

Plan Requirements

Glenwood Resource Center February 2009 Tour

DOJ Assessment

(Note that SRC paragraphs below are summarized and/or abbreviated to accommodate size of chart. No text in this chart is meant to augment or replace the actual language and requirements of the SRC Plan)

III. PROTECTION FROM HARM

A. RESTRAINTS

4a	Identify persons restrained in last 12 mos	Individuals receiving restraints are identified on an on-going basis in the restraint tracking system.	C
4b	Complete CFA on persons identified above	A functional analysis has been done for all individuals who have received restraints.	C
4c	Develop/implement BSPs for above persons; BSPs must contain min elements*	BSPs at GRC do not include programmatic restraints.	N/A
5K-1	Restraints will be documented according to plan	The standard format for BSPs identifies the person responsible for the plan and the staff authorized to implement; also included is a description of the frequency and manner of data collection required.	C
6	BSP reviewed and/or revised when >3 restraints occur within 4 wks	Dr. Taylor conducts QA event-based reviews of individuals who have had three restraints in four weeks, focusing on the adequacy of psychologists' documentation. Dr. Taylor also reviews time out logs and provides feedback regarding procedure and documentation.	C
		There appears to be adequate evidence that, when an individual experiences three restraints in a four-week period, the BSP is reviewed and revised as appropriate.	

IV. INTEGRATED PROTECTIONS, SERVICES, TREATMENTS & SUPPORTS

A. INTERDISCIPLINARY TEAMS

1	IDT shall seek personal independence/choice/quality of life	ISPs continue to improve with respect to facilitating choice, enhancing independence, and supporting self-determination. The peer review and team performance monitoring processes in place are having a positive effect with respect to this provision. Data are being collected with respect to the provision; this system appears adequate to provide teams with meaningful recommendations.	C
2	QM/RP ensures assessments & services are adequately provided	There have been very good improvements in interdisciplinary team functioning. A monitoring system is in place to assess team members' participation, data are routinely being collected. This system appears adequate to provide teams with meaningful recommendations.	C
3	IDT = Person, QM/RP, guardian & others as needed	The ISPs generally document efforts to engage guardians in annual reviews. Individuals did not participate in the M/R observed during the tour (held during school hours, individuals were school-age and did not wish to miss school). I encourage the facility to consider how to include individuals in the review process if they cannot attend the meeting.	C
4	Assess when needed, to ID strengths, preferences, needs	Annual assessments are routinely included in the ISP and appear to address significant changes in the individual's life, strengths, preferences, and needs.	C

5	ISP, w/supports & protections, based on assessments	The Comprehensive Functional Assessment is being routinely used to assist in selection of appropriate goals and objectives and to prioritize them. Chart reviews suggest improved IDT attention and responsiveness to significant events, including more frequent ISP revisions in response to assessment results. Data on the implementation and use of the CFA are being generated. This system appears adequate to provide teams with meaningful recommendations.	C
B INTEGRATED SUPPORT PLANS			
1	Policies/procedures requiring ISPs be consistent with standards of care	ISP policy appears appropriate.	C
2a, b	ISP quality will be consistent with professional standards of care	The ISPs adequately identify strengths, needs, preferences, and desires. The person centered planning process appears to build into the development of the ISP support for choice, independence, and self-determination. There has been improved emphasis on addressing the big picture when it comes to integrating assessment data into a package that moves people toward their long-term goals.	C
2c	ISP to identify measurable beh goals, supports to attain, & barriers	The habilitation plan includes goals and objectives and strategies to be employed; supports are identified. Identification of barriers to placement and the facility's efforts to overcome those barriers are improved.	C
2d	ISP will fully integrate all protections/svcs/supports/TX plans	Integration of ISPs is improved and the peer review process should continue and sustain this improvement.	C
2e	ISP will identify methods, time frames, pers responsible	The habilitation plan identifies methods for implementation, time frames for completion, and the persons responsible.	C
2f	ISP will identify methods to implement in most integrated setting	Interventions, strategies, and supports in the ISPs are increasingly practical, functional, and integrated. ISPs are generally adequate with respect to the amount of active treatment. Data are being collected with respect to the provision, and the system appears adequate to provide teams with meaningful recommendations.	C
2g	ISP will identify data collection requirements, incl who collects & who reviews	Individual program plans generally address these points.	C
3	Goals, objectives, outcomes, services, supports, TX integrated into ISP	ISP goals, objectives, anticipated outcomes, services, supports and treatments are generally better coordinated in ISPs. Continue monitoring is warranted to ensure that progress is maintained and extended.	C
4	ISP comprehensible for the capabilities of staff responsible for implementation	ISP language is generally accessible, comprehensible and appropriate for the capabilities of the staff responsible for implementing it.	C
5	Monthly progress reviewed by appropriate IDT member (one writing each program)	The Judgment of Progress Protocol appears to be implemented consistently.	C
6	ISP and IEPs consistent with one another	The facility appears to have in place processes for making ISPs and IEPs for school-age individuals consistent and compatible. Behavior plans appear to be adequately trained at school and such training is documented.	C

7	CBT on individualized goals for staff implementing programs	Competency-based training on the development and implementation of ISPs is in place and annual updates are occurring.	C
8	1 trainer responsible for IDT training and oversight	GRC has designated such a person.	C
9	Manageable caseloads for IDTs	The caseload for IDTs appears to be reasonable.	C
10	Implement ISP QA system to ensure B1-9 occurs & is effective	A QA process is in place and it appears to be having the desired effect of improving ISPs. Performance measures spell out minimum standards and best practice standards for each component of the ISP. Data are being collected with respect to the provision. This system appears adequate to provide teams with meaningful recommendations.	C

VII. PSYCHOLOGY			
1	Psychology Director responsible for psych services	The facility has a qualified director of psychology who has provided good leadership with respect to establishing and maintaining quality psychological care.	C
2	Psychology peer review system	The peer review process for BSPs continues to function well.	C
3a	Data protocols will incl info on target/replacement behs- when, where, freq, etc.	A data collection protocol is in place that appears to meet the provision.	C
3b	Monthly rev of data/progress by clinician - modify when no progress	Behavior data is reviewed and progress is characterized monthly. Behavior data review occurs in a variety of contexts (e.g., MLRs, psychiatric consults, BMC Data Reviews). MLR minutes reflect implementation of the Judgment of Progress Protocol and improved interpretation of data trends and action planning. There is continued improvement in documentation of psychology and the IDT responses to significant events.	C
3c	Protocols for assessing/rectifying data integrity issues	The protocol includes a method for assessing the reliability of data collection.	C
4a	Psychological asmt protocols in place with minimum elements	The facility has standard psychological assessment protocols that address the required areas.	C
4b	other psychological needs that may require intervention, including but not limited to, physical or severe emotional abuse or Post Traumatic Stress Disorder.	Dr. Taylor indicated that the repeat screening for victimization, along with risk for future victimization is continuing.	C
5	Asmnts based on current, accurate & complete clinical & beh data	Dr. Taylor is currently doing the peer review on all psychological evaluations. The process appears adequate to meet the provision.	C
6	Complete psych assessment w/ 30 days of admission and annually thereafter	All new admissions were assessed within one month.	C
7	Psych svcs w/ 30days of being ID'd as needing svcs per above	Data indicate appropriate provision of individual psychotherapy and group therapy services.	C
8	BSP w/ 30days of assessment & containing minimum components	All required components of the behavior plans are present (maintenance and generalization are addressed in the Functional Assessment report). Program integrity checks document implementation of the BSP.	C

9	BSPs must be able to be understood & implemented by RTWs	BSP reviews include consideration of the readability of the BSP. Data indicate continue progress in improving readability.	C
10	CBT on individualized BSP for staff implementing programs	The system for CBT on BSPs is well-established and serves as a model for CBT in other areas of the facility.	C
11	BSPs revised when needed	The BSPs document revisions introduced into the plan. BSPs appear to be revised relatively frequently in response to meeting the restraint trigger.	C
12	Ratios of psychologists (1:30) & psych assts (1 asst: 1 psychologist)	All positions are filled and the requisite ratio is met.	C

X. NURSING

3	Establish nursing protocols for assessment & reporting of medical conditions	Resident VC: A response protocol called for staff to call Nurse Stat before starting CPR. There was a Code Blue called from VC's house, however client was reported as unresponsive at 9:45 am and Code Blue was not called until 10:03 am. There were inconsistent responses by staff regarding the Code Blue policy. Staff failed to take his record and his medications to the hospital as directed by facility policy. Another concern is the failure of the staff to initiate Code Blue procedures in an appropriate fashion, and the confusion of staff interviewed about the proper procedures.	NC
6	Procedures for med admin, incl training, supervision, med error tracking	Resident VC, who died on 11/22/08 missed seizure medication following a return from the emergency room. There was no coherent procedure to assure that medications are given under conditions where an individual returns from an ER visit. He was found unresponsive at 9:45 am the next morning, transferred via EMS to the hospital and placed on mechanical ventilator support. He expired at 3:17 pm on 11/22/08. On the day following his ER visit, staff also failed to follow policy when one staff set up medications, while another staff administered them.	NC

XII. COMMUNICATION

1	SLP competent in augment/alter comm; assmts; prog dev/impl/monitoring & CBT	SLP staff includes individuals with training and experience in augmentative and alternative communication and a director for the SLP department has been hired. The present staffing in the speech / language department appears to be adequate.	C
2	System to ID persons needing augment/alternative communication devices	The facility has implemented a monthly Alternative / Augmentative Communication Clinic to evaluate individuals referred by the teams for possible implementation of AAC programs. These developments appear to meet this aspect of the agreement.	C

<p>3 Implement functional/adaptable comm plans for persons above; rev annually</p>	<p>Communication training continues to be a deficit at the facility, although there are plans in place that appear adequate to correct the deficit. Communication "plans" provided for review during this tour continue to be only communication matrices and did not include any reference to training programs intended to develop appropriate communication behaviors.</p> <p>The plan to push the department development process by having the director personally evaluating communication assessments, recommendations, and communication-related objectives and programs is sound and makes sense to get started on the right path. This approach, however, is not sustainable in the long term, nor is it likely to be a good long-term approach in any case. The question of how the facility will monitor progress in addressing communication needs is not yet answered. It is critical to have some clearly defined indicator of adequacy of communication assessment and programming for individuals and a system for monitoring that indicator that is not dependent on one person.</p> <p>The idea of having all communication-related programs, regardless of which domain they fall in, monitored by SLPs is sound. This approach will make it easier to quickly identify all communication related programs and it guarantees that communication related programs are being carefully watched by the staff persons who know the most about developing and supporting communication. The facility should consider establishing a process of formal peer review of the adequacy of communication programming.</p>	<p>NC</p>
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XIII. HABILITATION

<p>1 Ann assmts/qtrly rev of indiv strengths/prel/skills/needs/barriers to comm liv</p>	<p>Assessment in these areas has been improved and appears to be generally adequate.</p>	<p>C</p>
<p>2a-e Develop training/education/skill acquisition progs from above & incl min elements</p>	<p>Habilitation training programs continue to improve. A protocol is in place for writing goals and objectives. Programs generally specify strategies and supports adequately. Interventions are generally practical and functional and there are reasonable efforts to include training in community settings.</p>	<p>C</p>
<p>2f Programs have explicit data reqs, incl what data, freq, who collects & who reviews</p>	<p>The required components are included in the Individual Habilitation Plans.</p>	<p>C</p>
<p>3 CBT for staff implementing plans, both general and individual-specific</p>	<p>The new software looks promising for tracking training, though the system is not far enough along to evaluate outcomes. There is a need to create written procedures that describe how the tracking process works and that are then built into how the software works (e.g., notification of need for training).</p>	<p>NC</p>

<p>4</p> <p>Monthly rev by IDT member on progress/status/prog efficacy, revising as needed</p>	<p>The facility has adopted a Judgment of Progress protocol that establishes indicators of a need for program review / revision. The protocol appears to be adequate. However, the protocol is not yet being consistently implemented during MFRs with respect to habilitation programs. A random check on 8 individuals' most recent MFRs indicated that 25% did not report data on habilitation programs and 50% did not include an interpretive statement indicating whether the individual was making progress.</p>	<p>NC</p>
<p>5</p> <p>Ensure Habilitation QA process in place</p>	<p>The peer review for ISPs appears to be an adequate quality assurance process to meet this requirement.</p>	<p>C</p>