency medication twice. In each case the medication was appropriate for the situation.

In reviewing the data supplied by the facility, emergency medication were almost always Zyprexa, Benadryl, or Zyprexa and Benadryl. Zyprexa is available as an oral tablet, Zydis, an oral disintegrating tablet, and as an intramuscular injection and is, therefore, a convenient drug for emergency use. It is a good drug for agitation and aggression which is usually the reason for an emergency medication. Benadryl is less commonly used in this capacity. It can be administered orally or injected. The KBH data suggest good response to this medication in most instances. The Medical Director and the BOV consultant discussed this approach in October, and she feels it is quite an effective drug in adolescents and children. The adverse effects that are of concern in adults are rarely issues in young people. Therefore, even though it is a somewhat unusual selection, it is not inappropriate and seems to work well for her.

Another medication issue that have been brought up is the larger dosages of Seroquel. The BOV consultant discussed this issue with the Medical Director in August. The BOV consultant and the Medical Director agree that this medication is not very effective in the original dosages recommended by the manufacturer. The residents who are on the larger dosages were started on lower dosages and then titrated to larger dosages based on response. Only one of the cases reviewed during the January review was taking Seroquel and this was at a dosage of 250 mg daily. There were no identified adverse effects at this dosage. Therefore, the BOV consultant saw these dosages as appropriate under the circumstances.

The BOV consultant did not observe any resident on the unit during the tour or the observation time on the adolescent girls unit who appeared to be over-sedated.

Both the Clinical Nurse Specialist and the Medical Director appear to prescribe medication within acceptable limits and to adjust medications appropriately.

RECOMMENDATIONS

1. Assign a designated Therapist to each resident team.
2. Reallocate program management structure so that each Program Manager is responsible for one team of 12 residents; creating “mini-programs” within the overall program would lend itself to better, more cohesive treatment and an improved sense of ownership among all staff in each “mini-program”.
3. Improve the integration of the educational component and the mental health component by establishing more clearly that each classroom is a treatment environment; ensure that educational goals are consistent with the mental health treatment goals.
4. Improve/simplify the process for analyzing data.
5. CEO and corporate office should consult with Nursing Director and Resident Advocate regarding the kind of software that would meet their needs, provide those resources, and provide training in the use of the software.
6. Research “non-accidental injury” benchmarks for this population in other treatment venues nationally.
7. Develop a formal agency training plan for all positions. Incorporate training that is not solely provided by KBH.
8. Develop and implement training and support for leaders at all levels, especially people who have significant responsibility for implementation and sustenance of program improvements.
9. Develop and implement formal training program for MHA’s in addition to the orientation. This should include training provided by external sources.
10. Build in opportunities for staff to process and debrief outside of milieu responsibilities.
11. Provide therapists with regularly-scheduled individual supervision from a highly skilled and qualified clinical supervisor with experience in child, adolescent and family therapy.
12. Develop and implement a regular schedule of group and individual supervision for MHA and supervisory staff focusing on all areas of professional and personal growth.
13. Provide increased training and supervision to MHA’s focused on increasing their skills in proactive intervention before kids become dangerous to others.
14. Enhance incident report documentation format to provide information about pre-incident efforts to deescalate and to prevent physical intervention.
15. Enhance incident report documentation format to provide information about the proper use of MANDT techniques.
16. Analyze the current written description of the KBH treatment approach. Refine it so that it clearly describes a comprehensive treatment approach that includes the clear *integration* of individual, group, family, and milieu treatment with the educational and psychiatric services.
17. Revise the “RTF Admission Checklist” form to include these categories: (a) physical aggression, (b) sexual aggression or reactivity, (c) self-harming behaviors, (d) other symptomatology that should be considered in the screening process; and to include space for comments and signatures of all members of the Admission/Screening Committee in order to verify that they reviewed the referral information and that any concerns or questions are documented.
18. Include therapists in the referral screening process in order to take advantage of their clinical skills and experience.
19. Develop a comprehensive plan for rebuilding relationships with referral sources that are mutually reciprocal.
20. Involve clinical staff more in liaison work with referral source colleagues. This should not be primarily a “public relations” project.
21. Define, standardize, and maintain firm admission criteria.
22. Develop and implement a clear policy and procedures for making discharge decisions with particular emphasis on specific discharge criteria and benchmark behaviors or symptoms that may indicate the need for the resident to be removed from KBH.
23. Develop and implement a system for documenting discharges that includes more precision in articulating reasons for discharge, where the resident was discharged to, and post-discharge treatment recommendations.
24. Add a category of ‘history of aggression and/or assaultiveness towards others’ to the “Referral Information” form.
25. Require the “Referral Information” form to be completed by the referring agency before the referral will be considered by the admissions committee.
26. Voluntarily cap the census at KBH at a maximum of 70.
27. Actively include and involve MHAs in learning about milieu treatment; actively include MHAs in every aspect of the process of treatment - including direct involvement in treatment planning meetings, and ensure that MHAs are active participants in decision-making about the program’s effectiveness.
28. The Licensure Bureau and the Children’s Mental Health Bureau Review should review financial records with KBH to determine the appropriate parameters of reduction in staffing based on revenue.
29. Formulate a plan that designates who on each shift will respond to distress calls; educate these staff and the staff remain on units about the roles and responsibilities for each situation.
30. Realistically analyze the elopement risk and develop policies and procedures that appropriately address it, while optimizing all residents’ access to the outdoors.
31. Develop a plan to utilize the ~10 acres of agency-owned land surrounding the KBH facility for enriching the program through

landscaping, recreational equipment, and programmed access to the outdoors.

32. Make adequate outdoor play equipment and material be made available; for example, bicycles for the children's unit residents.

ADDENDUM 1 – 9/1/05 BOV Letter to KBH CEO

September 1, 2005

Pam Broughton, CEO
Kids Behavioral Health of Montana
55 Basin Creek Road
Butte, Montana 59701

Dear Pam:

The purpose of this letter is to formally express concern about the safety of the residents receiving services at KBH. Over the past several months, a number of residents have been the victims of resident-on-resident assaults. During our site review on August 25 – 26, our team became very concerned about the treatment environment at KBH and the feeling by both staff and residents that this environment is not safe. We detailed these and other concerns during a meeting with you on August 26. I have been informed since our review that at least one resident-on-resident assault took place over the weekend of August 20 – 21, the weekend prior to our site review on August 25 – 26. Your staff did not report this to the Board of Visitors as required in 53-21-107, MCA. This situation further raises our level of concern about the safety of residents living and receiving services at KBH.

This letter contains one recommendation that will be a precursor to additional recommendations that will be included in the written site review report per 53-21-104(3), MCA.

RECOMMENDATION:

Analyze the causes of and immediately put into place resources, procedures, and interventions to eliminate the occurrence of resident-on-resident assaults.

This recommendation is made in the context of both 53-21-104(3), MCA and 53-21-104(7), MCA. As such, you are required to respond to the recommendation "*within 10 working days*". Due to the urgent nature of the situation, I ask that you respond in writing to and implement the recommendation as soon as possible prior to the 10 day requirement.

Sincerely,

Gene Haire
Executive Director

cc: Joan Miles, Director
Department of Public Health and Human Services

ADDENDUM 2 – 9/2/05 Quality Assurance Division Notice of Violation and Order to KBH

BEFORE THE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES
OF THE STATE OF MONTANA

In the Matter of:)
)
KIDS BEHAVIORAL HEALTH OF MONTANA,)
55 Basin Creek Road)
Butte, Montana 59701)

NOTICE OF VIOLATIONS and ORDER

TO: Pam Broughton
Administrator
55 Basin Creek Road
Butte, Montana 59701

COMES NOW the Montana Department of Public Health and Human Services (Department), pursuant to Title 50, Chapter 5, Part 1 of the Montana Code Annotated (MCA), and hereby issues to Kids Behavioral Health of Montana (Kids), a residential treatment facility, by and through it's Administrator, Pam Broughton, the following Notice of Violations and Order to Cease New Admissions; Cease the Violations Within a Reasonable Time; and, to Increase Staff pursuant to Section 50-5-114 of the Montana Code Annotated (MCA).

The Department conducted a licensure survey at Kids on August 15-24, 2005. Department surveyors Julie Fink, Residential Care Program Manager; Beal Mossman, Mental Health Facility Surveyor; and, Bridget Parker, Community Residential Licensing Specialist reviewed and gathered the following documents: Kid's Daily Data Entry from August 2004 through July 2005; Kids' YDT FY Daily Entry form; and, the Kids' Incident Report from June 30, 2005 through July 31, 2005. Department Surveyors interviewed 9 residents and 13 employees; reviewed 9 resident charts; inspected the facility; and reviewed Kids' Policy Manual.

The foregoing review of the incident reports revealed that from June 30, 2005, through July 31, 2005, there were 113 incidents of aggressive resident behavior. Of this number, 68 incidents involved resident on resident aggression; and, 45 incidents involved residents on staff aggression. The records revealed a total of 65 injuries as a result of resident aggression. The Kids' Staff are unable to protect the residents from assaults by peers due to inadequate staffing thereby putting both residents and staff in danger.

The situation at Kids has grown increasingly hazardous for residents and staff resulting in an escalation of injuries from August 2004 to July 2005. Resident injury due to peer aggression went from 9 injuries in August 2004, up to 54 in July 2005. Self-inflicted resident injuries were 15 in August 2004; and 31 in July 2005. Resident injuries from physical restraints were 6 in August 2004; and 20 in July 2005. Staff injuries due to resident aggression were 0 in August 2004, and 11 in July 2005. Staff injuries during restraint was 1 injury in August, 2004, and 36 in July, 2005. In summary, the total non-accidental injuries at Kids went from 31 injuries in August 2004, up to 152 in July 2005.

NOTICE OF VIOLATIONS

Violation #1: 37.106.2202(1)(a)(iv)(A) ARM; plant, technology and safety management (PL), as specified for residential settings in Appendix A of PL.1; and, PI.1.1 of the Joint Commission on Accreditation of Health Care Organizations' 1993 Accreditation Manual for Mental Health, Chemical Dependency, and Mental Retardation/Developmental Disabilities.

PL.1 A Safety management program exists that is designed to provide a hazard-free physical environment and to manage staff activities to reduce the risk of human injury. The safety management program does not manage staff activities to reduce the risk of human injury.

PI.1 The governing body strives to assure a safe environment for patients, personnel, and visitors by requiring and supporting the establishment and maintenance of an effective safety management program.

The Governing Board of Kids Behavioral Health of Montana (Kids) has not strived to assure a safe environment for the residents and staff at Kids. The number of injuries to residents and staff has increased dramatically in the last year. Kids' daily data entry for August 2004 documents 31 non-accidental injuries to patients and staff. Over the past 12 months, the daily data entry for each month has steadily increased.

The most recent survey from August 15-24, 2005 revealed that Kids had 152 non-accidental injuries to patients and staff for July 2005. During this survey, staff members expressed concern for their own safety while at work. Staff reported incidents of residents physically assaulting staff. The survey also revealed that the resident to staff ratio was inadequate as staff are unable to control the resident's behaviors resulting in a dramatic increase in resident and staff injuries. Staff are unable to handle the resident's negative behavior and find that the work environment is in a continual state of one crisis after the next.

Staff reported they are not able to use less restrictive de-escalation techniques and have stated they are responding immediately with physical restraint followed by emergency medications such as benadryl and zyprexa. Since January 2005 the use of physical restraints and emergency medications has increased dramatically. In January 2005, Kids' staff used physical restraints 122 times. In July 2005, staff used physical restraint a total of 347 times. An increase in emergency medication use during this same period went from 53 in January, up to 147 in July.

Staff are frequently called off of their assigned units to assist in Emergency Safety Interventions which leaves one staff member alone with up to 14 residents. This puts staff and residents at great risk as the residents take advantage of the low staffing and assault other residents. Staff reported these concerns to Kids' Administrative Personnel however no change has occurred. For example, on July 26, 2005, a male resident was assaulted by a peer when staff were called to assist with a situation on the Gold Girls unit. The victim was sent to the emergency room with a fractured nose. There are many other examples of low staffing resulting in resident assaults and non-accidental injuries.

ORDER

Pursuant to Sections 50-5-114(1) and 2-4-631 MCA, the Department finds that public health, safety or welfare imperatively requires emergency action. Pending further proceedings, the Department Orders Kids Behavioral Health of Montana to comply with the following conditions:

- A. The department places a moratorium on new admissions, effective immediately, until additional information becomes available and immediate corrective action has proven to be effective.
- B. Immediately increase staffing to adequately meet the needs of the residents, supervise the residents, and prevent non-accidental injuries to residents and staff;
- C. Kid's Behavioral Health of Montana will report any aggressive behavior by residents to the Department of Public Health and Human Services, Quality Assurance Licensure Bureau.
- D. Correct all alleged violations by October 3, 2005.

NOTICE OF RIGHT TO ADMINISTRATIVE HEARING

Pursuant to §§ 50-5-114, MCA, Kids Behavioral Health of Montana is hereby given notice that it has a right to a hearing. The contested case provisions of the Montana Administrative Procedure Act, Title 2, chapter 4, part 6, MCA, would apply. This Order becomes final unless, within 30 days after this Notice is received, Kids requests, in writing, a hearing before the department. A request for hearing must be addressed to:

Office of Fair Hearings
Montana Department of Public Health and Human Services
201 Colonial Drive
P.O. Box 202953
Helena, Montana 59620-2953

Until issuance of a contrary decision by the department, this Order remains effective and enforceable.
DATED this _____ day of September, 2005.

MONTANA DEPARTMENT OF PUBLIC
HEALTH AND HUMAN SERVICES

By: _____
Mary Dalton, Administrator

ADDENDUM 3 – 9/14/05 KBH Response to BOV 9/1/05 Letter



September 14, 2005

TO: Gene Haire, Executive Director, Board of Visitors

FROM: Pam Broughton, CEO

Re: *Recommendation: Analyze the cause of and immediately put in place resources, procedures, and interventions to eliminate the occurrences of resident-to-resident assaults.*

After thorough analysis and review of our program, we have identified the following factors contributing to the occurrence of resident to resident assaults:

- Staff Supervision
- Staff Development and Training
- Program Structure

Be assured that KIDS Behavioral Health of Montana is serious about solving the identified problems. Our goal is to provide quality care for our residents, using positive techniques that promote the individual's personal strengths. We will continue ongoing efforts to improve the quality of our programs for the children that we serve.

Following are the immediate steps that we are now taking to meet this particular challenge.

Increase Direct Care Staffing Grid (See Attachment A, Staffing Grid)

Here are the steps we are taking to increase our direct care staff pool:

- Five new MHA orientees completed their two-week training course on September 9, 2005. They were immediately placed into rotation.
- Contract with local temporary agency for a Certified Nursing Assistants that will be placed in the MHA staffing grid immediately.
- Attending Montana Tech Career Fair September 15, 2005 for recruiting opportunity.

- Continuing to recruit for MHAs through newspaper, job services, Native America Indian Alliance and recruiting agencies.
- Inexperienced employees must receive proper training prior to entering the MHA pool. Our current two-week training program includes MANDT, CPR, First Aid, and clinical program-specific training. (*See Attachment B, Orientation Schedule*)
- Next Orientation is scheduled 9/26-10/7/05.

Leadership and Organizational Changes

Clinical Leadership changes effective September 13, 2005 are as follows:

- Promotion of Tawnya Mock from Admission Director to Program Director (a newly created position). Responsibilities include oversight of RTC, supervision of Program Leads (PLs), Assistant Program Leads (APLs), Mental Health Associates (MHAs), Activity Services and Education Department
- Valerie Marshall will assume the role of Admissions and Discharge Director
- Steve Heinz, PhD, Director of Clinical Services will continue supervision of therapists. Will add supervision of care managers, oversight of treatment planning to ensure adequate representation of all disciplines and compliance of all requirements, program development to include development of MHA group materials, evaluation of program structure and ongoing clinical staff development training.
- Lana Schaffer, RN appointed Director of Quality Assurance (a newly created position). The quality assurance/risk management function will now be separate from the Director of Nursing. Responsibilities will include the completion of investigations and reporting mandatory incidents to all outside agencies to ensure reporting requirement. This role will complement the Resident Advocate. Lana Schaffer will continue in the role of DON until a replacement is identified.
- Leadership team has implemented a procedure to offer clinical and administrative support, guidance and consultation to RTC personnel regarding unforeseen problems, decisions or incidents. (*See Attachment C, Leadership Schedule and Attachment D, AOC Checklist*)

Program and Treatment Changes

- Implementation of shift mapping form, detailing individual and group resident dynamics and how these are to be addressed, staff assignments and adjustments to the daily schedule. Copies of these are distributed to MHAs coming on shift, nursing staff, Clinical Director, and Morning Meeting team. Adolescent implementation began 8/18/05; children's implementation 8/22/05. (*See Attachment E, Shift Mapping Form*)
- Effective 9/1/05 meetings with direct care staff are being held to obtain feedback about questions, problems and issues with implementation of new programs.
- Currently recruiting a licensed Recreational Therapist or experience Activity Services Coordinator to supervise and work with Activity Services staff to provide more recreational activities that can be used as incentives for Level achievements and prosocial behaviors. A second Activity Services Associate will then be added.

- Provide training sessions with MHAs in basic skills for doing group sessions (followed up by a mentoring program), interacting with residents, and de-escalating residents who become emotionally escalated.
 - Group Skills training sessions at 1:45 and 3:15 p.m. 9/20 and 9/22/05 by Steve Heinz, PhD
 - Basic Behavior Modification Skills training sessions at 1:45 and 3:15 p.m. 10/4 and 10/6/05 by David Damschen, LCSW, Vice President of Clinical Services
- Quality Assurance Committee meets monthly to review Adverse Patient Outcomes (APO), identify trends and formulate action plans for correction. These include ESS/ESIs, incidents of aggression and injuries.
- Three Assistant Program Lead positions in place: one for Adolescent Girls, one for Adolescent Boys and one for Children's Program. These positions were created and filled to work on the units along side MHA staff, primarily on weekends and evening shifts.
- A training meeting was held with APLs and Nursing Supervisors/Charge Nurses to clarify expectations for supervision, role-modeling and coaching of MHA staff.
- Therapists, physician, nursing and education staff are routinely attending treatment planning meetings. Because of scheduling constraints, MHA staff are typically unable to attend – but their input is communicated by the staff who do attend and much of the behavioral data reported is derived from milieu points/levels and MHA medical records charting.
- Precautions meetings are held five times weekly and are attended by therapist and nursing staff to review status of residents on any sort of precautions/ restrictions.
- Weekly team meetings are held for each program attended by therapists and program leads to review residents' behaviors and therapy issues.
- Revised daily schedules
- Increased activities for all children and will add Activity Services staff (position posted)

Adolescents:

- Effective 8/19/05 hygiene breaks were changed. Residents go to the lounge instead of to their rooms; one resident at a time is using the bathroom.
- Division of adolescent team schedule with more appropriate timeframe and outline of group topics was done 8/26/05.

Children:

- School started 8/24/05; assessment of program schedule was done 8/27/05.
- Schedule changes were implemented 9/2/05.

Direct Care Training

- Implementation of Dialectical Behavioral Therapy (DBT) program on Girls Adolescent Program 5/31/05 (training ongoing) and Moral Recognition Therapy (MRT) program on Boys Adolescent Program (trainer scheduled for October 2005).
- Meetings were held with direct care staff to train them in program changes, answer questions, address issues. Meet with residents in each Program to explain new program.
- Implementation of Today/Tomorrow Positive Behavioral Support Program 8/31/05. Training was conducted by Steve Heinz, PhD for all direct care staff. (*See Attachment F, Today and Tomorrow Overview*)

- New Point System
- New Incentive Store
- Development of new Emergency Medications Policy and Seclusion and Restraint Policy 9/9/05. Both policies are in implementation process. *(See Attachment G, Emergency Medications and Attachment H, Seclusion and Restraint)*
- A consultant from a sister facility will be at the facility 9/12-9/16/05 to train and model improved child and adolescent supervision techniques and to review and make additional modifications to unit daily schedules.
- Implementation of Second Step, skill-based, curriculum across RTC. Second Step is designed to reduce acting-out behaviors by increasing the effectiveness of the resident's interpersonal skills, including:
 - Anger Management
 - Empathy
 - Problem Solving

A Second Step trainer will demonstrate and train on Second Step groups the week of 9/26/05. Tawnya Mock will attend Second Step train-the-trainer session in Seattle 11/05. *(See Attachment I, Second Step Overview)*
- Ken Robinson, PhD will conduct Moral Recognition Therapy (MRT) training for 12-15 staff 11/05. MRT is a 12-step behavior program that will be implemented on the boys program following the training.

Ongoing Staff Development Plan:

- Development of quarterly on-going staff development training schedule to ensure each MHA receives a minimum of one hour per month specific milieu and/or clinical intervention training. The Clinical Team will determine the training topics, Human Resources will schedule and coordinate the trainings. October, November and December training calendar to be completed by 9/23/05.
- KBH Clinical Quality Assurance Leadership Committee (CQALT), a collection of professional staff from all KBH facilities offers several training curriculum available for use at KIDS of Montana. *(See Attachment J, CQALT Training Schedule)*

ADDENDUM 4 –10/5/05 BOV Response to KBH 9/14/05 Letter

October 5, 2005

Pam Broughton, CEO
Residents Behavioral Health of Montana
55 Basin Creek Road
Butte, Montana 59701

Dear Pam:

This letter has two purposes:

1. to respond to your 9/14/05 letter and package of supporting documents¹
2. to make additional preliminary recommendations².

This letter is written and recommendations are made with the understanding that a number of positive and hopeful organizational changes are under way within Kids Behavioral Health of Montana (KBH). The forcefulness and tone of this letter is based on the Mental Disabilities Board of Visitors' (BOV) intense level of concern after its two recent reviews as exacerbated by recently acknowledged serious incidents that were not reported to BOV (described below). BOV has no reason to believe and assumes that the deficits in the treatment environment of KBH are not the result of deliberate actions or omissions, including the non-reporting of incidents required by 53-21-107, MCA. BOV does believe that the problems described in this letter are the result of significant dysfunction within KBH. To address such dysfunction requires, at the heart, a transformation of leadership. BOV is motivated and committed to working with KBH to address the fundamental changes that are needed. At the same time, BOV emphasizes that the scope of the needed change is great and the necessity for the senior managers to initiate immediate, hands-on, responsive, inspiring leadership is imperative.

¹ This letter and package was provided to the Mental Disabilities Board of Visitors in response to the Board's 9/1/05 letter to Residents Behavioral Health of Montana. The Board's 9/1/05 letter invoked 53-21-104(7), MCA by citing the Board's finding that KBH has not maintained a safe environment for residents as required by 53-21-142(13), MCA.

² The findings and recommendations in this letter require a response by KBH within 10 working days of 10/4/05.

This letter invokes 53-21-104(7), MCA with regard to the following provisions of the Mental Commitment and Treatment Act (Title 53, Chapter 21, Montana Code Annotated 2005):

- 1) 53-21-107. Abuse and neglect of persons admitted to mental health facility prohibited -- reporting -- investigations.
BOV FINDING: KBH does not properly detect, report, or investigate allegations of abuse and neglect.
- 2) 53-21-142(2). Rights of persons admitted to facility. Patients must be accorded the right to appropriate treatment and related services...
BOV FINDING: The dysfunctional treatment environment at KBH severely compromises appropriate treatment and related services.
- 3) 53-21-142(13). Rights of persons admitted to facility. Patients have a right to a humane psychological and physical environment within the mental health facilities.
BOV FINDING: KBH has not established and does not maintain a humane and safe environment for residents.
- 4) 53-21-146. Right to be free from physical restraint and isolation.
BOV FINDING: The inadequacy of training and supervision of KBH direct care staff and the chaotic nature of the treatment environment severely compromises staff ability to engage with residents in a manner that ensures that less restrictive approaches are used before physical interventions, and that when physical interventions are used, they are used properly.

These letters and KBH responses will form the basis for seeking a “mutually agreed upon resolution” as required by 53-21-104(7-c), MCA.

Background

As you know, since BOV sent its 9/1/05 letter to KBH, BOV conducted a follow-up to its initial 8/25-26 site review on 9/15-16. You provided your response to BOV’s 9/1/05 letter in person on 9/15/05. During its follow-up review on 9/15-16, even though KBH had implemented several positive changes designed to address some of the concerns that BOV and the Quality Assurance Division (QA) had expressed in the beginning of September, the significant concerns BOV developed in August – which were the reasons for the follow-up review – deepened. I briefly reviewed these ongoing concerns with you and Bill Vickers on 9/19/05 in Helena, and told you that BOV would be making additional preliminary recommendations as a precursor to its final report.

As was the recommendation in BOV's 9/1/05 letter, the additional recommendations below are made in the context of both 53-21-104(3), MCA and 53-21-104(7), MCA. Some or all of these recommendations may be repeated in BOV's final report on its review of KBH. BOV is making these preliminary recommendations at this time because of the extreme nature of its concerns about the KBH organization and its ability to serve its residents safely and effectively, and in the interest of the urgent need for the recommendations to be implemented as soon as possible.

The current intense attention that is being directed toward KBH is the culmination of the shared concern of the Quality Assurance Division, the Mental Disabilities Board of Visitors, and the Montana Advocacy Program (MAP) that began to develop in early Spring 2005, grew through late August, and continues to grow today. Starting in early Spring 2005, several of KBH's mandatory reports to these three organizations raised serious questions about how several critical incidents involving the safety and treatment of residents were being handled. Since then, it has become clear that these several incidents were not only representative of the substandard quality of the handling of these particular incidents, but that they were indicative of substandard treatment (though there are exceptions) at KBH generally. In addition, it has become clear that KBH has not reported thoroughly enough, not investigated in enough depth, or not reported at all a number of incidents involving abuse and neglect of residents as defined in 53-21-102, MCA and as required by 53-21-107, MCA. These incidents include a shocking number of "non-accidental injuries" to residents – in some cases caused by violently intense attacks by residents against other residents involving one or more attackers, as well as resident-on-resident aggression not causing physical injuries, resident on staff aggression, staff-on-resident abuse, and self inflicted injuries. In one instance, a resident inflicted severe injury to herself twice within four hours on the same day, both times in the absence of staff observation, both times with the same method (use of a broken piece of bathroom tile to lacerate her arm). Reported incidents have been investigated inadequately, with unclear administrative and clinical follow-up, and inadequate or unclear attention to staff and supervisory dynamics, or corrective actions.

BOV wants to make clear that the core of its grave concern about the environment of treatment at KBH is not simply that KBH needs to improve its reporting of and responding to critical incidents, *per se*, although BOV is very concerned about this. BOV emphasizes that it believes the plethora of "adverse patient outcomes" is an indicator of the dysfunction in the treatment environment and culture at KBH generally. The sheer number of incidents of resident-on-resident assault/aggression, non-accidental injuries (289 resident injuries and 132 staff injuries in July, August, and the first half of September 2005), and other critical incidents, the lack of appropriate reporting of incidents, and the casual and superficial manner in which incidents have been investigated and resolved – even life-threatening incidents – are symptomatic of the inconsistency, lack of leadership, and chaos that pervades the KBH treatment environment.¹

¹ One development, chilling in retrospect, was the curtailing of the role of the in-house Resident Advocate by KBH sometime in the summer of 2004. In BOV's opinion, this person was

This letter and BOV's final report will detail a number of organizational challenges that must be overcome in order to heal this environment. It is within this broader context that this citation of 53-21-104(7), MCA addresses the specific findings.

Since 9/16/05

On 9/19/05, I sent you an email detailing four alleged incidents that were reported to BOV by MAP, and asked for information. None of these incidents had been reported to BOV. In the Director of Nursing's response to my request for information, all four incidents were verified at least at the level that required notification of BOV. At least one of the incidents required notification of law enforcement per 53-21-107(3-c), MCA (an allegation of sexual assault of a female resident by a male staff person) and apparently was not². All of these incidents were serious, involving one resident-on-resident assault and three staff-on-resident abuse allegations – one of which resulted in termination of employment.

As recently as this past Wednesday and Thursday (9/28-29/05), BOV received 14 reports from KBH – 13 for resident-on-resident aggression/assault and one for staff-on-resident abuse. Of these, 13 were reported outside of the time frame required by 53-21-107, MCA. After communication with QA, it is unclear whether these reports or others are being made consistently to QA and BOV.

Since *one* indication as to whether KBH is making necessary changes in its treatment environment and culture is the number and handling of incidents involving resident-on-resident aggression, KBH's reporting of these incidents must be in accordance with Montana statute and other regulations – with regard not only to the congruence between the *occurrence* of incidents and the *reporting* of these incidents, but also with regard to both the *timeliness* and the *comprehensiveness* of the reports. In addition, these reports must indicate a level of *diligence* and development of insight into the *root causes* of the incidents, not just administrative actions related to policy changes, data tracking, or staff discipline. BOV must be able to trust this reporting process and to see in the reports a process of genuine and effective strategic *improvement* activity. As a result of recent examples as described above, it is difficult for BOV to trust the reporting process or (as described in the reports) the improvement activity.

BOV is working in coordination with QA to share impressions and findings, and is making ongoing recommendations to QA relative to its Notice and Order dated 9/2/05.

appropriately identifying functional problems that closely parallel some of the problems outlined in this letter, making pertinent recommendations to KBH, and communicating them to BOV. As a result, the Resident Advocate's ability to communicate directly with BOV was restricted by KBH and abuse/neglect reports started going through the Director of Nursing before being sent to BOV.

² KBH staff have reported to BOV that they have been discouraged from reporting to law enforcement until recently.

You and Mr. Vickers have expressed and BOV accepts at face value KBH's sincerity in working to address the many areas that require fundamental change in its operation. As you know, the process and organizational changes will only matter if they result in far-reaching and elemental changes in the way KBH works with the children in its Butte program. The key ingredient, frankly, that has been missing and that cannot go missing any longer is effective leadership.

I. Response to the KBH 9/14/05 letter and package of supporting documents

The recommendation BOV made in its 9/1/05 letter was for KBH to:

Analyze the causes of and immediately put into place resources, procedures, and interventions to eliminate the occurrence of resident-on-resident assaults.

KBH identifies the following factors as “contributing to the occurrence of resident-on-resident assaults”:

- staff supervision
- staff development and training
- program structure

KBH describes “immediate steps we are now taking to meet this particular challenge” under the following headings:

- increase direct care staffing grid
- leadership and organizational changes
- program and treatment changes
- direct care training
- ongoing staff development plan

Overall Impression

While the KBH response lists accurately several of the causes of resident-on-resident assaults and describes a number of positive steps it has taken and others it plans to take to address this symptomatic aspect of the overall dysfunctional treatment culture at KBH, many of the proposed solutions offer vague descriptions of processes without any meaningful description of targeted results, qualitative improvements, or measurable objectives ***that relate directly to critically necessary, fundamental changes in the treatment culture***. The administrative, clinical, and nursing leaders at the top of the organizational chart (with the exception of the Medical Director) seem remarkably out of touch with and unresponsive to the risks that staff and residents have been exposed to, and with the clearly articulated sense of staff and residents that the environment at KBH

is inherently unsafe; rather, there appears to be an obsession with technical aspects of data collection³ and trend analysis to the exclusion of the critical need to understand the human dynamics that underlie the KBH treatment culture. During BOV's second visit to KBH on 9/15-16, several staff members told BOV that KBH was experiencing a 'turnaround' in September, and that the units were calming down. While one would expect such a calming as the census has decreased steadily from full census, when BOV examined the injury reports for the first half of September, it found that the non-accidental injury rates for both residents and staff were actually somewhat higher than for July and August⁴. It may be that some of these numbers in September are attributable to recent increased documentation of these incidents, but that is not clear. Conversely, it may be that these incidents were under-documented in months prior to September (as indicated by several staff interviewed by BOV). It is simply premature to come to any meaningful conclusions about the effects of recent changes.

Positive Steps (with questions and comments in *bold*)

- Promotion of Tawnya Mock to the new position of Program Director. This change has the potential for clarifying chain of command confusion and lines of authority and accountability.
The Program Director should have supervisory authority over all staff who have a treatment role on the units – including nurses and therapists (not with regard to their professional judgments, but with regard to their role in the milieu as part of the unit team).
- Combining responsibilities for both admission and discharge coordination under Valerie Marshall. This change has the potential for improving communication with referring agencies as well as parents/guardians, and for improving treatment and service continuity as residents move into and out of KBH.
- Implementation by the Leadership Team of a procedure to offer clinical and administrative support, guidance, and consultation to RTC personnel.
- Implementation of a 'shift mapping' form. This change has the potential to become a useful tool for improving communication between shifts, and for enhancing consistency and continuity of treatment by personnel across three shifts.
- Meetings with direct care staff. If conducted effectively and if the meetings become a meaningful, ongoing part of the KBH culture, these meetings have the potential to improve the relationship between KBH administration and Mental Health Associates (MHA).
- Recruiting for a licensed Recreational Therapist.

³ For example, there are 107 coding criteria for describing adverse patient outcomes.

⁴ July: 100 injuries to residents, 50 injuries to staff. August: 125 injuries to residents, 50 injuries to staff. Through September 14: 64 injuries to residents, 32 injuries to staff.

- Training sessions for MHAs in basic skills for conducting group sessions (including a mentoring program), interacting with residents, and de-escalating residents.
- New Assistant Program Leads.
- Increased activities for all children.
- Plans to introduce new treatment approaches (Dialectical Behavioral Therapy[DBT], Moral Recognition Therapy, Today/Tomorrow, Second Step).
- Development of ongoing staff development training schedule that will provide a minimum of one hour per month of milieu/clinical training to each MHA.

This is a very positive move in the right direction. While BOV isn't making this recommendation now, we will recommend in our final report that the concept of the Mental Health Associate position be reworked into a paraprofessional Psychiatric Technician position. It is not acceptable for this critical position that has 95% of the face time with residents to be essentially an attendant/aide.

Inherent/Potential Problems with Parts of Improvement Plan

- Implementation by the Leadership Team of a “procedure to offer clinical and administrative support, guidance, and consultation to RTC personnel”.

BOV Comment: *Frankly, these are activities that leaders of an organization should be expected to provide. Staff at KBH do not need a procedure to follow in order to have needed leadership – they need leaders to lead. The Administrator, the Director of Nursing, and the Clinical Director must get out of their offices and establish credibility with the MHA and clinical staff before ‘support, guidance, and consultation’ will be seen with anything but cynicism.*

-
- Recruiting for and hiring new MHA staff; increase direct care staffing grid.

BOV Comment: *While increasing the number of MHAs and improving staff:resident ratios are positive interventions, cranking out more direct care staff who receive minimal and inadequate pre-service training, whose competence is sub-standard and inconsistent, who are alienated from the administrative and clinical leadership, and who enter into a dysfunctional treatment culture will only exacerbate the problem. The staff:resident ratio is not the problem, per se. If the treatment culture remains dysfunctional, changes in the ratios will have no effect.*

-
- “Because of scheduling constraints, MHA staff are typically unable to attend [treatment planning meetings] – but their input is communicated by the staff who do attend and much of the behavioral data reported is derived from milieu points/levels and MHA medical records charting.”

BOV Comment: *BOV believes strongly that the development of a genuine, empowered treatment role for MHAs is critical to addressing the problem of not only resident-on-resident assaults/aggression but - more importantly as its antecedent - the embedded negativity and control orientation of the treatment culture. Until KBH makes the commitment to ensuring that*

MHAs are actively involved in treatment planning meetings as well as in the day-to-day treatment of (as opposed to control of) residents, plans to overcome these challenges will be destined to fail.

- Changes in hygiene breaks, adolescent team schedules, group topics, and school schedules.

BOV Comment: These are red herring issues and will be meaningless without fundamental treatment environment/culture changes and the presence of dynamic leadership.

-
- Plans to introduce new treatment approaches (DBT, Moral Recognition Therapy, Today/Tomorrow, Second Step).

BOV Comment: Unless KBH establishes a clear model of treatment, it will continue to have a loosely conceptualized mixture of behavior management approaches designed to reactively reduce acting out behavior. Without fundamental change in treatment culture and leadership, no discrete treatment modalities will be effective.

Activities that Have Previously Been in Place Presented as New Steps to Resolve Current Crisis

- Inexperienced employees must receive proper training prior to entering the MHA pool.

BOV Comment: The Orientation Agenda dated August 29, 2005 – September 10, 2005 included in the BOV response package is identical to the one dated June 20 2005 – July 1, 2005⁵. There is inadequate time allotted to educate raw recruits about complex, abstract concepts and activities such as forming therapeutic rapport with residents, de-escalation, conducting effective skills groups, working together as a team, etc.

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- Quality Assurance Committee meets monthly to review Adverse Patient Outcomes.

BOV Comment: This is not frequent enough considering the scale of these problems. Something fundamentally different needs to be developed from a Quality Assurance perspective. Injury reports provided to BOV dating from January 2005 through September 14, 2005 had clearly not been analyzed for the entire time frame. Whole sections of the report forms where analysis is to be recorded were blank.

⁵ With the exception of some trainer personnel changes; the elimination of “Performing change of clothes procedure and pat-down, Performing room searches, and Resident return from LOA and inventory procedures” on Day 6, Maintaining Resident Safety; **and the elimination of teaching of procedures for “assault” on Day 4, Maintaining Resident Safety.**

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- Therapists, physician, nursing and education staff are routinely attending treatment planning meetings.

BOV Comment: *This is expected and is not a new strategy to address resident-on-resident assaults/aggression. Assuming that these have been ongoing, they have not impacted the problems. (see comments about MHA involvement above)*

Question: *Is anything new being done in these meetings that is fundamentally different and designed to effect positive change in the treatment culture?*

- Precautions meetings are held five times weekly and are attended by therapist and nursing staff to review status of residents on any sort of precautions/ restrictions.

BOV Comment: *Assuming that these have been ongoing, they have not impacted the problems. These meetings are not a new strategy to address resident-on-resident assaults/aggression. Meetings like this have the potential to be effective in assessing the relationship between "precautions/restrictions", tensions on the unit, relationships between MHAs and residents, and the overall quality of the milieu. However to do so, they must include the MHAs in a meaningful and empowered role.*

Question: *Is anything new being done in these meetings that is fundamentally different and designed to effect positive change in the treatment culture?*

- Weekly team meetings are held for each program attended by therapists and program leads to review residents' behaviors and therapy issues.

BOV Comment: *This is expected and is not a new strategy to address resident-on-resident assaults/aggression. Assuming that these have been ongoing, they have not impacted the problems.*

Question: *Is anything new being done in these meetings that is fundamentally different and designed to effect positive change in the treatment culture?*

BOV believes that there are at least eight additional primary causes of resident-on-resident assaults/aggression, and of the dysfunctional treatment culture that pervades KBH and from which the assaults/aggression emerge:

- 1) **The presence and acquiescence of a culture of violence and cynicism and a “corrections” atmosphere that has desensitized both staff and residents precludes the possibility for therapeutic engagement because the environment is not safe; staff are not in control of the treatment environment.**
 - Residents freely discuss their advantage over staff and how they manipulate the environment to create vulnerabilities.
 - In a group situation with the adolescent girls observed by BOV, girls came and went from the group as they pleased, and were disruptive; staff established no boundaries for this behavior.
 - Adolescent girls spoke of their manipulation of staff and their methods of making the staff vulnerable; of the staff they have injured; of their fear of being assaulted by their peers; of the staff’s inability to prevent or intervene on these situations; of having to get help for staff who were being attacked.
 - One adolescent girl stated, “I have never felt as unsafe as I do here.”
 - Staff talk about not knowing what to do to regain control.
 - Staff could describe no tools at their disposal except physical interventions.
 - No appropriate corrective strategies are identified on injury reports.
 - The Director of Nursing showed BOV the primary tool for communication and safety – a walkie talkie - hers was in a desk drawer with a dead battery.
 - *Incidents are not appropriately debriefed. Vicarious trauma identified by staff is not addressed, leaving them incapable of therapeutic engagement.*⁶
 - Children and staff describe a culture of being respectful of female staff. i.e.: standing until female staff sits down in the cafeteria. Youth witnessing a peer being held by a female staff person jeered at the held youth, “You better not hurt her”, etc. This culture does not extend to male staff. It puts an unhealthy burden on dysfunctional youth to be the guardians of the female staff and further fosters a culture of acceptance of violence as a provision of safety. Residents report that youth who “aggress” on female staff “get it later”. Staff have no insight into the danger and dysfunction established by allowing this to be the female staff’s tool of protection.
 - Categorization of injuries on the injury report goes from a ‘2’ which states...pain with no visible injury...to ‘3’ which is characterized by need for treatment in an ER. The distance between the two is vast. Consequently, most injuries are categorized as being minor at a level ‘2’ even if skin is torn, etc.

⁶ This dynamic in the treatment culture is key.

- Residents report being denied the ability to file police reports for attacks. Two youth reported having requested this but, “They never came back to take the pictures of my injury or took my statement”, “They kept saying I could and my parents wanted me to but they never followed through”.
- Frequent theme from staff and residents that “promises are broken”, “no one follows through”.
- Therapists report feeling “disempowered, invisible”.
- One child states, “A girl aggressed on me so I had to go to a different team. Now I will be here longer because I can’t go to my CD group. They bring me the material but I can’t read good enough.”
- Eight incidents in July of resident injuries related to broken bathroom tiles; only two of these were reported to maintenance.
- Outside area for adolescent recreation is a relatively small, foreboding area surrounded by a new, eight foot high chain link fence that looks and feels like a prison exercise yard. Residents and staff refer to it as the “rat cage”.

2) The lack of a coherent, clearly-articulated treatment paradigm.

- Throughout KBH literature and program documents, there are references to “residential treatment”, “quality programming”, “nurturing, healing, and healthy therapeutic environment”, “structured, therapeutic milieu”, “interactive resident community”, and “therapeutic intervention”. However no one BOV has spoken to at KBH can articulate clearly what the approach to treatment is.
- The Clinical Director refers to an ever-changing array of behavior-related approaches that appear to be reactive, not proactive approaches that support and are congruent with an overarching model. As stated above, several treatment modalities such as DBT, Moral Recognition Therapy, Today/Tomorrow, and Second Step are being implemented. However, these discrete treatment components must be parts of a coherent whole within a truly safe, nurturing treatment environment in which all staff approach residents consistently, firmly, skillfully, and compassionately. This kind of treatment environment is not in place.

3) The absence of a clinically-driven referral screening and admission decision-making protocol.

- The referral and admission decision-making process disregards and circumvents the Medical Director’s and other clinicians’ judgment about residents who should not be admitted because of overriding conduct disorder problems and histories of violence, assault, and disruption in previous treatment environments.

4) As a result of (3) above, the presence in the treatment environment of violent, seriously conduct-disordered youth who terrorize other residents and staff at will.

- In a very real and elemental sense, the resident mix at KBH is an ill-advised and volatile blend of children/adolescents who are either passive and/or victims of abuse and violence and children/adolescents who are perpetrators of abuse and violence against others.

5) Overcrowding - the presence of too many residents in the physical space available.

- The number of licensed beds has increased from 48 when the facility was built for the Rivendell program in 1988, to 85 currently without any increase in the space in the physical environment.
- Adolescents are housed three to a room.
- Overcrowding is constant during all waking hours and occurs in every aspect of the facility.
- There is inadequate room for anyone to go to unwind or to get away from a group.

6) Direct care staff are under-prepared, unsupported, inadequately supervised, do not have a treatment role, are unsafe in the treatment environment, and do not stay at KBH very long.

- Initial pre-service orientation does not provide adequate education to prepare MHAs to take a treatment role.
- There is inadequate ongoing education.
- No one adequately monitors the competency, skill, effectiveness, consistency, or compassion with which MHAs interact with residents or conduct skills groups.
- BOV observed MHA staff interacting with residents as if they were commiserating about their common situation having to be at KBH; on these occasions, staff appeared to have no concept of professional boundaries and appeared to share some of the anti-social traits of some of the residents.
- Nurses report inconsistency of MHA training and MHA skill deficits as being a major source of difficulty on the units.
- 132 staff injuries in 2.5 months.
- Staff routinely hold residents for 45 minutes or longer.
- The therapeutic value of holds is very unclear.
- During the multitude of emergencies, available staff go to help, leaving remaining staff vulnerable.
- Staff are not able to describe treatment objectives.
- BOV overheard one staff talking to a youth saying, "At least we don't have to be in DBT class."

- Charting revealed issues of power struggles between staff and residents - even involving senior staff.
- 6 – 12 new employees are cycled into the “pool” each month to replace others who have left.

7) Confusion about the chain of command.

Even with new leadership and organizational changes – which, as stated above, are positive and hopeful steps - BOV is concerned that the lines of authority and accountability - from corporate to line staff – are not clear enough, and that there continues to be potential for confusion and compartmentalization (and the resulting ambiguity about accountability) regarding the chain of command.

The following authority / accountability lines are not clear:

- disconnect between the Nurse as unit leaders and the Team Leads as unit leaders (BOV observed MHA staff openly criticizing a Team Lead’s direction regarding holding a child, the Nurse who was present telling the MHA that she could not override the Team Lead, then the Nurse directing the MHA and the Team Lead to take another course of action).
- disconnect between clinical, nursing, and line staff (with the new Program Director position in place, these three staff groups still follow parallel chains of command that do not connect before the CEO level)
- disconnect between Program Director, Clinical Director, Nursing Director, Medical Director (same situation as stated in the bullet above - in reverse)

8) The absence of anyone in a leadership position at either the Butte or corporate level who has demonstrated adequate awareness or insight into clear evidence of pervasive dysfunction and related safety and treatment issues, who has called out for an explanation of and accountability for this dysfunction, who has demanded solutions and empowered others to seek them, who can see beyond the data and statistical trends, who can be truly present in the milieu and form relationships with the staff in the trenches, and who can rally the staff at all levels.

- Unanalyzed injury reports dating back at least 9 months (January 2005 through September 14, 2005).
- No corporate awareness of the crisis or the need for intervention prior to BOV/QA/MAP direct involvement.
- No interactions with the Butte-level “Governing Board” until very recently.
- Compartmentalization of information and analysis at every organizational level.
- Director of Nursing does not have contact with the nurses on the units.

- Unit staff report no meaningful contact with the Clinical Director.
 - The Director of Nursing showed BOV the primary tool for communication and safety – a walkie talkie - hers was in a desk drawer with a dead battery.
 - Seriously injured staff given the same unit assignment immediately after an attack by a resident, no action taken, no one in a leadership position acknowledged staff person's experience or inquired about her physical or mental well being.⁷
 - One staff person in a mid-level leadership position reports never having been approached by or having had a conversation with a senior leader in three years of employment.
 - Approximately 60% of resident and staff non-accidental injuries occur before 5:00pm when ancillary staff and leadership are available (but do not respond to incidents).
-

⁷ As reported to BOV, this is representative of situations in which staff are injured by residents.

II. Recommendations

(the following recommendations are made in the context of and invoke the response requirements of 53-21-104(3), MCA and 53-21-104(7), MCA.)

- 1) Voluntarily continue the moratorium on admissions. Stop lobbying QA to lift the moratorium.
- 2) Do not resume admissions until KBH demonstrates competence and stability with a smaller resident population over a meaningful time frame as evidenced by (but not limited to):
 - appropriate admission decisions and process (verified by outside oversight)
 - discharge of residents who represent an unacceptable risk to other residents and staff
 - adoption of a coherent, overarching treatment paradigm consistent with evidence-based practices in the treatment of children with serious emotional disturbance (established with outside clinical consultation)
 - a monthly root cause analysis report of all 'adverse patient outcomes' that includes an ongoing action plan, specific corrective interventions, and a description of the results of corrective interventions (including, but not limited to reduction of adverse patient outcomes – especially non-accidental injuries) submitted to QA and BOV
 - demonstration of 100% MHA competence in all areas relating to resident interactions and related treatment activities, including skills groups
- 3) Determine the maximum number of children that can be safely and effectively served in the current KBH facility. Articulate the rationale for this number.
- 4) Stabilize unit staffing by establishing the optimum (not minimum) number of staff per unit/shift – schedule this number regardless of census; assign the same individuals to the same units/shifts consistently unless an emergency staffing problem exists.
- 5) Establish 30 minute shift exchanges between night and AM shift (6:45am – 7:15am) and between AM shift and PM shift (2:45pm – 3:15pm) supervised by Team Leads and Assistant Team Leads or other supervisors as needed.
- 6) Adjust the referral screening and acceptance procedure so that referrals with clear diagnostic profiles and/or behavioral histories that include documented violence against others and/or significant disruption in other settings, or other indications of high potential for violence against KBH residents or disruption of the KBH milieu are not admitted to KBH.
- 7) Adjust the referral screening and acceptance procedure so that the Medical Director has the final decision-making authority.
- 8) Identify and discharge residents who represent an unacceptable risk to other residents and staff.

- 9) Begin analyzing every 'non-accidental injury' of residents and staff for root cause and submit a monthly root cause analysis report that includes ongoing aggressive action plans, specific corrective interventions, and results of corrective interventions to QA and BOV.
 - adopt a 'rapid cycle' evaluation and response model (no longer than 48 hours post event)
 - direct and senior supervisory follow-up in person with each injured resident and staff within 24 hours of each injury
- 10) Develop a 'STAT team' which consists of ancillary staff (CEO, Clinical Director, Director of Nursing, Clinical Nurse Specialist, Medical Director, Program Director, Director of Admissions and Discharges, Resident Advocate, Care Managers), trained to respond to emergency situations to reduce the number of MHA staff who have to be pulled from duty stations.
- 11) Begin immediately to report abuse/neglect allegations as required under 53-21-107, MCA.
- 12) Arrange for outside, independent investigation of all allegations of resident abuse/neglect that meet a severity threshold to be determined by KBH/QA/BOV or in which any kind of conflict exists.
- 13) Tear down the "rat cage"; involve MHA staff, residents, and Governing Board in the design of a new, larger, comfortably landscaped, non-correctional, outdoor recreation area for adolescents.
- 14) No later than November 1, 2005, send a letter to each parent or guardian and referral source of each child currently residing at KBH and of each child admitted to KBH into the indefinite future (until competence and stability are demonstrated per recommendation #2). In this letter, explain the problems that KBH has been experiencing, the oversight activities that are taking place (QA and BOV), and KBH plans to address the problems. Compose this letter with the input of BOV.
- 15) Distribute the 9/1/05 BOV letter, the KBH response that letter, this letter, and the KBH response to this letter to all KBH staff and to the Governing Board.
- 16) Distribute the QA Licensing Deficiency Survey Report and the Plan of Correction to all KBH staff and to the Governing Board.
- 17) The CEO, Director of Nursing, and Clinical Director should meet with all KBH employees in small groups no later than November 1, 2005, apologize for and take ownership for the mistakes that led to the current situation, explain the corrective actions that are in place and planned, ask for their support, and ask for their ideas about healing KBH.

Sincerely,

Gene Haire
 Executive Director
 Mental Disabilities Board of Visitors

cc: Joan Miles, Director
Department of Public Health and Human Services

ADDENDUM 5 - 10/7/05 BOV review of medication records and interview with Medical Director

Kids Behavioral Health of Montana
Report date: October 9, 2005
Bill Docktor, PharmD

Hypothesis: As needed or emergency medication use is high do to inadequate milieu management, inadequate training for direct care staff, and/or inadequate leadership.

There are several lines of evidence that this hypothesis is true.

- 1) There have been several hundred emergency medications used since January 2005 for up to 85 residents. This appears to be a much larger number than one would expect.
- 2) The medical director, Dr. Spilan, stated that prn use is high due to an unskilled staff. She added that they are not trained to deescalate, are understaffed, and the training provided is ineffectual.
- 3) Review of cases (three) revealed a pattern of repeated behaviors without much mention of attempts to control these behaviors other than holds and medications. Treatment plans did not change despite repeated need for ESI and/or medication.

In case 3782-01, the notes mention numerous episodes of barricading herself and others in rooms, refusing to leave the courtyard, and attempts to help other residents get out of holds. There were several notes which documented acting out and swearing without any consequences. When the behavior escalated to a more severe level, ESI and/or medications were used. There is little stated in the notes documenting attempts to control these behaviors otherwise. In one case, the resident left in the middle of a therapy session upset, escalated, and "required" an ESI. During these nine months plus, no changes were made in the treatment plan.

In case 3847-01, a very similar pattern occurred. One additional observation is noteworthy. On 9/3/05, her "hs" or bedtime dosage of Seroquel was given at 1750 for acting out. After settling down at the nurse's station, she returned to the team. I do not know if this was authorized by the physician, but there was no mention of calling the physician about doing this.

In case 3800-01, also had a similar pattern, but with fewer emergency medication uses.

An unrelated finding is worth noting in this case. This person was taking levothyroxine which had been started this summer due to one set of laboratory values indicating

hypothyroidism (low free T4 and high TSH). Thyroid studies before and after this were normal. Lithium was discontinued 7/31/05. Since lithium can produce hypothyroidism, it would probably make sense to discontinue the thyroid to see if it is still needed. The dosage is lower (50 mcg) than would be expected for full replacement.

Other Matters Discussed:

Dr. Spilan complained about non-physicians accepting patient she would not and recommended that they not be accepted. She found and showed us one where the admission screening form has been signed by a PhD on the medical director line.

The corporation brought in a pharmacist to discuss medication. He apparently was suggesting chlorpromazine (Thorazine) as a less expensive alternative to the second generation agents. Dr. Spilan has avoided using first generation agents due to the greater "cognitive dulling" they cause in comparison to the second generation agents. I tend to agree with her assessment, but there is not real good data showing this is really the case. It is mostly a perception shared by many clinicians based on how their patients feel on the medications.

She stated that she will probably start using chlorpromazine for a few clients. She went on to say that this would be not for the benefit of the patient but for the other residents and staff.

She also stated that nurses will not give a medication even in the acute situation and ordered by the physician unless the parent/guardian has approved the use of that medication. She feels this needs to be remedied to allow use of medication for safety reasons even without parental consent.

ADDENDUM 6 - 11-9-05 KBH response to 10-5-05 BOV letter

1. Voluntarily continue the moratorium on admissions. Stop lobbying QA to lift the moratorium.

KBH Response: *Because of financial hardship caused by the moratorium, KBH is unable to voluntarily continue the moratorium on admissions. However, KBH continue to offer to come to an interim agreement with QA to cap the occupancy levels, until such time reasonable clinical stability is demonstrated. This level must be such, that KBH of MT can meet their minimum financial obligations (i.e., break even).*

2. Do not resume admissions until KBH demonstrates competence and stability with a smaller resident population over a meaningful time frame as evidenced by (but not limited to):

- appropriate admission decisions and process (verified by outside oversight)

KBH Response: *Once admissions resume, the Medical Director will have final decision-making authority.*

- discharge of residents who represent an unacceptable risk to other residents and staff

KBH Response: *KBH has discharged residents who represent an unacceptable risk to other residents and staff, after an appropriate placement has been secured.*

- adoption of a coherent, overarching treatment paradigm consistent with evidence-based practices in the treatment of children with serious emotional disturbance (established with outside clinical consultation)

KBH Response: *KBH has established several new treatment modalities. These interventions are evidence-based practices. See attached Quality Assurance Report, Exhibit A*

- a monthly root cause analysis report of all 'adverse patient outcomes' that includes an ongoing action plan, specific corrective interventions, and a description of the results of corrective interventions (including, but not limited

to reduction of adverse patient outcomes – especially non-accidental injuries) submitted to QA and BOV

KBH Response: *On a daily basis, KBH reviews all Adverse Patient Outcomes, identifies corrective actions or specific interventions. The required reporting of those incidents are submitted to BOV and QA.*

- demonstration of 100% MHA competence in all areas relating to resident interactions and related treatment activities, including skills groups

KBH Response: *See attached Quality Assurance Report, Exhibit A, page 6. Additionally, the following timelines have been set:*

- MHA competency form revisions by 11/11/05
- MHA evaluations by 11/30/05
- Group skills training by 11/30/05

3. Determine the maximum number of children that can be safely and effectively served in the current KBH facility. Articulate the rationale for this number.

During recent meeting, KBH has agreed to set aside one, possibility two rooms, to be used for infection control purposes or special needs for children (i.e., privacy).

KBH Response: *The number of children KBH can serve safely and effectively is 85, by reason of;*

- a. *DPHHS has agreed by their own measurement, there is adequate space for 85 beds.*
- b. *KBH is licensed for 85 beds.*
- c. *KBH has the ability to staff for 85 beds.*
- d. *KBH has an overarching treatment paradigm consistent with evidence-based practices and treatment.*
- e. *On going extensive training is occurring with MHA staff.*
- f. *Increased MHA competency, relating to residents and treatment activities, has occurred and will continue to occur on a regular basis.*
- g. *KBH has satisfactorily addressed all issues in the DPHHS Quality Assurance order.*

4. Stabilize unit staffing by establishing the optimum (not minimum) number of staff per unit/shift – schedule this number regardless of census; assign the same individuals to the same units/shifts consistently unless an emergency staffing problem exists.

KBH Response: ***Effective 9/9/05, KBH has made the following changes::***

- **1:3 for the youngest children's team**
 - **1:4.5 for other children;**
 - **1:5.5 for adolescents, during day shift**
 - **1:5 for adolescents, during evening shift**
-
- **The Unit Coordinator, who reports directly to the new DON, will develop a monthly master schedule for MHA's.**
 - **Nurses will review the schedule daily and complete the shift mapping form, which they will be trained on by 10/31/05.**
 - **RN Supervisor will contact staff to fill the openings, if required staffing is not met for the on-coming shift due to call-offs or other reasons not controlled by the facility. Additionally, the RN will call in any additional staff needed for acuity.**
 - **Nursing, Program Managers, Program Leads have made MHA staff assignments per team and per shift to ensure unit consistency.**
5. Establish 30 minute shift exchanges between night and AM shift (6:45am – 7:15am) and between AM shift and PM shift (2:45pm – 3:15pm) supervised by Team Leads and Assistant Team Leads or other supervisors as needed.

KBH Response: *Program Leads and Assistant Program Leads have established a new shift dynamic form to communicate from shift to shift. The Assistant Program Leads are responsible for completing the form at the beginning of the 3-11pm shift. The Shift Dynamic form for the 7am-3pm shift is completed the night before and checked in the morning by the Program Manager to assure that the information is correct and to include any additional information for the day. The Program Lead and/or the Assistant Program Lead reviews this with MHA staff on each shift. See attachment, Exhibit B.*

6. Adjust the referral screening and acceptance procedure so that referrals with clear diagnostic profiles and/or behavioral histories that include documented violence against others and/or significant disruption in other settings, or other indications of high potential for violence against KBH residents or disruption of the KBH milieu are not admitted to KBH.

KBH Response: *KBH currently has an admission criteria policy which was recently reviewed by the Medical Staff. Revisions are currently being made to include, admission considerations will be made based on; 1) current milieu acuity, 2) overall benefit of treatment, and the Medical Director having final decision-making authority.*

7. Adjust the referral screening and acceptance procedure so that the Medical Director has the final decision-making authority.

KBH Response: *KBH currently has an admission criteria policy as stated above and upon resuming admissions, the Medical Director will have final decision-making authority.*

8. Identify and discharge residents who represent an unacceptable risk to other residents and staff.

KBH Response: *KBH has discharged residents who represent an unacceptable risk to other residents and staff, after an appropriate placement has been secured.*

9. Begin analyzing every 'non-accidental injury' of residents and staff for root cause and submit a monthly root cause analysis report that includes ongoing aggressive action plans, specific corrective interventions, and results of corrective interventions to QA and BOV.

KBH Response: *On a daily basis, KBH reviews all Adverse Patient Outcomes, identifies corrective actions or specific interventions, including non-accidental injuries. The required reporting of those incidents are submitted to BOV and QA.*

- adopt a 'rapid cycle' evaluation and response model (no longer than 48 hours post event)

KBH Response: *For ESI's, debriefing occurs within 24 hours with Nursing and Direct Care Staff. Non-accidental injuries require Nursing assessment upon notification of the non-accidental injury.*

- direct and senior supervisory follow-up in person with each injured resident and staff within 24 hours of each injury

KBH Response: *Program Manager(s) and/or the Director of Nursing will be responsible to follow up with each injured resident.*

10. Develop a 'STAT team' which consists of ancillary staff (CEO, Clinical Director, Director of Nursing, Clinical Nurse Specialist, Medical Director, Program Director, Director of Admissions and Discharges, Resident Advocate, Care Managers), trained to respond to emergency situations to reduce the number of MHA staff who have to be pulled from duty stations.

KBH Response: *The current "Code Yellow" policy is being revised to include, Clinical Management Team members requirement to be trained and maintain current MANDT certification to respond to emergency situations. This expectation will be added to each job descriptions and reviewed with the*

Clinical Management Team member.

11. Begin immediately to report abuse/neglect allegations as required under 53-21-107, MCA.

KBH Response: *We report all allegations of abuse/neglect.*

12. Arrange for outside, independent investigation of all allegations of resident abuse/neglect that meet a severity threshold to be determined by KBH/QA/BOV or in which any kind of conflict exists.

KBH Response: *We are interested in meeting with QA/BOV to establish an acceptable severity threshold to initiate external investigations.*

13. Tear down the “rat cage”; involve MHA staff, residents, and Governing Board in the design of a new, larger, comfortably landscaped, non-correctional, outdoor recreation area for adolescents.

KBH Response: *Although we do not agree with the terminology “rat cage”, the fence behind the facility was removed on 10/12/05. A new playground was installed in September 2005, which includes a play area, 6 swing sets and a sandbox. Additional recreational items will be explored in 2006.*

14. No later than November 1, 2005, send a letter to each parent or guardian and referral source of each child currently residing at KBH and of each child admitted to KBH into the indefinite future (until competence and stability are demonstrated per recommendation #2). In this letter, explain the problems that KBH has been experiencing, the oversight activities that are taking place (QA and BOV), and KBH plans to address the problems. Compose this letter with the input of BOV.

KBH Response: *After discussion with legal counsel, KBH is unable to fulfill this request. However, we have and will continue to openly address all questions and concerns from families and referrals sources, regarding the current situation.*

15. Distribute the 9/1/05 BOV letter, the KBH response that letter, this letter, and the KBH response to this letter to all KBH staff and to the Governing Board.

KBH Response: *KBH will continue to distribute to the Governing Board, as necessary. We respectfully decline to send a letter to all staff to avoid further disruption to the program. We have and will continue to openly share all information and address questions and concerns regarding the situation with staff.*

16. Distribute the QA Licensing Deficiency Survey Report and the Plan of Correction to all KBH staff and to the Governing Board.

KBH Response: *The Licensure Deficiency Report/POC were distributed to Department Heads to share with their staff, as well as to all Governing Board Members. It is our belief that this substantially complies with this request.*

17. The CEO, Director of Nursing, and Clinical Director should meet with all KBH employees in small groups no later than November 1, 2005, apologize for and take ownership for the mistakes that led to the current situation, explain the corrective actions that are in place and planned, ask for their support, and ask for their ideas about healing KBH.

KBH Response: *The following leadership team changes have occurred:*

- *Effective 10/10/05, the Chief Executive Officer (CEO) resigned and replaced by an interim CEO.*
- *Effective 10/17/05, the Director of Nursing (DON)resigned and replaced by a new DON.*
- *Effective 10/28/05, the Clinical Director resigned. A new Manager of Social Services position will be filled by 11/10/05.*
- *New Children's Program Manager position has been hired.*

The Vice President of Clinical Services for KBH, continues to assist in rebuilding the program structure.

KBH continues to improve the programs, and explain the corrective actions that are being taken and planned, to all staff. We are asking for their ideas and support in implementation. KBH communicates to our staff through; community meetings, department heads and managers, union leadership, management members working weekends on the units, employee surveys and management's open door policy.

Additionally, we continue to survey employees to evaluate the changes that KBH is making, recent result are available for review. See attachment, Exhibit C.

As included, is a copy of the survey results for the Case Management questionnaire, recently distributed. See attachment, Exhibit D.

KBH is very pleased at these results as it appears that Case Management personnel continue to be very supportive of the program and facility.

FACILITY RESPONSE – 6/21/06



KIDS BEHAVIORAL HEALTH OF MONTANA **RESPONSE TO RECOMMENDATION** **JUNE 21, 2006**

1. Assign a designated Therapist to each residents team.

KBH does assign designated Therapists to each resident team. Occasionally, a Therapist may have a resident outside of the normal case load because of changes in the resident populations.

2. Reallocate program management structure so that each Program Manager is responsible for one team of 12 residents; creating “mini-programs” within the overall program would lend itself to better, more cohesive treatment and an improved sense of ownership among all staff in each “mini-program”.

KBH has improved the program management structure to include additional supervisors, two Program Leads and three Assistant Program Leads. This structure allows for on-site program supervision seven days a week, 16 hours a day.

3. Improve the integration of the educational component and the mental health component by establishing more clearly that each classroom is a treatment environment; ensure that educational goals are consistent with the mental health treatment goals.

KBH has enhanced the overall Treatment Planning process and reestablished the expectation of the multidisciplinary team which includes the participation of education. The teachers participate in the Treatment Plan meetings. The residents point sheets and assessment sheets include educational goals. Additionally the Principal in the Education Department and Program Managers have established goals for educational outings to occur one time per week per team.

4. Improve/simplify the process for analyzing data.

The process for analyzing data has improved to include daily, weekly and monthly analysis evaluations on key statistics to include resident specific statistics. KBH is currently utilizing spreadsheets and developing a database to track and trend the statistics in a more simplified way.

5. CEO and corporate office should consult with Nursing Director and Resident Advocate regarding the kind of software that would meet their needs, provide those resources, and provide training in the use of the software.

The CEO has consulted with the DON and Resident Advocate regarding the kind of software that would meet their needs. If the addition of a database does not address this issue, alternative software will be explored.

6. Research “non-accidental injury” benchmarks for this population in other treatment venues nationally.

Research has been conducted with no success by the facility and the corporation to identify “non-accidental injury” benchmarks for our population. We would welcome BOV to conduct research and provide any National statistics on “non-accidental injury” benchmarks for our population.

7. Develop a formal agency training plan for all positions. Incorporate training that is not solely provided by KBH.

KBH has developed a formal Training Plan for 2006 with goals and guidelines set through the Performance Improvement Team. (Attachment A). KBH has sent staff, including managers, to outside seminars and trainings to become trainers, advance their knowledge and train other facility staff. (Attachment B). A total of 13 seminars and/or trainings in 2006 with additional future trainings planned. Additionally, prior to 2006, five staff were trained in Dialectical Behavioral Therapy.

8. Develop and implement training and support for leaders at all levels, especially people who have significant responsibility for implementation and sustenance of program improvements.

See #7 response and Attachments A & B.

9. Develop and implement formal training program for MHAs in addition to the orientation. This should include training provided by external sources.

See #7 response and Attachments A & B.

10. Build in opportunities for staff to process and debrief outside of milieu responsibilities.

Program Management staff conduct team meetings with their MHAs for training purposes,

planning sessions, debriefing and unit issues. In addition, Program Management meet individually with MHA staff to debrief.

11. Provide therapists with regularly-scheduled individual supervision from a highly skilled and qualified clinical supervisor with experience in child, adolescent and family therapy.

The Manager of Social Services meets regularly with Therapists. She meets with new and inexperienced Therapists individually weekly for clinical supervision. All Therapists meet on Wednesday with the Medical Staff for case consultation, training and clinical discussion. Additionally, through the KBH Mastery Achievement Performance Improvement Process peer reviews are conducted monthly.

12. Develop and implement a regular schedule of group and individual supervision for MHA and supervisory staff focusing on all areas of professional and personal growth.

Program Management staff conduct MHA team meetings for the purpose of training, discussing unit issues, debriefing and other items. Supervisors met with MHAs routinely on an as needed basis to provide feedback and one-on-one teaching and training. Annual meetings are conducted to discuss performance, training needs, measure competency, and professional goals.

13. Provide increased training and supervision to MHAs focused on increasing their skills in proactive intervention before kids become dangerous to others.

See #7 response and Attachments A & B regarding training. Additionally KBH has added early intervention de-escalation training as an additionally Mandatory training ever six-month. It is currently trained as a part of MANDT in new employee orientation and annually. The new six month requirement is in addition to the existing training.

14. Enhance incident report documentation format to provide information about pre-incident efforts to deescalate and to prevent physical intervention.

KBH has modified the ESS/ESI Form to include more information about proactive measures taken, specific interventions used, the application of MANDT and the debriefing sections as reformatted and enhanced to make it easier to complete. The ESS/ESI form requires two sets of debriefings. The form will be submitted to the Medical Staff for approval and implementation in July, pending Governing Board approval. (Attachment C). The information from the modified ESS/ESI Form provides additional information that is being used to develop clinical plans based on pre-incident efforts to deescalate and prevent physical intervention.

15. Enhance incident report documentation format to provide information about the proper use of MANDT techniques.

See #14 response and Attachment C.

16. Analyze the current written description of the KBH treatment approach. Refine it so that

it clearly describes a comprehensive treatment approach that includes the clear *integration* of individual, group, family, and milieu treatment with the educational and psychiatric services.

KBH Program Managers have been working with David Damschen, KBH VP of Clinical Services over the past several months to write comprehensive Program Manuals for the Adolescent Program and Children's Program that clearly define the integration of the multidisciplinary team. These Manual are expected to be completed and approved by the governing board in July.

17. Revise the "RTF Admission Checklist" form to include these categories: (a) physical aggression, (b) sexual aggression or reactivity, (c) self-harming behaviors, (d) other symptomatology that should be considered in the screening process; and to include space for comments and signatures of all members of the Admission/Screening Committee in order to verify that they reviewed the referral information and that any concerns or questions are documented.

- a) *Addressed in #4 of Attachment D, RTC Admission Checklist (persistent patterns of disruptive behaviors.*
- b) *Addressed in #6 and #9 of Attachment D, RTC Admission Checklist - #9 could be changed to address reasons for need of private room for sexually reactive children and adolescent.*
- c) *Addressed in #6 of Attachment D, RTC Admission Checklist..*

Will change RTC Admission Checklist form to include space for comments and signatures.

18. Include therapists in the referral screening process in order to take advantage of their clinical skills and experience.

The Manager of Social Services is involved in the referral screening process and makes the appropriate therapist assignment

19. Develop a comprehensive plan for rebuilding relationships with referral sources that are mutually reciprocal.

KBH meets with external referral sources on a routine basis to build mutually reciprocal relationships. Quarterly meetings will be offered to youth case management organizations, personnel from acute hospitals, juvenile probation officers and State and tribal social service agencies.

KBH clinical, administrative and marketing staff will continue to be available to referral agencies to met and discuss general program topics or specific concerns or issues with residents in treatment.

A representative from KBH marketing travels throughout the State to go over program plans and

address issues with individual referrals in their home communities.

20. Involve clinical staff more in liaison work with referral source colleagues. This should not be primarily a “public relations” project.

KBH Therapists work directly and ongoing with Community care Managers, Department and Family Services workers, Probations Officers and other referrals on a collegial basis.

21. Define, standardize, and maintain firm admission criteria.

KBH has defined, standardized and firm admission criteria.

22. Develop and implement a clear policy and procedure for making discharge decisions with particular emphasis on specific discharge criteria and benchmark behaviors or symptoms that may indicate the need for the resident to be removed from KBH.

Each resident has different treatment needs that justifies the need for individual treatment plans. It would be efficient to develop a single treatment plan to be used for all the kids, however we would be doing a gross disservice to the resident. To establish benchmark behaviors or symptoms to determine when a resident needs to be discharged would also do a disservice to the resident. A resident is discharged from the treatment facility when they no longer can benefit from our clinical services. KBH assists all referral sources and guardians with alternative placements, step down placements and community support services.

23. Develop and implement a system for documenting discharges that includes more precision in articulating reasons for discharge, where the resident was discharged to, and post-discharge treatment recommendations.

The “Treatment Planning Process” consisting of the guardian, community case manager, resident, KBH’s multidisciplinary teams address and formulate the discharge plans for the resident, articulating reasons for the discharge, where the resident is being discharged to and post-discharge treatment recommendations. KBH’s Discharge Summary and After-Care Plan also reflect the points in the recommendation.

24. Add a category of ‘history of aggression and/or assaultiveness towards others’ to the “Referral Information” form.

We request psychological and psychiatric evaluations and only use the referral Information Sheet to give referral sources an idea of the information we are looking for. Previously in the past when referral sources have filled out the form, they don’t give us enough detailed information that the psychological and psychiatric evaluations do.

25. Require the “Referral Information” form to be completed by the referring agency before the referral will be considered by the admissions committee.

See #24 response.

26. Voluntarily cap the census at KBH at a maximum of 70.

KBH is licensed for 85 beds. It meets the licensing requirements for 85 beds. KBH does have internal renovation plans to create additional resident space that have been approved by Licensing.

27. Actively include and involve MHAs in learning about milieu treatment; actively include MHAs in every aspect of the process of treatment - including direct involvement in treatment planning meetings, and ensure that MHAs are active participants in decision-making about the program's effectiveness.

KBH Program Management staff does include MHA in discussion and are open to feedback about program effectiveness, resident interventions, resident point sheets, assessment card, medication effects and other areas of programming. It is the goal of KBH to include MHA's in Treatment Planning meetings in the future.

28. The Licensure Bureau and the Children's Mental Health Bureau Review should review financial records with KBH to determine the appropriate parameters of reduction in staffing based on revenue.

KBH does not reduce staff based on revenues. KBH manages staffing levels based on established resident to staff ratios and acuity of the resident population. The current resident to staff ratios were presented and approved by licensing September, 2005.

29. Formulate a plan that designates who on each shift will respond to distress calls; educate these staff and the staff remain on units about the roles and responsibilities for each situation.

*We have modified our Code Yellow policy to Emergency Resident Behavior Management. The policy will be submitted to the Medical Staff for approval and implementation in July, pending Governing Board approval. (Attachment **NEED**)*

30. Realistically analyze the elopement risk and develop policies and procedures that appropriately address it, while optimizing all residents' access to the outdoors.

KBH does analyze elopement risks daily on each shift and before each outing. When risk is present a physicians order places the resident on elopement precautions that restrict their access to unsecured outside areas. Residents on elopement precautions utilize the outside courtyard which presents no risk of elopement.

31. Develop a plan to utilize the ~10 acres of agency-owned land surrounding the KBH facility for enriching the program through landscaping, recreational equipment, and programmed access to the outdoors.

See #32 response. Resident outdoor time is scheduled daily for all teams. Additionally

Education outings and Recreational therapy outings occur at least twice per week per team. When weather permits gym time is also outdoor time.

32. Make adequate outdoor play equipment and material be made available; for example, bicycles for the children's unit residents.

The existing outdoor play equipment is less than one year old and is adequate. Outdoor materials are purchased and updated by season to include games, balls, water games and toys, wading pools, ice skates, sleds, toys, kites, etc. KBH is considering the acquisition of bicycles and scooters, developing a sand volleyball court, tether ball poles and adding additional picnic tables.

ATTACHMENT A - to KBH 6/21/06 Response

ATTACHMENT B - to KBH 6/21/06 Response

ATTACHMENT C - to KBH 6/21/06 Response

ATTACHMENT D - to KBH 6/21/06 Response

ATTACHMENT E - to KBH 6/21/06 Response

BOARD of VISITORS COMMENT on the 6/21/06 KBH RESPONSE to this REPORT

Since BOV received the KBH response to the this site review report on 6/23/06, the Executive Director and the review team have studied the response. Several of the responses to the 32 recommendations are adequate - addressing not only the letter of the statutory requirement for BOV recommendation responses, but also the spirit. BOV appreciates the effort that KBH staff put into developing Goals, Training Plans and other processes indicated in the RESPONSE ATTACHMENTS.

However, many of the responses are inadequate – either stating that KBH is already doing what a recommendation specifies without adequate evidence, or that KBH is going to address a recommendation without a description of a specific plan with time frames.

Additionally, the overall tone of the response is – in our team’s collective opinion – less than forthcoming. As we stated in the report, KBH has implemented changes that begin to address the very problematic situation that BOV and DPHHS reviewers found in mid 2005. But there continues to be a long way to go. The KBH response to our recommendations does not enhance our confidence in this process.

All of this is exacerbated by the pending sale of KBH. In our opinion, the necessary improvement processes from 8/05 through the present – while having been pursued sincerely – have also been hampered in scope and depth and to some degree postponed by corporate tactical decisions related to positioning KBH for sale.

BOV will proceed with its oversight of KBH without regard for the identity of its ownership. It is important for any new owner to understand that – while BOV will embrace the new ownership scenario positively and hopefully – we will hold the new owners accountable for responsibilities they inherit from the previous owner, and for their active participation in the process in which BOV and KBH have been engaged since August 2005 – including addressing the deficits in the KBH responses to BOV site review recommendations.

BOV will wait to revisit these concerns until KBH’s new owner is in place. At that time BOV will do two things: (1) arrange a meeting with the new CEO to discuss BOV’s concerns with the response, (2) schedule a follow-up site review with BOV’s original team.