



Minnesota Department of **Human Services**

Rule 40: Monitoring, Reporting, Oversight Work Group Summary-REVISED
Revised as of 10.22.12 advisory committee meeting
Rule advisory committee's recommendation to DHS

Attended some or all work group meetings:

Rick Amado, DHS-SOS; **Mark Anderson**, Barbara Schneider Foundation; **Steve Anderson**, Rule 40 Advisory Committee Member, Mt. Olivet; **Rick Cardenas**, ACT; **Don Chandler**, DHS-SOS; **Erwin Concepcion**, DHS-SOS; **Stacy Danov**, DHS-SOS; **Alicia Donahue**, OMHDD; **Katherine Finlayson**, DHS – Licensing; **Brad Hansen**, Arc Greater Twin Cities; **Anne Henry**, Rule 40 Advisory Committee Member, Minnesota Disability Law Center; **Kay Hendrikson**, Rule 40 Advisory Committee Member, OMHDD; **Dan Hohmann**, DHS – MSOCS; **Renee Jenson**, Barbara Schneider Foundation; **Jill Johnson**, DHS-CMH; **Barb Kleist**, Rule 40 Advisory Committee Member, Arc; **Bob Klukas**, DHS-rules; **Pat Kuehn**, Rule 40 Advisory Committee Member, Ramsey County; **Jim Leibert**, DHS-DSD; Dr. **Gail Lorenz**, Barbara Schneider Foundation; **Chris Michel**, OMHDD; **Tim Moore**, Rule 40 Advisory Committee Member, U of M; **Michelle Ness**, MDH/OHFC; **Dean Ritzman**, DHS-DSD; **Kelly Ruiz**, Rule 40 Advisory Committee Member, Dakota County; **Lauren Siegel**, DHS-DSD; **Mike Tessneer**, DHS-Compliance **Charles Young**, DHS-DSD; **Suzanne Todnem**, DHS-DSD, project lead; **Gail Dekker**, DHS-DSD, facilitator

This summary is intended to reflect the work group's recommendation to the advisory committee in regard to monitoring, reporting and oversight. Not all specific ideas discussed are included; please refer to each work group meeting date notes for greater detail. Rather, multiple suggestions are represented here with broader concepts statements.

I. Context and reminders

A. Givens

1. The charge of the work group was to recommend standards that will apply to persons with disabilities
2. The standards will be expressed in statute, rule, and manual

B. Resource: "Monitoring, Reporting and Training on the Use of Restrictive Procedures: A Comparison Table of Arizona, Nebraska, Georgia and Kansas" (August Advisory Committee meeting handout #5)

C. Purpose

1. Develop content for monitoring, documentation, reporting, review, and oversight of new standards.

D. Product

1. Recommendations to be presented to the Rule 40 Advisory Committee for their consideration at the October 22 meeting.

II. Goals of successful monitoring, reporting and oversight

A. Ensure persons progress/improve/grow

1. Provide resources, non-punitive support to providers

B. Improve person's lives across settings and populations

C. Improve the safety of all persons

D. Reduce the use of emergency restraints

III. Successful process has:

- A. Data reported and available on a website that is properly maintained and updated

- 1. Of each provider, and
 - 2. Aggregate data
 - B. Clear and transparent standards and process
 - C. Timely
 - D. Efficient yet recognized each person
 - E. Meaningful
 - F. User-friendly
 - G. Satisfied persons
 - H. High-quality services
- IV. Values
 - A. Improvement; not punishment
 - 1. Re: services
 - 2. Re: standards
 - 3. Re: resources
 - 4. Incentivizes desired outcomes
 - B. Growth of
 - 1. Provider (competency)
 - 2. Persons (e.g., skill building, satisfaction)
 - C. Individualization, person-centered services
 - D. Resources
 - E. Responsive
- V. Comprehensive monitoring
 - A. High-level for trends, patterns
 - B. Including positive indicators
 - C. Outcomes
 - D. And comprehensive triggers
 - 1. E.g., various reviews, training, early intervention/support to provider, access to timely triage after a restraint incident, etc.
- VI. Restraint monitoring
 - A. Of person and process during a restraint
 - B. Of techniques used by provider
- VII. Reporting and notifications
 - A. Of use of restraint in an emergency (a.k.a. “incident”; incident reporting – process already in place, we can model after or piggyback on existing process such as to ombudsman office)
 - 1. Process
 - a. Online, computer-based
 - b. Notifications to:
 - a. Administration of the organization (owner, manager, etc.)
 - b. Designated internal reviewer within the organization
 - c. Person’s family or guardian
 - d. Person’s case manager
 - e. External reviewer
 - f. DHS
 - c. Verbal reports
 - d. Written reports
 - e. Aggregate reports
 - f. Reviews (see below)
 - g. Debrief of all staff involved in an incident and the person before staff leave at the end of the shift; debrief is intended to address any trauma, feelings or immediate emotional needs of person and staff involved.
 - B. Of other options used
 - 1. Hospital usage

2. 911 calls
- C. Of other techniques used by providers
 1. E.g., Permissible token programs that do not take back tokens
- D. What is reported:
 1. All people involved (staff, person, etc.)
 2. Start and end time of restraint
 3. What measures were taken to avoid restraint (what, when, how long)
 4. What was learned
 5. Any injury to staff or person
 6. Etc.

VIII. Reviews

- A. Internal review (see 8.31.12 notes)
 1. Purpose: to determine what happened and what can be learned from the situation; focus on the incident context and antecedent circumstances
 2. Trigger for internal review: every emergency use of restraint
 3. Who: designated staff member will lead; review will include all staff involved with the restraint or on their shift when the restraint occurred, the person when possible
 4. When: during the staff's shift, and no later than when staff leave at the end of the shift
- B. Debrief (see 8.31.12 notes, page 3)
 1. Different from the internal review
 2. Purpose: to address any trauma, feelings or immediate emotional needs of persons and staff involved in the restraint
- C. External review
 1. Purpose:
 - a. to provide outside, non-punitive clinical technical assistance for quality improvement
 - b. to look at the provider's system/program level of issues, trends, processes and competencies that may feed into the emergency use of restraints
 - c. to determine if person/provider is a good fit
 2. Trigger for external review: every emergency use of restraint
 3. Who: Ombudsman for MHDD would house the external review panel or clinical experts
 - a. Would need funding for this responsibility.
 4. When: TBD – but more than a monthly meeting of the review panel
 5. What: flexible – every use of restraint would be reported to the review panel; the review panel decides how it will respond – review would be proportionate with situation reported.
 6. Recommendation issued, copy sent to:
 - a. License holder
 - b. Person, family/guardian (HIPAA compliant)
 - c. Ombudsman's office
 - d. DHS – policy area (possibly licensing but triggers regulation of recommendation)
 - e. Counties/case managers
- D. Processes policies
 1. DHS will create a process flowchart for providers, case managers, and others to know what needs to happen when restraint occurs.

IX. DHS Oversight

- A. Regulatory (licensing)
 1. Use of prohibited techniques
 2. Restraint use
 - a. Type

- b. Duration
 - c. Number of incidents
 - d. Person and staff involved
 - e. Context (e.g., alternatives/de-escalation tried, person-centered plan, etc.)
 - f. Etc.
 - B. Data
 - 1. Demographic information of persons restrained (aggregate, anonymous)
 - 2. Data collection has consistent standards from individual, provider, provider type, to statewide so data can be aggregated consistently at all levels
 - 3. Provider statistics:
 - a. Number of restraints
 - b. Number of person-centered plans (ratio with number of persons)
 - c. Number of person-centered plan goals met (ratio?)
 - d. Client satisfaction (a rating system?)
 - e. Staff satisfaction (rating system?)
 - f. Calls to law enforcement, hospital use, etc.
 - C. Interdisciplinary teams / regional committees
 - D. Statewide review board
 - E. Outcomes
- X. Feasibility – recommendations to create wide applicability (see 10.15.12 notes, pg. 3-4)
 - A. provide templates, standardize processes and documentation; use technology (e.g., online reports)
 - B. build on existing infrastructure
 - C. make things quantifiable, transparent, clear

Note

There are additional comments and additional recommendations below from the October advisory committee meeting. Additional Recommendations include new items to the recommendations of the work group. Sometimes Comments are repeated as Additional Recommendations; this is intentional. The requested changes to the summary and recommendation document discussed at the October meeting have already been implemented and reflected above.

Comments from Advisory Committee Members on October 22

1. Who monitors use of prohibited techniques?
 - A. Response: DHS Licensing Division under the Vulnerable Adult Act.
2. What is the family’s role in internal and external reviews? What is the community’s role?
3. Internal review documents following the emergency use of restraints should be sent to Licensing Division, Ombudsman, and External Review Panel.
4. Note that the Office of Health Facility Complaints (OHFC located in the Health Department) has authority over MDH-licensed programs only, a limitation on this office’s ability to be the location for the external review panel.
5. There should be ongoing stakeholder review of the implementation of these recommendations. Volunteers could be part of another existing group like the Minnesota Council on Quality or the State Quality Council.
6. Reporting, monitoring, internal review, debriefing of staff must accommodate organizations with one or two staff or one or two staff on duty. Allow more time for internal review and debriefing, perhaps 24 hours (not just until the end of a shift).
7. A debriefing of the emergency use of restraints with the person on whom the restraints were applied may occur too soon if it is required before the end of a shift. Instead follow the person’s plan to determine timing or type of debriefing, or if there is no plan, do this within 24 hours.
8. Do all clients need a debriefing? It may provide the wrong kind of attention.

9. Direct care staff need training and a model for how to do a debriefing and an internal review.
10. Over time, the debriefing of the person on whom restraints have been used should occur more and more frequently within the context of the individual's person-centered plan.
11. Does the person's plan address the crisis that occurred? An internal review should ask this.
12. These recommendations require the provider to act—this is good.
13. Where there are multiple providers serving a client, one of them may be doing less well than the others. What should be done then?
14. There may be a problem with a lack of system resources, such as the availability of people qualified to conduct sensory integration assessments. What should be done in these cases?
 - A. The external review panel can be charged to advocate for system-wide resources where these are under-developed.
 - B. Where does a recommendation about system resource needs go? Response: To the ongoing stakeholder group for faster response. And to regional quality councils.
15. The internal review process will look at individual incidents of the emergency use of restraints. This will be followed by the external review.
16. The person being served must have input into reviews, whether individually, in the review itself (a group setting), or by conversation or interview, whatever the person prefers.
17. Distinguish between debrief of staff and debrief of person following emergency use of restraints.
18. Add to data collected information on training: Who has been trained? What topics have they been trained on?
19. Ensure that original reports are preserved.
 - A. Disagree-don't require this. First draft may be emotional and unclear. This document has legal implications.
 - B. Follow-up reports can include additions but not changes to the original reports
 - C. Provide best practices guidelines through training and in a manual for what should happen in a crisis.
 - D. Yet, investigators do need to be trained.
 - E. Favor first blush, raw feeling. This is important information to know.
 - F. Dealing with the emotional content of a report is a provider training issue.
 - G. The first person's comment is not a full report, but important.
 - H. Notification/reporting requirements can affect a report's comprehensiveness. If the first person sends something without the provider's review, this can cause problems. Process and timing matter.
 - I. This is an internal operations issue for the provider/manager.
20. The incident report and internal review should be submitted within 24 hours. The incident report is available for internal review.
 - A. Can an incident report be verbal? Response: No, the provider should submit it online, use an online form.
 - B. Providers still make phone calls as needed.
 - C. The provider organization may need more time to review a person-centered plan than 24 hours so that the external reviewer can have the benefit of these observations.
 - D. This can be addressed in the internal review as "follow up as needed" where the provider says what steps they intend to take and their implementation timeline. This is what would be sent to the External Review Panel.
 - E. Is it redundant to have both progress notes and an incident report?
21. When a staff member applies hands to a person multiple times in a few minutes, is each application of hands a separate incident requiring multiple incident reports?

- A. Response: An “episode” or incident describes all uses of manual restraints and how long each use of manual restraints lasts. The provider defines the episode or incident, which is then reviewed internally and externally.
 - B. The design of the reporting form permits full description of each use of restraints during an incident.
 - C. Internal review is done when the incident (or episode or crisis) is over.
22. The steps taken to reintegrate the person back into their environment following the emergency use of restraints must be part of the incident report.
23. The incident report must include the person’s assessment of what happened and what should happen next. Consider the SOAP Note model or another similar model that includes the person’s view of what happened. (SOAP = person’s subjective experience, provider’s objective note , assessment, and plan).
24. The provider should consult with the Interdisciplinary Team as part of the internal review process.
- A. Concern about mandating a meeting of the team for every incident.
 - B. This consultation could be done by phone.
 - C. The policy and practices manual should list the best practices re: the interdisciplinary team and internal review.
 - D. Every person does not have an interdisciplinary team. We need a broad term.
 - E. Include other providers, too.
 - F. Include families, too.
25. The incident report should contain:
- A. Information on the person’s goals and progress toward them, to be used by both the internal review and external review.
 - B. Positive indicators (See 9-12-12 Meeting Notes, page 5)
 - C. Whether the person has a case manager.
26. Add to Goals of Successful Monitoring, Reports and Oversight (Section I of recommendation)
- A. Promote recovery and wellness
 - B. Eliminate use of restraints
 - C. Monitor effectiveness of training
 - D. Monitor adequacy of resources
27. Training of providers should include training on trauma-informed care.
28. Will external review panel follow up with provider to see the results of the provider’s implementation plan following the internal review of the emergency use of restraints?
- A. Response: The external review panel has flexibility to determine how it will respond, and may choose to do this.
 - B. The provider should report on the implementation of any plan to the external review panel and to Licensing and to the Minnesota Council on Quality and the State Quality Council.
 - C. The case manager must follow up with the provider on provider’s implementation plan. If the case manager is not getting provider follow-up, then Licensing staff can go out.
 - D. If the person has no case manager, but restraints are being used, this suggests the person may require a case manager.
29. We need to build more expertise in the crisis system.
30. The external review panel provides technical assistance (TA); it does not delivery training. It does not monitor the implementation of plans.
31. Who monitors at the provider level?
- A. Response: This is part of DHS oversight.

Additional Recommendations

These recommendations were added by the Advisory Committee to the Summary of the Monitoring Work Group's recommendations.

1. Internal review documents following the emergency use of restraints must be sent to Licensing Division, Ombudsman, and External Review Panel.
2. There should be ongoing stakeholder review of the implementation of these recommendations. Volunteers could be part of another existing group like the Minnesota Council on Quality or the State Quality Council.
3. Reporting, monitoring, internal review, debriefing of staff must accommodate organizations with one or two staff or one or two staff on duty. Allow up to 24 hours for internal review and debriefing, not just until the end of a shift.
4. When debriefing the person on whom the emergency use of restraints was applied, follow the person's plan to determine the timing or type of debriefing, or if there is no plan, hold the briefing within 24 hours.
5. Direct care staff must have training on how to conduct or participate in a debriefing and an internal review following the emergency use of restraints.
6. The internal review must ask whether person's plan addresses the crisis that resulted in the emergency use of restraints and the staff must revise the plan, if needed.
7. The external review panel is responsible to advocate for system resources. The external review panel's recommendation about the need for system resources will be forwarded to the ongoing stakeholder group (Refer to Item #2 above) and to regional quality councils, too.
8. The person being served must have input into both the internal and external review. This input must be offered in a way the person prefers, whether at the reviews, by individual interview or conversation, and with the people present that the person wants present to support him or her.
9. DHS, as part of its oversight role, must collect data on training related to emergency use of restraints, monitoring, reporting, reviews, including who has been trained and what topics they have been trained on.
10. Ensure that original reports on the emergency use of restraints are preserved.
 - A. Follow-up reports can include additions but not changes to the original reports
 - B. Provide best practices guidelines through training and in a manual for what should happen in a crisis.
 - C. The incident report must be completed online and submitted within 24 hours of the emergency use of restraints. The incident report must be used in the internal review, which must also occur within 24 hours.
11. The provider must indicate in the internal review documents what the plan of action is and the timetable. This information must also be sent to the external review panel.
12. An incident describes all uses of manual restraints and how long each use of manual restraints lasts. The provider defines the incident, which is then reviewed internally and externally.
13. The design of the reporting form will permit a full description of each emergency use of restraints during an incident.
14. The steps taken to reintegrate the person back into their environment following the emergency use of restraints must be part of the incident report.
15. The incident report must include the person's assessment of what happened before and during the emergency use of restraints and what should happen next.
16. The policy and procedures manual will include best practices regarding consultation with the Interdisciplinary Team for the internal review process.

17. Included in the internal review process:
 - A. If the person has one, the provider should consult with the Interdisciplinary Team as part of the internal review process. The consultation may be done by phone or electronically.
 - B. If the person uses other providers, the provider should consult with other providers.
 - C. The person's family or guardian.

18. The incident report must contain:
 - A. Information on the person's goals and progress toward them, to be used by both the internal review and external review.
 - B. Positive indicators
 - C. Whether the person has a case manager and must list the case manager's name and contact information.

19. Add to Goals of Successful Monitoring, Reports and Oversight (Section I of recommendation)
 - A. Promote recovery and wellness
 - B. Eliminate use of restraints
 - C. Monitor effectiveness of training
 - D. Monitor adequacy of resources

20. Training of providers must include training on trauma-informed care.
21. The provider must send regular reports on its implementation of its plan following its internal review to the external review panel and to the appropriate regional or state body responsible for quality reviews.
 - A. The external review panel has flexibility to determine how it will respond, and may choose to follow up on how well the provider has carried out its implementation plan following the internal review of the emergency use of restraints.
 - B. The case manager must follow up with the provider on provider's implementation plan. If the case manager is not getting provider follow-up, then Licensing staff can cite the provider.