OFFICE OF THE STATE INSPECTOR GENERAL

Report to Commissioner Debra K. Ferguson

Review of the Application of the Human Rights System in State-Operated Behavioral Health Facilities

August 2014

June W. Jennings, CPA
State Inspector General

Report No. 2014-BHDS-008

COMMONWEALTH OF VIRGINIA

Office of the State Inspector General

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August 28, 2014

Debra K. Ferguson, PhD, Commissioner
Virginia Department of Behavioral Health and Developmental Services
1220 Bank Street
Richmond, VA 23219

Dear Commissioner Ferguson:

The Office of the State Inspector General (OSIG) conducted unannounced reviews of the Department of Behavioral Health and Developmental Services' eight adult behavioral health hospitals, one facility for children and adolescents, and one free-standing medical center. These reviews initiated in February 2014 and concluded in April 2014.

Overall, the OSIG found that facility human rights policies were aligned with Human Rights Regulations. However, practices varied among facilities, and there was not a clear process in place to identify practices that should be standardized. Additionally, the OSIG's visits determined the secure site database used to document facility and community services board discharge planning activities was often not available and monitoring and accountability procedures were limited.

On behalf of OSIG, I would like to express our appreciation for the assistance the leadership team and staff provided during our review.

If you have any questions, please call me at 804-625-3255 or email me at june.jennings@osig.virginia.gov. I am also available to meet with you in person to discuss this report.

Sincerely,

June W. Jennings
State Inspector General

CC: Paul Reagan, Chief of Staff for Governor McAuliffe
Suzette Denslow, Deputy Chief of Staff for Governor McAuliffe
Dr. William Hazel, MD, Secretary of Health and Human Resources

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Executive Summary

Pursuant to *Code of Virginia* (*Code*) §2.2-309.1(B)[1][2], the Office of the State Inspector General (OSIG) conducted unannounced reviews of the Department of Behavioral Health and Developmental Services' (DBHDS) eight adult behavioral health hospitals, one facility for children and adolescents, and one free-standing medical center.[1] This review initiated in February 2014 and concluded in April 2014.

Overall, the OSIG found that facility human rights policies were aligned with Human Rights Regulations. However, practices varied among facilities, and there was not a clear process in place to identify practices that should be standardized. Additionally, the OSIG's visits determined the secure site database, used to document facility and community services board (CSB) discharge planning activities was often not available, and monitoring and accountability procedures were limited.

To prepare for site visits, the OSIG staff reviewed:

- *Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by the Department of Behavioral Health and Developmental Services*[2]
- *State Human Rights Committee 2012 Annual Report on the Status of the Human Rights System*[3]
- June 2013 Human Rights Complaint Process Stakeholder Survey and Focus Group Results Summary
- Current Office of Human Rights staffing information
- DBHDS Departmental Instruction 201: *Reporting and Investigating Abuse and Neglect of Individuals Receiving Services in Department Facilities*
- Current DBHDS *Discharge Protocols for Community Services Boards and State Hospitals*[4]
- *Collaborative Discharge Protocols for Community Services Boards and State Behavioral Health Facilities (draft)*

The OSIG expresses our appreciation for the cooperation and assistance the Department of Behavioral Health and Developmental Services (DBHDS) facilities and central office leadership extended to us during the course of this review.

[1] Hereafter the report will use the term "facility" to refer to the setting of the review.
[2] DBHDS. Human Rights: Regulations Tab: Human Rights Regulations: Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by the Department of Behavioral Health and Developmental Services. DBHDS website. http://www.dbhds.virginia.gov/individuals-and-families/human-rights. Accessed August 26, 2014.
[3] DBHDS. State Human Rights Committee: Annual Reports: 2012: State Human Rights Committee 2012 Annual Report On the Status of the Human Rights System. DBHDS website. http://www.dbhds.virginia.gov/individuals-and-families/human-rights/state-human-rights-committee. Accessed August 26, 2014.
[4] DBHDS. Protocols, Procedures & Screening Guidance: Discharge Protocols for CSBs and Mental Health Facilities: Discharge Protocols for Community Services Boards and State Hospitals. DBHDS website. http://www.dbhds.virginia.gov/professionals-and-service-providers/mental-health-practices-procedures-and-law/protocols-and-procedures. Accessed August 26, 2014.

Purpose and Scope of the Review

The primary purpose of the unannounced visits in all 10 facilities involved understanding how DBHDS addresses Human Rights Regulations and identifying best practices or areas of concern.

For nine of the facilities, when an individual had more than one admission in the preceding 12 months, the OSIG reviewed the individual's records to understand how the facility and CSB documented discharge planning activities assigned to them through DBHDS's *Discharge Protocols for Community Services Boards and State Hospitals.* This aspect of the review focused on facility and CSB use of the DBHDS secure site database for documenting discharge planning efforts.[5] Coinciding with the creation of this report, DBHDS distributed a draft of "*Collaborative Discharge Protocols for Community Services Boards and State Behavioral Health Facilities*," expected to be implemented on July 1, 2014.

The OSIG's visit to two facilities included a secondary focus on issues distinct to each facility.

- **Virginia Center for Behavioral Health Rehabilitation (VCBR)**—Focus on the double-bunking strategy's progression, including identification of any specific concerns or challenges directly linked to this process.
- **Commonwealth Center for Children and Adolescents (CCCA)**—Focus on environmental safety.

Results of these secondary reviews are addressed in separate reports.

[5] OSIG also considered record entries when secure site database information was not available.

Background

Virginia's Human Rights Regulations (Regulations)—initially called *Rules and Regulations to Assure the Rights of Residents of Facilities*—were established in 1978. In 2001 these Regulations, along with the *Rules and Regulations to Assure the Rights of Clients in Community Programs*, were replaced by the *Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers of Mental Health, Mental Retardation and Substance Abuse Services*.

In 2012 the Regulations were again amended and became the *Regulations to Assure the Rights of Individuals Receiving Services from Providers, Licensed, Funded, or Operated by the Department of Behavioral Health and Developmental Services*. During the process of this review, DBHDS told OSIG staff that new Regulations had been drafted, but were not expected to go into effect until after 2014.[6]

It is the OSIG's understanding the drafted Regulations may address a number of the recommendations included in this report, including an emphasis on greater efficiency and more Human Rights Advocate time devoted to training and direct support for individuals receiving services.

DBHDS's Human Rights System

DBHDS's Human Rights System is a complex network, with Regulations forming the common foundation. Regulations, aligned with DBHDS's core initiatives, promote recovery for individuals with mental illness, and maximum self-determination and independence for individuals with intellectual or developmental disabilities. More recent efforts to advance person-centered and trauma-informed treatment share the goals and objectives established 36 years ago with the first Regulations.

Components of the Human Rights System

OFFICE OF HUMAN RIGHTS

The Office of Human Rights assists DBHDS in fulfilling its legislative mandate to assure and protect the legal and human rights of individuals who receive services in facilities or programs operated, licensed, or funded by DBHDS. The Director of the Office of Human Rights reports to the DBHDS Commissioner and Assistant Commissioner for Quality Management and Development.

HUMAN RIGHTS ADVOCATES

Human Rights Advocates represent consumers with alleged rights violations and help prevent rights violations. Each State facility has at least one assigned Human Rights Advocate. Regional Human Rights Advocates, who work with consumers in community programs, are located throughout the State. Human Rights Advocates' duties include investigating complaints, examining conditions that impact consumer rights, and monitoring compliance with Regulations. Concurrent with the creation of this report, there were six Regional Advocates and 13 Human Rights Advocates. Human Rights Advocates in DBHDS facilities retain their status as employees of the Office of Human Rights, assuring their independence.

[6] Based on interview of the Director of the Office of Human Rights on April 22, 2014.

PROVIDER STAFF

Staff in all programs operated or licensed by DBHDS are responsible for understanding Regulations and reporting Regulations violations. Staff also help individuals connect with a Human Rights Advocate. In DBHDS facilities, designated staff may assume responsibilities for responding to human rights complaints and may provide initial or annual human rights training.

ABUSE AND NEGLECT INVESTIGATORS

In DBHDS facilities designated facility staff, called Abuse and Neglect Investigators, investigate allegations of abuse or neglect. During an investigation, Abuse and Neglect Investigators must be independent of the facility and receive supervision from the DBHDS Abuse and Neglect Manager, who works within the Office of Quality Management and Development.

DBHDS OFFICE OF QUALITY MANAGEMENT

The Office of Clinical Quality and Risk Management's (CQRM) mission is to ensure that activities standardize, improve, and monitor the quality of care in State facilities and community programs, and that these activities are integrated throughout the organization. CQRM's specific responsibilities include compliance with State and national standards of quality, creation of performance expectations and measures, data collection, targeted studies, and intense analysis of the organization's clinical processes and outcomes. CQRM also focuses on the improvement, design, and redesign of clinical processes, and sustaining improvements through staff education, training, and technical assistance.

LOCAL HUMAN RIGHTS COMMITTEES

A Local Human Rights Committee (LHRC) is a group of at least five people appointed by the State Human Rights Committee (SHRC). Membership offers a broad representation of professional and consumer interests. At least two members must be individuals receiving or having received mental health, intellectual disability, or substance abuse services within five years of their initial appointment. At least one-third of the members must be consumers or family members of consumers. All licensed providers must be affiliated with an LHRC.[7]

STATE HUMAN RIGHTS COMMITTEE

The SHRC consists of nine volunteers appointed by the State DBHDS Board, who represent various professional and consumer groups and different geographic areas of the State. The SHRC is an independent body responsible for oversight of the DBHDS Human Rights System. Its duties include:

- Receiving, coordinating, and making recommendations for Regulations revisions
- Reviewing training program scope and content
- Monitoring and evaluating Regulations implementation and enforcement
- Hearing and rendering decisions on appeals from complaints not resolved at the LHRC level
- Reviewing and approving requests for Regulations variances
- Reviewing and approving LHRC bylaws
- Appointing LHRC members[7]

[7] Virginia Administrative Code. 12VAC35-115-250. Offices, Composition and Duties. Division of Legislative Automated Systems website. http://law.lis.virginia.gov/admincode/title12/agency35/chapter115/section250. Accessed July 3, 2014.

EXTERNAL MONITORING

While the Regulations emphasize the responsibility of the facility or licensed provider to respond to, and address, complaints or allegations, individuals also may seek assistance from external sources. The OSIG and the disAbility Law Center are the two entities that may monitor or review provider responses or initiate investigations.[8]

The Human Rights Complaint Process

THE COMPLAINT[9]

The complaint process begins when an allegation is brought to the provider's or Human Rights Advocate's attention.

1. Anyone who believes a provider has violated an individual's rights under the Regulations may report it to the Facility Director or the Human Rights Advocate for resolution.
2. If the report is made to the Director, but not to the Human Rights Advocate, the Director or Director's designee shall immediately notify the Human Rights Advocate. If the report is made on a weekend or holiday, the Director or Director's designee shall notify the Human Rights Advocate on the next business day.
3. If the report is made to the Human Rights Advocate, but not to the Director, the Human Rights Advocate shall immediately notify the Director. If the report is made on a weekend or holiday, the Human Rights Advocate shall notify the Director on the next business day.
4. The Human Rights Advocate, the Director, or the Director's designee shall discuss the report with the individual and notify the individual of the right to pursue a complaint through the process established in the Regulations. The steps in the informal and formal complaint process established in the Regulations shall be thoroughly explained to the individual.
5. The Human Rights Advocate, the Director, or the Director's designee shall ask the individual if the complaint process is understood and if the individual's choices are clear before asking the individual how to pursue the complaint. The individual shall then be given the choice of pursuing the complaint through the informal or formal complaint process. If the individual does not make a choice, the complaint shall be managed through the informal process.

INFORMAL PROCESS

The following steps apply to the informal process:

- Step 1: The Director or Director's designee shall attempt to resolve the complaint immediately. If the complaint is resolved, no further action is required.
- Step 2: If the complaint is not resolved within five working days, the Director or Director's designee shall refer it for resolution under the formal process. The individual may extend the informal process five-day time frame for good cause. All such extensions shall be reported to the Human Rights Advocate by the Director or Director's designee.

[8] The disAbility Law Center was formally known as the Virginia Office of Protection and Advocacy (VOPA). A full overview of the agency can be accessed at http://disabilitylawva.org/.
[9] DBHDS/Office of Human Rights. The Life of a Complaint.[PowerPoint presentation].

FORMAL PROCESS

The following steps apply to the formal process:

- Step 1: The Director or Director's designee shall try to resolve the complaint within 24 hours (the next business day if it is a weekend or holiday) by meeting with the individual and the individual's chosen representative, the Human Rights Advocate, and others as appropriate. The Director or Director's designee shall conduct an investigation of the complaint, if necessary.
- Step 2: The Director or Director's designee shall give the individual and the individual's chosen representative a written preliminary decision, and, where appropriate, an action plan for resolving the complaint within 10 working days of receipt. Along with the action plan, the Director shall provide written notice to the individual about the time frame for the individual's response (see Step 3), information on contacting the Human Rights Advocate for assistance with the process, and a statement that the complaint will be closed if the individual does not respond.
- Step 3: If the individual disagrees with the Director's preliminary decision or action plan, the individual can respond to the Director in writing within five working days after receiving the preliminary decision and action plan. If the individual has not responded within five working days, the complaint will be closed.
- Step 4: If the individual disagrees with the preliminary decision or action plan and reports the disagreement to the Director in writing within five working days after receiving the decision or action plan, the Director shall investigate further, as appropriate, and shall make a final decision regarding the complaint.
- Step 5: If the individual disagrees with the Director's final decision or action plan, the individual may file a petition for a hearing with the LHRC using the procedures prescribed in *Virginia Administrative Code* 12VAC35-115-180. If the individual has accepted the relief offered by the Director, the matter is not subject to further review.[10]

LHRC Engagement

During the formal complaint process, if the Human Rights Advocate finds substantial risk for serious or irreparable harm if the complaint is not resolved immediately, the Human Rights Advocate shall inform the Director, the provider, the provider's governing body, and the LHRC. One through 5 of *Virginia Administrative Code* 12VAC35-115-250 (A) shall not be followed. Instead, the LHRC shall conduct a hearing according to the special procedures for emergency hearings in *Virginia Administrative Code* 12VAC35-115-180.

Any individual or authorized representative may request an LHRC hearing, if the individual or authorized representative does not accept the relief offered by the Director or disagrees with a Director's:

- Final decision and action plan resulting from the complaint resolution.
- Final action following a report of abuse, neglect, or exploitation.
- Final decision following a complaint of discrimination in the provision of services.

[10] Virginia Administrative Code. 12VAC35-115-180. Local Human Rights Committee Hearing and Review Procedures. Division of Legislative Automated Systems website. http://law.lis.virginia.gov/admincode/title12/agency35/chapter115/section180. Accessed July 7, 2014.

SHRC Appeals

Any party may appeal to the SHRC if not satisfied with any of the following:

1. LHRC's final findings of fact and recommendations following a hearing.
2. Director's final action plan following an LHRC hearing.
3. LHRC's final decision regarding the capacity of an individual to consent to treatment, services, or research or authorize disclosure of information.
4. LHRC's final decision concerning whether consent or authorization is needed for the Director to take a certain action.

The Discharge Planning Process

The discharge planning process, a secondary focal point of the OSIG's visits, is a collaborative process that ensures an individual returns to the community with access to needed services and supports. The *Discharge Protocols for Community Services Boards and State Hospitals* provides detailed guidance to facility and CSB staff regarding their responsibilities. DBHDS developed a web-based secure site database for facility and CSB staff to use as a means for documenting their collaboration throughout the discharge planning process.[11] Access to the secure site database is subject to provisions regulated by the Health Insurance Portability and Accountability Act (HIPAA). Under HIPAA, access to protected health information is limited to authorize or registered personnel. According to DBHDS, 1,367 CSB staff members are registered as users of the secure site.[12] In the state-operated behavioral health facilities, access is limited to designated members of the individual's treatment team.

[11] The OSIG believes that an effective discharge planning process is an essential component of a recovery-oriented system of care, and it also helps promote the most effective use of the state's inpatient bed resources.

[12] Data provided by DBHDS.

Review Methodology

Regulations Implementation Review

The OSIG staff developed a general understanding of each facility's implementation of the Regulations by obtaining copies of policies and procedures; interviewing Advocates, facility leadership; and residents; and reviewing hospital records. Additionally, the OSIG obtained confidential staff surveys from staff at each facility across shifts in four of the hospital units.[13]

In the course of these visits the OSIG staff:
Interviewed

- Ten facility Directors
- Nine Advocates
- Fifty-three facility administrative staff
- Thirty-three facility residents
- Director, CQRM
- Manager, Abuse and Neglect Investigations
- Assistant Commissioner, Quality Management and Development

Collected

- Five hundred sixty-four unit level staff surveys

Reviewed

- Two hundred twelve medical records
- Individuals' narrative comments added to the OSIG's staff survey[14]

At each facility OSIG obtained a report on the use of seclusion and/or restraint for the period of July 1, 2013 to the date of the visit. Randomly selected records were used to determine if the facility was adhering to the guidelines detailed in DBHDS's Departmental Instruction 201.

Discharge Planning Documentation Review

The OSIG staff gained a general understanding of DBHDS facility staff and CSB discharge planning responsibilities by reviewing DBHDS's current *Discharge Protocols for Community Services Boards and State Hospitals*. At each facility, the OSIG staff obtained a report identifying individuals admitted to the facility more than once during the preceding 12 months.

The OSIG staff randomly selected records (electronic and paper) to determine if secure site database and paper records contained documentation of facility and CSB staff's adherence to the *Discharge*

[13] All review instruments are included in the appendices section of the report.
[14] The OSIG received 117 narrative comments from staff on the survey forms. While this represents 21% of the total completed surveys, 41% (48 of 117) comments came from one facility.

Protocols for Community Services Boards and State Hospitals. Due to HIPAA regulations, facility staff assisted the OSIG with access to the secure site database as access is restricted to registered users.[15]

[15] OSIG first looked for secure site documentation as this allowed for clear indication of the desired collaboration of facility and CSB staff. When the secure site was not accessible, or information was not recorded in the secure site, OSIG did look elsewhere in the record.

Review Results

Findings of Merit

1. DBHDS facilities' human rights policies reflect the intent of the Regulations.
2. Facility Directors are largely seen as human rights "champions" by their respective facilities' program leadership.
3. Facilities have strong practices in place for documenting efforts to minimize the use of seclusion and/or restraint and monitoring use of seclusion and/or restraint.
4. Unit level staff in most facilities did not perceive an increase in the use of seclusion and/or restraint over the six months that preceded the site visit.
5. Advocates place great emphasis on responsiveness to the unique needs of each individual and fully ensuring the individual's rights.

Findings of Concern

1. The process for implementing and monitoring adherence with Regulations is highly complex, and the growth in community providers and LHRCs, along with a reduction in the number of Advocates, has reduced the amount of time Advocates devote to direct support of individuals in DBHDS behavioral health facilities.
2. Facilities' daily practices for adhering with Regulations are "home grown," leading to significant operational variations among facilities, and a system-wide process to promote best practices among facilities that measures the effectiveness of facility initiatives and practices is not in place.[16]
3. Unit level staff in all facilities feel that the individuals being served have more rights than staff and written comment expressed feeling devalued within the facility setting.
4. The documentation of a debriefing process for staff and the individual after the use of seclusion and/or restraint varies from facility to facility.
5. Growth in providers and staff losses in the Office of Human Rights has contributed to facility staff assuming duties once reserved for the Advocate, leading to Advocate roles varying from facility to facility.
6. Staff in several facilities agreed that peer-to-peer aggression had increased in the six months preceding the site visit.
7. There is wide variation in how facility program leadership and unit level staff perceive the facility Director's leadership in areas related to human rights.
8. The web-based secure site database discharge planning system is not used consistently, and there are no systemic quality oversight or accountability mechanisms in place.

Summary Recommendations

Below are recommendations that if implemented will bring greater consistency to the implementation of the Regulations and adherence to the discharge planning protocols, and create opportunities for addressing several key challenges identified in this review. Recommendations are grouped in four key areas of organizational management.

[16] "Home grown" refers to facility having developed day-to-day operational practices based on their interpretation of the regulations.

Leadership

- That DBHDS continually seek to align their stated values of recovery and person-centered treatment and the human rights regulations and practices in order to meet each individual's treatment needs and to use resources efficiently.
- That DBHDS continually align their stated values of a recovery and person-centered system of care in all training and communications relevant to the human rights regulations.
- That DBHDS incorporate reviews of human rights information, including abuse and neglect data, in senior leadership meetings, mirroring the efforts that facilities make to monitor this information within facility senior leadership meetings.
- That DBHDS work with facilities where program leadership and unit staff have a shared perception of human rights being valued, in order to identify strategies, activities, or practices that may warrant replication.[17]
- That DBHDS take additional steps to determine what factors influence staff's negative perceptions of facility leadership in areas related to human rights and empowerment to assist individuals residing in their facility.[18]

Quality Improvement

- That DBHDS conduct a performance review of key indicators of a trauma-informed environment to assure that the nationally identified strategies for reducing incidents of complaints, abuse and neglect allegations, and the use of restrictive procedures, such as seclusion and restraint, are in practice at state-operated facilities.
- That DBHDS work with facilities to create a means through which facilities can share and identify quality improvement processes that contribute to the consistent application of human rights.
- That DBHDS establish a work group comprised of facility Directors, facility department leadership, and unit level staff to identify practices that can help address staff's negative perception regarding the balance of patient and staff rights. The OSIG believes this recommendation can impact the overall culture of a unit or facility, which can impact a range of other areas, including peer-to-peer aggression rates.[19]
- That DBHDS work with facilities to establish a process for more effectively tracking the number of individuals who initiate or develop Advanced Health Directives or self-management plans while receiving treatment.

Consistency of Practice

- That DBHDS work with facilities to improve the documentation of individual and staff debriefings after incidents of seclusion and/or restraint. Practices in facilities with high rates of unit level staff affirmation of staff debriefings after incidents of seclusion or restraint may offer valuable models for standardization.[20]

[17] OSIG will provide data to DBHDS to identify these facilities.
[18] OSIG will provide data to DBHDS to identify these facilities.
[19] Per the Director of the Office of Human Rights from an interview on April 22, 2014: "A person-centered culture applies to the patient and the staff. It has to feel like a supportive environment for both."
[20] OSIG will provide information to identify these facilities.

- That DBHDS consider steps to increase the availability of the Advocate to conduct initial and annual human rights training and increase Advocate visibility on the units.
- That DBHDS work with facilities to assure greater consistency in rules or regulations regarding access to outside food and sharing meals with friends and families.
- That DBHDS work with facilities and CSBs to improve documentation of discharge planning activities using the secure site database, and that a mechanism is created for monitoring adherence to discharge protocols, including empowering a DBHDS or regional entity to address accountability.

Resource Allocation

- That DBHDS establish a mechanism for assuring that Office of Human Rights resources are sufficient enough to address responsibilities within facilities and the community.

Detailed Findings and Recommendations

Focus Area: Regulations Implementation

In initiating this review, the OSIG sought to understand how DBHDS behavioral health facilities were implementing Regulations and to identify promising practices or areas of concern.[21] This review focused on answering three questions concerning the policies and practices developed and utilized by the 10 facilities reviewed:

1. Are Regulations consistently implemented in DBHDS behavioral health facilities?
2. Are Regulations consistently supported by leadership and staff in DBHDS behavioral health facilities?
3. Are there any consistent concerns or challenges associated with implementing the Regulations in DBHDS behavioral health facilities?

Review Results

Question 1: Are Regulations consistently implemented in DBHDS behavioral health facilities?

FINDINGS

1. Facilities have consistent human rights policies in place that mirror the Regulations.
    - Human rights policies collected at each facility were fully aligned with the Regulations.

2. Facilities provide training to new staff on Regulations and annual competency training takes place. In all but one instance, survey respondents and program leadership responded affirmatively to questions about training.
    - Interviews of 53 facility administrative staff and 10 Advocates consistently referenced training of new staff and annual training as key components in the quality assurance effort.
    - Ninety-two percent (504 of 548) of respondents to the confidential staff survey "strongly agreed" or "agreed" that annual human rights competency training for all staff was required.[22]
        - The affirmative response at individual facilities was over 90% in five of the 10 facilities, between 80% and 90% in four facilities.
        - One facility had 76% (50 of 66) of their respondents answer affirmatively.

3. Facilities provide training to new staff on use of seclusion and/or restraint and annual competency training takes place.
    - Ninety-four percent (511 of 546) of all respondents to the confidential staff survey "strongly agreed" or "agreed" that annual competency training in the use of seclusion and restraint was required of all staff.

[21]Community providers were not included, as the review was conducted pursuant to the Virginia Code requirement that the OSIG conduct unannounced visits of DBHDS facilities at least annually. http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+2.2-309.1

[22] Percentages for "all respondents" will have a varying denominator. While 564 individuals completed surveys, some questions did not receive a response.

4. Most individuals are informed of their rights on admission. However, records reviewed suggested problems in follow-up when an individual was not able to receive rights information on admission due to the extent of his/her illness, or when the individual remained in a facility for a year and was to receive his/her annual notice of human rights. Facilities also vary in how they document the notice and the format of notification.
    - Seventy-five percent (96 of 128) of records reviewed contained documentation that the individual was informed of his/her rights at the time of admission.[23]
    - Of the remaining records, 83% (24 of 29) did not have documentation at admission due to "incapacity" or "inability to comprehend," and did not contain documentation of subsequent notification, and three records had no documentation.
    - Fifty-nine percent (19 of 32) of records for individuals that had been in the facility for more than one year did not contain documentation of annual notification of rights.
    - Facility notification practices vary, including signed notification forms detailing all rights, summary notices, or simply referencing a person was advised of his/her rights.
    - One facility had a notice that combined pictorial and narrative information, designed to maximize understanding for individuals with low literacy skills (see Appendix VII).

5. Facilities are asking individuals about Advance Health Directives or self-management plans (e.g., Wellness Recovery Action Plans [WRAP]) on admission and offering an opportunity to develop an advance directive or plan, but there is no mechanism in place to determine if these important recovery tools are initiated or developed during the treatment period.
    - Eighty-nine percent (109 of 123) of records contained documentation of the facility asking the individual if they had an advanced directive and informing them of their right to develop an advanced directive.[24]
    - No facility was able to provide information about the number of advanced directives or self-management plans initiated or developed in their facility.[25]

6. Facilities have a wide range of activities in place to assure the consistent application of human rights, but these activities appear to be self-directed, and there is not a system-wide process in place to measure the effectiveness of particular activities in order to promote best practices.
    - Facility Directors (10) and facility program leaders (53) identified 194 distinct responses to the question of "What quality improvement processes are in place within the facility to assure the consistent application of human rights?"
    - Interviews with facility Directors and DBHDS Central Office staff suggest they do not have a mechanism in place to determine what processes developed within facilities may be worthy of standardization throughout all facilities. Facility Directors identified the Computerized Human Rights Information System (CHRIS) as the sole mechanism for monitoring facility human rights efforts.

7. Facilities have strong procedures in place to document the reason for the use of seclusion and/or restraint, the alternative interventions used prior to the seclusion and/or restraint, the supervision of the individual

[23] A total of 128 records were reviewed for documentation of human rights notification.
[24] Five records contained language indicating that the person was not able to receive this information due to state of condition.
[25] The OSIG acknowledges that self-management plans (e.g., WRAP) are owned by the individual and are not expected to be in a facility record. However, knowing the number of advanced directives or self-management plans developed or initiated during the period of facility treatment is a meaningful measure of the facilities recovery culture.

during the period of seclusion and/or restraint, the time period of the seclusion and/or restraint, and the physician order for the use of seclusion and/or restraint.

Out of 44 randomly selected and reviewed records from facilities with reports on the use of seclusion or restraint for the period of July 1, 2013 to the date of the visit:

- One hundred percent contained documentation of the behavior that resulted in the use of seclusion or restraint.
- Ninety-five percent contained documentation of the use of less restrictive interventions before the use of seclusion or restraint.
- One hundred percent contained documentation of clinical supervision throughout the restrictive intervention period, including video or visual monitoring, bathroom breaks, and offers of food and drink.
- One hundred percent contained documentation of a signed physicians order for the use of seclusion or restraint that included the length of time for usage and the criteria for release.
- One hundred percent contained documentation of the period of seclusion or restraint being consistent with Regulations.[26]

8. Facilities vary in how they document the debriefing processes for staff and the individual when there is an incident of seclusion and/or restraint.
   - Sixty-four percent (28 of 44) of records contained documentation of a debriefing with staff; however, there was a wide variation in documentation amongst the facilities.[27]
   - Sixty-seven percent (363 of 539) of confidential staff survey respondents answered affirmatively that debriefings with staff routinely took place after an event of seclusion or restraint. There was wide variation in how unit level staff responded among facilities, ranging from 40% to 97%.
   - Seventy-three percent (32 of 44) of records contained documentation of a debriefing with the individual after an event of seclusion or restraint. There was greater consistency in practice in this area among the facilities, with seven facilities having 100% documentation rates.[28]
   - Seventy-six percent (411 of 542) of confidential staff survey respondents answered affirmatively that debriefings with the individual were routine after an event of seclusion or restraint. There was greater consistency of unit level staff affirmative responses among the facilities, with four facilities having affirmative response between 83% and 89% and three facilities with affirmative responses between 71% and 78%. One facility had a 49% affirmative response and one facility had a 58% response due to their policy of not documenting unless injury or change in medical condition.
9. Facilities support legal and social rights of individuals, such as access to law enforcement or calling 911, visits with family and friends, ordering food, or sharing a private meal with friends; however, practices vary among facilities. Restrictions are most likely to be present in forensic programs.
   - Ninety-one percent (498 of 546) of confidential staff survey respondents affirmed that individuals residing at their facility had a right to private contact with friends and family members.[29]

[26] Regulations require that each use of seclusion, restraint, or time-out shall end immediately when the criteria for removal of the restriction are met.
[27] Six facilities had 100% documentation of staff debriefing. Three facilities had rates of documentation of 40%, 67%, and 50%. One facility did not have documentation of staff debriefing due to the facility's policy to only conduct a debriefing when an injury or change in medical condition occurred.
[28] One facility had an 83% documentation rate and a second facility had a 67% rate. There was no documentation in the facility that had a policy of debriefing only when there was an injury or change in medical condition.

- Fifty-three facility department leaders interviewed consistently affirmed the right of individuals to have visitors, but access to food from outside or sharing meals with family or friends varied. Phone access was noted as available, but abuse of the privilege (e.g., repeated calls to 911 deemed inappropriate) can lead to restrictions and incorporation into the treatment plan.

RECOMMENDATION NO. 1-A

That DBHDS conduct a performance review of key indicators of a trauma-informed environment to assure that the nationally identified strategies for reducing incidents of complaints, abuse and neglect allegations, and the use of restrictive procedures, such as seclusion and restraint, are in practice at state-operated facilities.

DBHDS Response

DBHDS concurs with this recommendation and will convene a committee, consisting of facility directors and Central Office staff to review best practices and key indicators of a trauma informed environment of care which can be implemented and monitored throughout all state-operated facilities.

RECOMMENDATION NO. 1-B

That DBHDS work with facilities to create a means through which facilities can share and identify quality improvement processes that contribute to the consistent application of human rights.

DBHDS Response

The DBHDS concurs with this recommendation and will convene a committee consisting of facility directors and Central Office staff to identify and implement quality improvement processes for the consistent application of human rights.

RECOMMENDATION NO. 1-C

That DBHDS consider steps that would increase the availability of the Human Rights Advocate to conduct initial and annual human rights training and increase their visibility on the units.

DBHDS Response

The DBHDS concurs with this recommendation and will identify opportunities to increase facility advocates' time on the units, as well as time to provide onsite training for staff in state-operated hospitals. DBHDS is taking several steps to accomplish this. First, the Office of Human Rights (OHR) is exploring the option of collapsing regional boundaries to increase the flexibility of staff deployment and reduce community responsibilities for facility advocates. Secondly, with the finalization of the new regulations, the administrative processes will be streamlined, thus allowing advocates to shift their time from supporting multiple LHRCs to providing more facility and community oversight. This will increase the overall availability of advocate resources for the facilities.

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[29] The OSIG notes that all surveys were completed by staff working on civil units. Forensic units are known to have limitations on these rights.

RECOMMENDATION NO. 1-D

That DBHDS work with facilities to establish a process for more effectively tracking the number of individuals that initiate or develop Advanced Health Directives or self-management plans while receiving treatment.

DBHDS Response

The DBHDS concurs with this recommendation. DBHDS will work with the community service boards and other stakeholders to develop a consistent process for maintaining and communicating Advanced Health Directives and WRAP across the systems of care so that emergency service workers and hospital admission staff are aware of the individual's directives and stated preferences.

RECOMMENDATION NO. 1-E

That DBHDS work with facilities to improve the documentation of individual and staff debriefings after incidents of seclusion and/or restraint. Practices in facilities with high rates of unit level staff affirmation of debriefings may offer valuable models for standardization.

DBHDS Response

The DBHDS concurs with this recommendation and will convene a committee, consisting of facility directors and Central Office staff to identify and establish processes for replicating best practices for consistent and documented debriefings of individuals and staff following incidents of seclusion and/or restraint.

RECOMMENDATION NO. 1-F

That DBHDS work with facilities to assure greater consistency in rules or regulations regarding access to outside food and sharing meals with friends and families.

DBHDS Response

The DBHDS will survey state hospitals to review policies related to access to outside food and sharing meals with friends and family and identify opportunities for these activities to occur without compromising health and safety in our state-operated hospitals.

Question 2: Are State Human Rights Regulations consistently supported by leadership and staff in DBHDS behavioral health facilities?

FINDINGS

1. Facility Directors are taking an active leadership role with human rights issues, and they see the championing of human rights as a responsibility of many others within their facility as well.
    - Directors most frequently identified themselves (6 responses) and the Human Rights Advocate (6 responses) as the "champions of human rights" within their facility.

- Directors provided responses that fell into 29 areas, many of which were broad, e.g., "everyone is a champion," "leadership team."

2. Facility department level leadership consistently identified "human rights champion" behaviors with their facility Director, with one exception.
    - The 53 facility department leaders interviewed collectively provided 161 examples of how their facility Director models "human rights champion" behaviors.
    - One hundred percent (153 of 153) of the responses from nine of the 10 facilities reviewed deemed the Director of their respective facility as championing human rights.
    - Fifty percent (8 of 16) of responses about the facility Director in one facility were judged to be inconsistent with championing human rights.

3. Facility Directors are not consistently seen as a "human right champion" by the staff that works with individuals residing in the facility, but there is wide variation in how individual Directors are perceived.
    - Sixty-eight percent (361 of 530) of confidential staff survey respondents provided an affirmative rating to the statement "Our facility Director is a champion of human rights."
    - The percent range of Strongly Agree/Agree (SA/A) answers points to wide variation in how unit level staff perceive their Director.
        - SA/A greater than 90%—two facilities
        - SA/A greater than 75% and less than 90%—two facilities
        - SA/A greater than 60% and less than 75%—four facilities
        - SA/A less than 60%—two facilities

4. Unit staff in most facilities feel they are empowered to assist the individuals they serve with addressing their concerns or complaints.
    - Eighty percent (441 of 553) of confidential staff survey respondents affirmed they were empowered to assist the individuals served in their facility.
    - The percent range of SA/A answers varied in staff sense of empowerment.
        - SA/A greater than 90%—one facility
        - SA/A greater than 75% and less than 90%—seven facilities
        - SA/A less than 60%—one facility

RECOMMENDATION NO. 2-A

That DBHDS continually align their stated values of a recovery and person-centered system of care in all training and communications relevant to the human rights regulations.

DBHDS Response

The DBHDS concurs with this recommendation. The OHR will develop a human rights training that incorporates DBHDS' values, mission, and vision, and includes DBHDS' commitment to recovery oriented, trauma informed, and person centered practices. This training will become the standard for all DBHDS facilities to ensure consistency.

RECOMMENDATION NO. 2-B

That DBHDS incorporate reviews of human rights information, including A&N data, in their Senior Leadership Team meetings, mirroring the efforts that facilities make to monitor this information within their senior leadership meetings.

DBHDS Response

Abuse and neglect data is reviewed by the Quality Improvement Committee which includes representatives from the Senior Leadership Team. As a result of this review, the Quality Improvement Committee is drilling down in the "Other" category for neglect to acquire a better understanding of the factors contributing to these events. The Division of Quality Management and Development is also developing a Dashboard to track and trend critical incidents including serious injuries and deaths and abuse and neglect data for public and private providers. This data will be used to determine used by region to determine what additional quality improvement plans should be developed.

RECOMMENDATION NO. 2-C

That DBHDS work with facilities where program leadership and unit staff have a shared perception of human rights being valued, in order to identify strategies, activities, or practices that may warrant replication.

DBHDS Response

DBHDS concurs with this recommendation. The initiatives contained in the responses to recommendations 1-A through 1-F will provide a foundation for an evolving culture which shares and values human rights. These initiatives will also include measureable indicators for achieving this objective.

RECOMMENDATION NO. 2-D

That DBHDS take additional steps to determine what factors are influencing staff's negative perceptions of facility leadership in areas related to human rights and empowerment to assist individuals residing in their facility.

DBHDS Response

The DBHDS concurs with this recommendation and will work with facility directors and human resources staff to identify validated survey instruments and other processes s that can be used to solicit input from employees.

Question 3: Are there any consistent concerns or challenges associated with implementing the Regulations in DBHDS facilities?

FINDINGS

1. An expanded community-based system, growth in the number of LHRCs, and a reduction in the number of Advocates create challenges to consistent implementation of the Regulations.

- The number of providers licensed by DBHDS to provide services and supports has grown from 481 in fiscal year (FY) 2006 to 906 in FY 2014. The number of licensed services has grown from 1,175 in 2006 to 2,161 in 2014. In FY 2006 services were provided in 2,764 distinct locations. Currently services are provided in 7,305 distinct locations.[30],[31],[32]
- The number of LHRCs has grown from 53 to 676.
    - Nineteen Advocates are responsible for attending 450 meetings a year.[33]
- The number of Advocates fully dedicated to monitoring provider and DBHDS facility adherence to the Regulations has decreased by six since 2004.[34]

2. Most unit level staff perceives that the rights of the person served in their facility get in the way of treatment sometimes. A smaller majority express the belief that there are times when clinical considerations outweigh human rights.
    - Seventy-one percent (387 of 539) of confidential staff survey respondents affirmed that "the rights of the person served sometimes gets in the way of treatment."
    - Fifty-six percent (306 of 543) of confidential staff survey respondents affirmed that "there are times when clinical considerations outweigh human rights."

3. A significant number of unit level staff in all facilities thought that individuals being served have more rights than staff and express a sense of secondary importance within the facility setting.
    - Eighty-one percent (436 of 541) of confidential staff survey respondents affirmed that "the persons served have more rights than the staff."[35]
    - Thirty-nine percent (167 of 430) of unit staff confidential staff survey narrative comments focused on individuals' freedom to harm staff, individuals not receiving consequences for their behavior, and staff's worries that any efforts to stop peer-to-peer aggression would lead to problems for staff.

4. Advocates provide support to individuals in all facilities, but their visibility in the facilities is not evident to unit level staff.
    - Fifty-two percent (282 of 538) of confidential staff survey respondents did not think the Advocate was actively engaging staff in addressing the rights of the person served.
    - Fifty percent (263 of 525) of confidential staff survey respondents did not think that the Advocate visited the units regularly.

5. Office of Human Rights resources are not adequate to respond to facilities' needs.
    - The breakdown of facilities and Advocates includes:
        - Four facilities with an Advocate who is also responsible for responding to another DBHDS facility, as well as community programs.
        - Five facilities with a dedicated Advocate who is also responsible for community programs.

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[30] DBHDS Office of Licensing. *Office of Licensing Annual Report—Fiscal Year 2006*.
[31] Data and Financial Information: DBHDS Annual Financial Reports: FY 2013 DBHDS Annual Financial Report . DBHDS website. http://www.dbhds.virginia.gov/professionals-and-service-providers/data%20and%20financial%20information. Accessed August 26, 2014.
[32] All providers, services, and locations are subject to the Regulations.
[33] From interview of DBHDS Director of Office of Human Rights on April 22, 2014
[34] From the Office of Human Rights. DBHDS has recently hired three Advocates solely dedicated to monitoring providers who serve individuals discharged from DBHDS training centers as part of the Department of Justice (DOJ) and DBHDS Settlement Agreement.
[35] The percent of agreements ranged from 66% to 93%. Six facilities had agreement percentages above 80%.

    - One facility with three Advocates who are also responsible for community programs.
- Advocates do not provide initial or annual human rights training in all facilities. This role has increasingly become the responsibility of facility staff, largely due to the expanded community duties of the Advocates.
- Only one Advocate identified staff training as one of the three most important aspects of his/her job.
- Fifty-two percent (282 of 538) of confidential staff survey respondents think the Advocate "actively engages staff in addressing the rights of the person served."
- Fifty percent (263 of 525) of confidential staff survey respondents did not think the Advocate "visited the units regularly." One facility had an affirmative response of 80%, while four facilities had affirmative response rates below 40%, with the lowest rate equaling 22%.

6. Unit level staff in most facilities did not perceive an increase in the use of seclusion and/or restraint over the six months that preceded the site visit, but staff in several facilities agreed that peer-to-peer aggression had increased during the same period.
    - Sixty-eight percent (365 of 538) of confidential staff survey respondents did not think the use of seclusion had increased in the preceding six months.
    - Seventy-two percent (391 of 540) of confidential staff survey respondents did not think the use of restraint had increased in the preceding six months.
    - Fifty-four percent (291 of 541) of confidential staff survey respondents did think that peer-to-peer aggression had increased in the preceding six months. However, there was wide variation in this perception, with:
        - One facility at a 64% rate
        - One facility at a 68% rate
        - One facility at a 71% rate
        - One facility at a 76% rate
        - Two facilities at a 28% rate

7. While the Regulations are protecting the rights of individuals receiving treatment in DBHDS facilities, it is possible for one individual to place extensive demands on the facility staff by repeatedly making formal complaints and seeking appeals of decisions made within the facility.[36]

RECOMMENDATION NO. 3-A

That DBHDS continually seek to align their stated values of recovery and person-centered treatment and the human rights regulations and practices in order to meet each individual's needs and to use resources efficiently.

DBHDS Response

When resources are not being used efficiently, the OHR will assist facility leadership with evaluating the appropriateness of applying for a variance or exemption to the Human Rights regulations in a manner consistent with recovery and person-centered treatment.

[36] The OSIG observed such instances, however, no supporting information is being provided as including this information may lead to the confidentiality of individuals being violated.

RECOMMENDATION NO. 3-B

That DBHDS establish a mechanism for assuring that Office of Human Rights resources are sufficient to address responsibilities within facilities and the community.

DBHDS Response

The DBHDS concurs with this recommendation and is taking several steps to achieve this recommendation. First, the Office of Human Rights (OHR) is exploring the option of collapsing regional boundaries to increase the flexibility of staff deployment to the areas of greatest need. Secondly, with the finalization of the new regulations, the administrative processes will be streamlined, thus allowing advocates to shift their time from supporting multiple LHRCs to providing more community and facility oversight. Finally, pending the implementation of the new regulations, the OHR is working with the SHRC to identify opportunities within the current regulations for restructuring the LHRCs to support a more efficient and effective means of oversight.

RECOMMENDATION NO. 3-C

That DBHDS establish a work group comprised of facility Directors, facility department leadership, and unit level staff to identify practices that can help address staff's negative perception regarding the balance of patient and staff rights. This OSIG believes this recommendation can impact the overall culture of a unit or facility, which can impact a range of other areas, including rate of peer-to-peer aggression rates.[37]

DBHDS Response

The DBHDS concurs with this recommendation and will expand the initiatives contained in the responses to recommendations 1-A through 1-F to identify and implement practices that can help address staff's negative perception regarding the balance of patient and staff rights.

Focus Area: Secure Site Database Documentation of Discharge Planning for Individuals Readmitted to DBHDS Facilities

The OSIG reviewed the records from nine facilities of individuals who had more than one admission in the preceding 12 months in order to understand how facilities and CSBs were documenting discharge planning activities assigned by DBHDS's *Discharge Protocols for Community Services Boards and State Hospitals.* Concurrent with the creation of this report, DBHDS distributed a draft of *Collaborative Discharge Protocols for Community Services Boards and State Behavioral Health Facilities* for implementation July 1, 2014.

The OSIG staff's review focused on answering the following questions:

1. Do facility records or the secure site database contain clear documentation of the facility and CSB performing the duties assigned to them in the *Discharge Protocols for Community Services Boards and State Hospitals*?
2. Do facilities and CSBs consistently document discharge planning?

[37] The OSIG supports the comment from the Director of the Office of Human Rights in an interview on April 22, 2014 that: "A person-centered culture applies to the patient and the staff. It has to feel like a supportive environment for both."

Review Results

Note: Due to the limited capacity to measure facility and CSB adherence to the discharge planning protocols via the proposed methodology, the OSIG ultimately reduced the scope of this review, with 40 records reviewed.

Question 1: Do facility records or the secure site database contain clear documentation of the facility and CSB performing the duties assigned to them in the Discharge Protocols for Community Services Boards and State Hospitals?

FINDINGS

1. There was minimal capacity to measure facility and CSB adherence to the discharge planning protocols.
    - The OSIG found that secure site database information was often not available for individuals readmitted to a facility, if they had subsequently been discharged before the OSIG site visit. Facility staff reported that secure site data was no longer accessible within days or weeks of an individual's discharge. Staff in two facilities indicated they could not access previous information within 24 hours of a person's discharge. DBHDS staff noted that secure site data from a prior admission could be accessed by facility staff, upon request.
    - CSBs do not usually make entries in facility records, but instead record any discharge planning activities in an individual's CSB record. This information is only accessible through onsite record reviews at CSBs.

2. An ongoing monitoring and accountability process is not in place at a state, regional, or local level to advance compliance with the required use of the secure site database.
    - OSIG staff saw one instance of a Regional Manager monitoring and prompting adherence to secure site database entry requirements.

3. The lack of a monitoring and accountability process for assuring compliance with required secure site database documentation, and the lack of information availability subsequent to discharge, minimize opportunities for continuous quality improvement.

RECOMMENDATION NO.1

That DBHDS work with facilities and CSB's to improve documentation of discharge planning activities on the secure site and that a mechanism is created for monitoring adherence to the protocols, to include empowering a DBHDS or regional entity that can address accountability.

DBHDS Response

The DBHDS believes the most fundamental aspect of discharge planning is aiming treatment at successful discharge, active and integrated discharge planning between facilities and CSBs, and expeditious implementation of discharge plans. To this end, the DBHDS has made this the primary focus of the annual peer review process. The DBHDS has also recently revised the Discharge Protocol and will be developing a new web based software application, which will be much more user friendly.

Plans are to begin beta testing the new application as the electronic health record goes live at state hospitals. DBHDS anticipates that both the quality and the compliance with documentation requirements will improve with an enhanced documentation process. DBHDS will continue to monitor quality and compliance and will implement a plan of correction if indicated by quality reviews.

Question 2: Do facilities and CSBs consistently document discharge planning?

FINDING

When secure site data was available, either via the web application or by looking at printed copies in the facility record, there was wide variation in the quality of the documentation.

- While 55% (24 of 44) records contained Discharge Plan Form (DBH 1190C) on which all of the services and supports need upon discharge, the providers that have agreed to provide those services and supports, and the frequency of those services and supports was noted, 88% (21 or 24) of those records were from three facilities.

RECOMMENDATION NO. 2

Same as Recommendation 1.

DBHDS Response

See response from Recommendation No. 1.

Appendix I—Glossary of Terms

Abuse	Any act that was performed or knowingly failed to be performed by an employee or other person responsible for the care of an individual in a facility or program operated, licensed, or funded by DBHDS—excluding those operated by the Virginia Department of Corrections.
Advance directive	A legal document that contains an individual's directions about his/her health care instructions and preferences at a future time when the individual may be unable to communicate those decisions because of injury or illness.
Authorized representative	A legally recognized individual (or entity) who (that) makes decisions for a person who cannot represent him/herself.
Debriefing	A review or learning activity that takes place after incidents of seclusion or restraint. Joint Commission Standard PC.12.160 states that patient and staff should participate in a debriefing after a restraint or seclusion episode when restraint or seclusion is used for behavioral health care reasons. The debriefing should occur after every episode of restraint or seclusion; it should occur as soon as possible, but no longer than 24 hours after the episode; the patient, patient's family (as applicable), and the staff members involved in the episode should be part of the debriefing.
Discharge plan	The written plan that establishes the criteria for an individual's discharge from a DBHDS facility, including needed services and support upon discharge and the entities that will provide or secure those services and support.
Neglect	The failure of a person or program/facility operated, licensed, or funded by DBHDS—excluding those operated by the Virginia Department of Corrections—to provide services, care, or goods necessary to the health, safety, or welfare of an individual receiving care or treatment for mental illness, intellectual disability, or substance abuse.
Peer-to-peer	Refers to an act that involved one resident of a facility and another resident. Peer-to-peer aggression is the most common reference within this report.
Restraint	Use of a mechanical device, medication, physical intervention, or hands-on hold to prevent an individual from moving his or her body.
Seclusion	Per the Code of Federal Regulations (§ 482.13): The involuntary confinement of a person in a room or an area where the person is physically prevented from leaving.
Secure site database	The secure, online database that contains patient information, including case management, CSB, and facility notes. The database also contains individual-specific discharge implementation and planning documentation as required by the *Discharge Protocols for Community Services Boards and State Hospitals*. This documentation includes the Needs Upon Discharge Form, Discharge Plan Form, Safety and Support Plan, Extraordinary Barriers to Discharge Report, and CSB Discharge Planning Notes.
Wellness Recovery Action Plan (WRAP)	A recovery model authored and designed by Mary Ellen Copeland and The Copeland Center for Wellness and Recovery. It is an evidence-based practice, consisting of a personalized wellness and crisis plan development program, and is included on the SAMHSA National Registry for Evidence-Based Programs and Practices. The WRAP model was developed with the help of a team of people with lived experience. WRAP is a fluid, holistic, and pliable program that can be adapted and modified to apply to mental health recovery and dealing with the effects of trauma, addictions, diabetes, and fibromyalgia. WRAP can be modified for families, veterans, and children, and other emerging recovery models. Some elements of WRAP focus on peer support and peer education.

Appendix II—Review Instruments

Clinical Record Reviews

1. Signed copy of human rights acknowledgement is in the record? Y N
   Comment:

2. If not signed at the time of admission, is there evidence that the human rights acknowledgement was addressed with the person at a later date? Y N N/A
   Comment:

3. Is there evidence of the facility asking if the individual has or wishes to develop an Advance Directive? Y N
   Comment:

4. Is there an Advance Directive or WRAP Plan located in the chart? Y N
   Comment:

5. If yes, does it identify an alternative decision marker? Y N N/A
   Comment:

6. If yes, is there evidence that human rights information was provided to the alternative decision maker? Y N N/A
   Comment:

7. For individuals who have been at the facility for over a year, is there a signed updated acknowledgment of human rights? Y N N/A
   Comment:

Human Rights Questions for Human Rights Advocate(s)

1. What is the ratio of advocates to persons served at this facility?
   Response:

2. What would you say are the three most important aspects of your job?
   Response:

3. How do you monitor informal complaints and their outcome?
   Response:

4. Over the past 12 months, what have been the top three complaints filed by the persons served?
   Response:

5. Over the past 12 months, how many complaints were heard by the LHRC?
   Response:

6. Over the past 12 months have any of the complaints filed been heard by the SHRC?
   Response:

7. What information is routinely shared with the LHRC and the SHRC?
   Response:

8. What quality improvement processes are in place both within the facility and the Central Office to enhance the application of human rights?
   Response:

9. Describe the CHRIS reporting system and how it supports the work that you do?
   Response:

10. Human rights comments occur in the context of the person's illness. What processes are in place at the facility to assure that a person's complaints are addressed even when the complaint may be a manifestation of their illness? How about when the person's illness impacts their ability to meet regulation deadlines?
    Response:

11. Are timeframes within the regulations ever viewed as flexible depending on the person's mental status or residual symptoms?
    Response:

12. What would you say are the 3 most challenging aspects of your job?
    Response:

13. Do you have a role in the discharge planning process? Can you provide an example?
    Response:

14. How are legal or social rights handled such as access to local law enforcement or 911? Visits with friends and family? Ordering food with one's own money? Sharing a private meal with friends?
    Response:

Human Rights Questions for the Facility Director

1. Who do you identify as the "champions" of human rights within your facility?
   Response:

If Director includes himself/herself, ask question #2. If not, record "no" in #2 and go to #3.

2. How do you serve as a model for "championing" human rights within the facility.
   Response:

3. What steps has the facility taken to create a culture that supports both the consistent application of human rights for all the persons served while addressing individualized recovery principles of self-determination and person-centered practices?
   Response:

4. What are your expectations regarding the use of seclusion and restraint within the facility and how are these expectations communicated to staff at all levels?
   Response:

5. What quality improvement processes are in place within the facility to assure the consistent application of human rights?
   Response:

6. What are your human rights reporting requirements and what is your understanding about how this information is used to advance human rights in this setting and across all facilities?
   Response:

7. Does the facility currently have any exemptions to the human rights regulations that were granted by the Central Office? If so, please describe.
   Response:

Human Rights Questions for the Medical/Director of Clinical Services

1. Do you know how many persons that are currently hospitalized have advanced directives as an integral part of their treatment record and process? If yes, what is that number?

   Response:

2. What quality improvement processes are in place within the facility to assure the consistent application of human rights?

   Response:

3. Describe ways in which the facility Director serves as a model for "championing" human rights within the organization.

   Response:

4. How are legal or social rights handled such as access to local law enforcement or 911? Visits with friends and family? Ordering food with one's own money? Sharing a private meal with friends?

   Response:

5. What challenges do you see exists between the effective delivery of clinical services and the application of human rights?

   Response:

6. What strategies have been developed to reduce the use of seclusion and restraint in this setting?

   Response:

7. What measures are in place to determine the effectiveness of the strategies?

   Response:

8. What clinical links are there between the use of seclusion and restraint and the development of behavioral plans?

   Response:

Human Rights Questions for Facility Department Leadership Personnel

1. What quality improvement processes are in place within the facility to assure the consistent application of human rights?
   Response:

2. Describe ways in which the facility Director serves as a model for "championing" human rights within the organization.
   Response:

3. How are legal or social rights handled such as access to local law enforcement or 911? Visits with friends and family? Ordering food with one's own money? Sharing a private meal with friends?
   Response:

4. What challenges do you see exists between the effective delivery of clinical services and the application of human rights?
   Response:

5. What strategies have been developed to reduce the use of seclusion and restraint in this setting?
   Response:

6. What measures are in place to determine the effectiveness of the strategies?
   Response:

7. What clinical links are there between the use of seclusion and restraint and the development of behavioral plans?

Response:

Human Rights Questions for Individuals Residing in Facility

1. Have you been informed of your rights while living at this facility?

   Response: Yes No

2. Do you know what steps to take if you wanted to file a human rights complaint?

   Response: Yes No

3. Do you know who the Human Rights Advocate is at this facility?

   Response: Yes No

(If yes, proceed to #4. If no, provide this information.)

4. Does the Human Rights Advocate visit this unit?

   Response: Yes No Don't Know

5. Have you ever filed a complaint?

   Response: Yes No

   If yes—Do you feel the facility handled the complaint to your satisfaction? Response: Yes No

Appendix III—Staff Surveys

Facility: _____

	Statement	Strongly Agree 4	Agree 3	Disagree 2	Strongly Disagree 1
1.	I believe our facility director is a champion of human rights.				
2.	I feel empowered to assist the persons I serve in addressing their concerns/ complaints.				
3.	In my experience, informal and formal complaints of the persons served are shared with the human rights advocate.				
4.	Individuals have a right to private contact with friends and family members at this facility.				
5.	There are times in which clinical considerations outweigh human rights at this facility.				
6.	The use of seclusion has increased over the past six months.				
7.	The use of restraint has increased over the past six months.				
8.	Peer to peer aggression has increased over the past six months.				
9.	All staff receives annual competency training in human rights.				
10.	All staff receives annual competency training in the use of seclusion and restraint.				
11.	It has been my experience that the advocate asks for my input about complaints made by the person's I serve.				
12.	The human rights advocate visits the units regularly.				
13.	The rights of the persons served sometimes gets in the way of treatment.				
14.	The persons served have more rights than the staff.				
15.	Debriefings with staff after an incident of S/R occur routinely				
16.	Debriefings with the person served after an incident of S/R occur routinely.				

Comments: We are interested in your work environment. Please take the time to offer comments below or on the back of this form that would help us understand those areas that are working well at this facility and those that need improvement.

Appendix IV—Unit Observations

1. Are human rights posters prominently displayed? Y N
   Comment:

2. Are other avenues for filing complaints readily available to the persons served, such as VOPA, OSIG and/or the hotline complaint system? Y N
   Comment: **(A Yes response does not require all other avenues are available)**
   Please list the names of other organizations posted.

Appendix V—Seclusion/Restraint Survey

Facility: _____

For records of individuals who have experienced seclusion and/or restraint, complete the following for each incident of seclusion and restraint that occurred in the selected sample.

1. The behavior that resulted in seclusion and restraint is clearly documented. Y N
   Comment:

2. Less restrictive interventions used are clearly documented. Y N
   Comment:

3. Clinical supervision is documented throughout the restrictive intervention period as required by the regulations; video monitoring, visual monitoring, bathroom breaks, offers of food and drink, etc. Y N
   Comment:

4. The time period of seclusion and restraint is consistent with regulations. Y N
   Comment:

5. There is a signed physician order in the record for the use of seclusion and restrain that includes the length of time for usage and the criteria for release. Y N
   Comment:

6. There is evidence that a debriefing with staff occurred. Y N
   Comment:

7. There is evidence that a debriefing with the person occurred. Y N
   Comment:

Appendix VI—Readmission Record Review

#	Review Criteria	Y	N
1	Individual's most recent discharged took place after the individual was in the hospital for more than seven days? If yes, continue. If no, stop.		
Comment:			
2	The individuals record or the Secure Site Data Base contains *Discharge Plan Form (DBH 1190C)* on which all of the services and supports to be received upon discharge are shown, the providers that have agreed to provide those services and supports are identified, the frequency of those services and supports is noted, and a specific date of discharge is entered.		
Comment:			
3	Record or Secure Site Data Base documents that the treatment team, in consultation with CSB staff, sought to address the individual's placement preferences upon discharge.		
Comment:			
4	Record or Secure Site Data Base contains a *Safety and Support Plan* that is part of the individual's final discharge plan.		
Comment:			
5	Record or Secure Site Data Base contains documentation of a CSB representative having face-to-face or video conferencing contact with the individual within 7 days of the discharge (*Policy is within 45 days of discharge, unless the individual was receiving acute care and they were quickly discharged or the CSB had a history of working with the person)?*		
Comment:			
6	Record or Secure Site Data Base contains documentation of a CSB representative having phone contact with the individual within 7 days of the discharge (See policy note in #5)?		
Comment:			
7	Record or Secure Site Data Base documents that an appointment, within seven days of discharge, was scheduled with the identified CSB of the individual's residence? Note if the individual refused to participate in follow-up services.		
Comment:			

Appendix VII—Sample Notice of Rights and Responsibilities

Piedmont Geriatric Hospital
A LEADER IN GERIATRIC PSYCHIATRY

Review of Rights and Responsibilities of the Patient

Patient Name:_____

Unit:_____ Reg. #:_____Date:_____

☐ Admission Review ☐ Annual Review

Completed by Social Work Staff:
- ☐ Physician determined patient not capable to complete patient annual review of patient rights and responsibility form
- ☐ Patient declined to complete

Documentation that the "Rights and Responsibilities of the Patient" were reviewed with the patient, and the patient was offered a copy of "Information for Patients and Authorized Representatives" at admission and annually as follows:

Do you know you have the right to:

1. 	2. 	3. 	4. 	5. 
Have Visitors	Make and receive phone calls in private	Privacy and a place to put your things	Send or receive personal mail	Be treated with dignity and respect
6. 	7. It is your right to: 	8. 	9. 	10. 
Vote	Ask questions and get help with your rights	Religion	Not be abused or neglected	Participate in your Recovery Plan
11. 	12. 	13. 	14. 	15. 
Have treatment explained to you and say what you prefer	Refuse treatment unless a doctor believes it's necessary	See a private physician at your own expense	Receive timely evaluation and treatment	Have an advocate you trust who can help you speak up

Do you understand your rights? (check one)

☐ Patient Understands ☐ Patient Partially Understands

☐ Patient Doesn't Understand At All

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Do you know that you have the responsibility to:

1. 	2. 	3. 	4. 	5. 
Cooperate with the reimbursement office about hospital costs	Report violation of rights immediately to staff or Advocate	Ask questions about matters you don't understand	Follow Recovery Treatment Plan	Accept results of not following treatment plan
6. 	7. 	8. 	9. 	10. 
Report change in your condition to nurse, doctor, or staff	Be honest with your doctor	Report safety concerns to staff	Follow all hospital rules	Respect the rights/property of others

Do you understand your responsibilities? (check one)

☐ Patient Understands ☐ Patient Partially Understands

☐ Patient Doesn't Understand At All

Do you want to discuss any questions/answers in this review? ☐ Yes ☐ No

Comments:

Further questions or reports regarding patient rights should be referred to the Patient Advocate.

Was patient referred to Patient Advocate? ☐ Yes ☐ No

Comments:

Patient Signature/Date

Reviewer Signature/Date

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