OFFICE OF THE STATE INSPECTOR GENERAL

Report to Interim Commissioner Jack Barber

FY 2015 Unannounced Inspection of the Commonwealth Center for Children and Adolescents

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State Inspector General

Report No. 2015-BHDS-004

COMMONWEALTH OF VIRGINIA

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November 18, 2015

Jack Barber, MD, Interim Commissioner
Virginia Department of Behavioral Health and Developmental Services
1220 Bank Street
Richmond, VA 23219

Dear Dr. Barber:

The Office of the State Inspector General (OSIG) performed an unannounced inspection at the Commonwealth Center for Children and Adolescents (CCCA), pursuant to the *Code of Virginia* § 2.2-309.1[B](1)(4), on June 29, 2015. The objectives of unannounced inspections are to review quality of services and make policy and operational recommendations to state facilities in order to prevent problems, abuses, and deficiencies and improve the effectiveness of programs and services. The primary goal of this inspection was to determine the impact of the Department of Behavioral Health and Developmental Service's implementation of the temporary detention requirements as outlined in Code of Virginia § 37.2-809.1[B], facility of temporary detention.

On behalf of OSIG, I would like to express our appreciation for the assistance the CCCA leadership team and staff provided during our inspection. If you have any questions, please call me at (804) 625-3251 or email me at june.jennings@osig.virginia.gov . I am also available to meet with you in person to discuss this report.

Respectfully,

June W Jennings

June Jennings, CPA
State Inspector General

CC: Paul J. Reagan, Chief of Staff to Governor McAuliffe

Suzette P. Denslow, Deputy Chief of Staff to Governor McAuliffe
Dr. William A. Hazel, Jr., Secretary of Health and Human Resources

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Executive Summary

Effective July 1, 2014, several changes in Virginia's statutes relevant to the involuntary admission of individuals to behavioral health facilities became law. *Code of Virginia* (Code) § 37.2-809.1[B] states that a state facility "shall not fail or refuse to admit an individual who meets the criteria for Temporary Detention" unless an alternative facility that is able to provide temporary detention and appropriate care agrees to accept the individual, in effect making state hospitals the "facilities of last resort."

On June 29, 2015, OSIG performed the FY 2015 annual unannounced inspection of the Commonwealth Center for Children and Adolescents (CCCA), as required by § 2.2-309.1[B](1)(4). The purpose of the inspection was to assess the impact of § 37.2.809.1[B], hereafter referred to as "the safety net law," on the facility and to follow up on open findings and recommendations from previous OSIG reports. Overall, OSIG found that the impact of the 2014 Code change was less significant for CCCA than other behavioral health facilities operated by DBHDS. As Virginia's only state operated inpatient treatment facility for children and adolescents with behavioral health needs, CCCA has functioned as an acute-care and safety net facility for children and adolescents for the past decade, treating children and adolescents who present with more aggressive behaviors, forensic involvement, and/or limited resources.

The following issues were identified during the course of the investigation:

- Virginia lacks a system of adequate community-based services and supports, and appropriate treatment settings to serve children and adolescents with intellectual and developmental disabilities (ID/DD), Autism Spectrum Disorder (ASD), and forensic involvement. Until adequate programs are operational in the community, CCCA will continue to face challenges with bed capacity and possession of the staffing and programmatic resources necessary to provide quality services to diverse populations.
- CCCA's physical plant and unit design is not suited to effectively manage the treatment needs of the diverse populations it serves.
- Staff overtime hours and costs, high turnover rates, position vacancies, and increased incidents of aggression by the patients are significant human resources risks to the facility and DBHDS.
- CCCA direct-care staff are not receiving adequate training required to work with the diverse populations served.

Upon completion of the inspection, OSIG makes the following recommendations:

- **Observation #1 Recommendation**: The Virginia General Assembly should approve funding for the development of community-based child and adolescent treatment programs

including crisis services, integrated treatment for children and adolescents with co-occurring needs (including ID/DD, ASD), and the forensically involved. DBHDS should publish a plan for development of such services on their website, require updates semi-annually and include targeted outcomes, dates, and responsible parties.

- **Observation #2 Recommendation**: DBHDS and the State Board of Behavioral Health and Developmental Disabilities in collaboration with the CSBs and the Virginia Hospital and Healthcare Association (VHHA) should review and revise the mission of the CCCA and define the patient population best served at CCCA and those best served in other settings. They should also develop short term alternative treatment settings for children and adolescents with co-occurring special needs until such time as alternative settings are fully funded and operational.
- **Observation #3 Recommendation**: CCCA develop a revised Master Staffing Plan to address current facility needs based upon patient mix, skill sets needed, and programming needs. The revised Master Staffing Plan should be utilized to determine current nursing position needs and guide recruitment and retention efforts.
- **Observation #4 Recommendation**: CCCA develop and implement a training curriculum for new and existing staff at all levels that addresses skills in treating children and adolescents with ID/DD, ASD, medically complex presentations, and forensic involvement.

Purpose and Scope of the Review

OSIG performed the FY 2015 annual unannounced inspection at CCCA, pursuant to § 2.2-309.1[B](1)(4). The purpose of this inspection was to assess the impact of the 2014 safety net law on CCCA and the children and adolescents admitted under that law and to report to legislators and policy makers the results of the inspection in order that they utilize the observations and recommendations to inform Code changes, operational and financial decisions going forward. The inspection was not designed to assess the impact of the safety net law on community or private providers, or to review the total financial impact of the safety net law on CCCA.

Background

State-operated behavioral health facilities have historically been viewed as Virginia's safety net providers for uninsured and/or persons with complex needs requiring care that could not otherwise be provided by private providers or in alternative settings. The State Board of the Department of Behavioral Health and Developmental Services (DBHDS) has described this role in Policy 1038 (SYS) 06-1 The Safety Net of Public Services[1], but it was not until the safety net law passed in 2014 that this role was codified.

Beginning in November 2013, multiple committees, taskforces, and initiatives were developed to reassess the operations of Virginia's behavioral health system of care and revise mental health laws in order to ensure Community Services Boards (CSBs) would be able to locate available beds within required timeframes and that individuals requiring an inpatient bed for the treatment of mental health issues would be able to access such a bed in a timely manner. Among these are:

- The Governor's Taskforce on Improving Mental Health Services and Crisis Response, which met in 2013 and 2014, was charged with formulating recommendations for reforming the behavioral health system of care's crisis response. The final report of the taskforce, which included 25 recommendations, was issued in September 2014[2].
- The Virginia General Assembly introduced and passed new mental health laws during both the 2014 and 2015 legislative sessions related to the commitment process, including the development of an online-bed registry for locating available psychiatric beds during crisis situations.
- The General Assembly established a Joint Legislative Committee that has initiated a multiyear comprehensive study of Virginia's behavioral health system. The committee's first report is scheduled for delivery to the Governor and General Assembly in December 2015, with its final report and recommendations due for the 2018 General Assembly session[3].
- DBHDS established four "Transformation Teams" to make recommendations to DBHDS regarding the operations and delivery of mental health services and supports in Virginia. One of the teams was created to focus on child and adolescent behavioral health services. Transformation teams were assigned the task of developing strategic proposals for services, delivery, and infrastructure. Initial recommendations by the transformation teams were published on the DBHDS web site in March 2015[4].
- The General Assembly provided additional funding for children's behavioral health services, which included $4.5 million annually since FY 2013 with an additional $4.65 million to be added in FY 2016. These funds are primarily targeted for children's crisis response and

[1] State Board of Behavioral Health and Developmental Services, Policy Number 1038, *The Safety Net of Public Services*, April 7, 2006.

[2] Governor's Task Force on Improving Mental Health Services and Crisis Response, *Report of the Governor's Task Force on Improving Mental Health Services and Crisis Response*, September 30, 2014.

[3] Senate Joint Resolution No. 47

[4] DBHDS Transformation Teams, *Transformation Team Recommendations*, May 2015.

psychiatric services.

Inpatient System of Care for Children and Adolescents

CCCA is the only inpatient behavioral health facility operated by DBHDS dedicated to the treatment of children and adolescents. The facility has a total capacity of 48 beds. One of four treatment units at CCCA was closed from April 2015 to September 14, 2015, due to capital improvement projects, effectively reducing the total capacity to 36. The census on June 29, 2015, was 21 (58 % occupancy rate). In addition to CCCA, there are currently 16 licensed private child and/or adolescent inpatient treatment facilities across the Commonwealth with a total of 344 beds. However, not all of the 344 beds are available to accept admissions due to the programs not being staffed at full licensed capacity. The total number of statewide community child and/or adolescent "staffed" or operational beds is 287 or 83% of the full licensed capacity. Of the 14 operational facilities, nine do not provide services to children under the age of 12, which limits the number of private beds available to children under 12 to 138 beds. The table below shows the number of community-based licensed beds and each setting's operational capacity.

NUMBER OF COMMUNITY-BASED ACUTE BEDS FOR CHILDREN AND/OR ADOLESCENTS AS OF JULY 1, 2015		
FACILITY NAME	**DBHDS LICENSED BEDS**	**STAFFED BEDS**
Bon Secours Maryview Medical Center	16	12
Carillion Medical Center	12	12
Centra Health/ Virginia Baptist	20	20
Chippenham Hospital and Johnston Willis Hospital	19	19
Dominion Hospital	52	52
INOVA Fairfax Hospital	6	0
INOVA Mount Vernon Hospital	6	0
Kempsville Center for Behavioral Health	48	48
Lewis Gale Medical Center	24	12
Poplar Springs Hospital	45	45
Riverside Behavioral Health	20	7
Mary Washington Healthcare -Snowden at Fredericksburg	12	10
Virginia Commonwealth University Medical Center	26	24
Newport News Behavioral Center	24	12
Leland House (Crisis Stabilization Unit)	8	8
St. Joseph's Villa (Crisis Stabilization Unit)	6	6
TOTAL	**344**	**287**

Source: DBHDS Licensing Office

CCCA Admissions and Programming

As an acute care facility, CCCA is designed to provide comprehensive diagnostic services, crisis stabilization, and intensive short-term treatment. Treatment at CCCA is provided by

multidisciplinary teams primarily consisting of psychiatrists, clinical psychologists, nurses, social workers, activities therapists, teachers, and behaviorally trained direct care staff.

There are two treatment programs at the facility based upon the age and maturity level of the child or adolescent. The Child and Pre-Adolescent Program typically serves children up to the age of 14, depending on level of maturity. As the youngest child treated at CCCA was 3 years old, this grouping would mean that a child that age was residing on a unit with significantly older children with vastly different developmental stages and needs. The Adolescent Program serves individuals between the ages of 13 and 18. The program provides a full range of treatment modalities including, but not limited to: individual, group, and family therapy, as well as medication management. There is also a requirement to provide educational programming at the facility. Academic experiences are provided through the Staunton public school system, except during the summer months when CCCA provides a curriculum of enrichment programs.

There were 759 admissions to CCCA during FY 2015. While this represents a 9% decrease in the number of admissions that occurred during the previous fiscal year, this number is misleading for two reasons:

- Unlike the adult behavioral health facilities, there is no other DBHDS-operated child and adolescent hospital that accepts admissions. To ensure placement of the total number of admissions referred to CCCA, DBHDS entered into a contract with Poplar Springs Hospital in Petersburg to purchase beds that could accept less acutely symptomatic CCCA admissions. This was done so CCCA's beds would be available for the most challenging patients and/or those with limited resources. The number of admissions diverted to Poplar Springs during FY 2015 was 171.
- The operational capacity of CCCA was diminished by 12 beds for the last three months of the fiscal year due to several capital improvement projects.

Of the total number of admissions to CCCA in FY 2015, 560 (74%) were temporary detention order (TDO) admissions. The table below shows the percentage of TDO admissions at CCCA during the past five fiscal years. The total number of TDO admissions includes civil and forensically involved, or forensic patients. Forensic TDOs include children and adolescents admitted from local detention centers or Department of Juvenile Justice (DJJ) facilities.

PERCENTAGE OF CCCA ADMISSIONS UNDER A TDO FY 2011 Through FY 2015

Fiscal Year	Total Admissions	TDO Admissions	Percentage of TDO Admissions
2011	780	449	58%
2012	775	426	55%
2013	691	392	57%
2014	833	499	60%
2015	759	560	74%

Source: CCCA

Additional admission data for FY 2015 includes the following:

- The highest number of admissions at the facility in a single month during FY 2015 occurred in October 2014 with 102 admissions.
- The majority, 467 (62%) of the admissions were male.
- 223 admissions (29%) were children 12 years old or younger.

CCCA received admissions from each Health Planning Region (HPR) in the Commonwealth. (CCCA is located in HPR I). The table below displays the distribution of admissions to CCCA by HPR for FY 2015.

ADMISSIONS TO CCCA BY HEALTH PLANNING REGION – FY 2015		
HPR	**Admissions**	**Percentage of Total Admissions**
I	232	31%
II	92	12%
III	177	23%
IV	132	17%
V	126	17%
TOTAL	**759**	**100%**

Diverse Populations

CCCA serves a widely diverse population as the single state-operated inpatient facility for children and adolescents, a role that is further challenged by the lack of community and crisis programs designed to serve the complex needs of diverse populations. Each population requires specialized treatment programs and skilled providers. Admissions often present with significant histories of trauma, cognitive-deficits, medical issues, legal charges, and family instability. The facility is not only required to address the psychiatric needs of children and families in crisis, but to take into account the emotional and physical needs associated with the normal developmental stages for children ages 3-18.

Co-occurring Mental Health and Substance Use Disorders

According to SAMHSA, "estimated rates of co-occurring mental illness and substance use disorders among adolescents range from 60 to 75 percent."[5] Since a co-occurring mental health and substance use disorder is likely, an assessment for substance use and/or substance abuse issues occurs during each admission at CCCA. Even if the child does not meet the criteria required for making a definitive diagnosis of a substance use disorder, exposure to substance use educational opportunities are offered when input from the child and the family indicate that intervention might be beneficial.

Treating both conditions concurrently is important for successfully addressing either, and rates of recovery improve dramatically if treatment is simultaneous. However, during the brief crisis or short-term admission, treatment is generally targeted toward the presenting symptoms for which hospitalization was sought. The relatively shorter admission stays at CCCA lessening the likelihood of successful engagement in treatment coupled with the shortage of community-based co-occurring treatment programs for youth increases the risk for readmission.

Co-occurring Mental Health, ID/DD, and ASD

CCCA has experienced an increase in the number of children served that have co-occurring mental health and ID/DD, as well as ASD in FY 2015. Twenty-seven percent of the total admissions, or 205 individuals, in FY 2015 had these co-occurring disorders.

While there are advantages to serving these populations in inpatient behavioral health settings, such as exposure to a team of professionals, often for the first time, with psychiatric expertise, the current literature provides evidence of numerous disadvantages as well. These disadvantages are as follows:

- Children with ID/DD may be subject to exploitation or abuse by others.
- Children with ID/DD often express frustration and other emotions through aggressive or assaultive behaviors and, as such, are also more likely to be restrained or receive seclusion and need one-to-one staff coverage.
- General needs for support and care (hygiene, communication, nutrition, toileting, safety, etc.) arising from persons with ID/DD are time-consuming for staff.
- Activities offered in the therapy program may not be appropriate.
- The 'patient mix' makes it difficult to design programs to meet every patient's needs adequately.
- ID/DD patients may have extended stays, lessening the facility's ability to accept other TDO admissions.

While OSIG acknowledges the following cases are limited to two individuals and may not be common occurrences, these cases merit attention:

[5] SAMHSA, Youth.gov: http://youth.gov/youth-topics/substance-abuse/co-occurring.

- **Case #1:** An adolescent patient diagnosed with ASD and Moderate ID touched an adolescent peer with a behavioral health disorder on the arm, a behavior not uncommon with this population. While other behavioral health patients understood they should avoid direct touching the patient experiencing psychotic thoughts, the patient with autism and intellectually disabilities, did not. When the psychotic peer attacked him, hitting him in the head and kicking him, the boy with ASD and ID did not realize what had occurred, why he had been assaulted, or how to prevent such an occurrence in the future.
- **Case #2:** A non-verbal adolescent patient diagnosed with ASD and Moderate ID often walked around the unit making humming sounds. A patient from a juvenile detention center found the boy annoying and organized an attack with another peer on the lower functioning patient to make them "shut him up."

Both nursing-management and direct-care staff expressed concern that not only are the individuals with ID and/or ASD often more behaviorally challenged, but a number of the children admitted are non-verbal or have limited verbal skills that requires a different treatment environment, structure, and skill set. As a result, there has been an increase in use of one-to-one staffing. When the treatment team implements one-to-one staffing, the assigned staff member cannot be counted as part of the regular staffing pattern so either additional staff are required or the unit functions with less than recommended staffing for the duration of the one-to-one order.

Forensic Population at CCCA

Another population that presents unique challenges for the facility is children and adolescents with forensic involvement or forensic issues. This population primarily consists of adolescents from detention settings who are court-ordered for 10-day pre-trial evaluations or from the Department of Juvenile Justice (DJJ).

Interviews with staff indicated that the higher functioning adolescents from correctional settings often prey on the more vulnerable children, are less tolerant of the symptoms of their peers who are actively psychotic or cognitively impaired, and often bring a "street" mentality to the treatment setting.

Medically Complex Children

One impact of the safety net law is that DBHDS-operated facilities must accept persons with greater medical complexities and risk than in the past if a TDO is issued. This is uniquely challenging for the CCCA as they do not have a physician on site 24 hours a day. The facility contracts with a local pediatrician who is on-site approximately 12 to 15 hours a month to oversee medical care. While this coverage is adequate for the majority of the patients, there have been several patients in FY 2015 that have required more consistent availability of specialized skills in order to manage their chronic conditions. For example, CCCA had an admission that was in a wheelchair with compromised mobility, range of motion, and limited self-help abilities; a child with a feeding tube; a child with

cerebral palsy; and other conditions that require specialized nursing skills and medical oversight. These patients, because of the nature of their illnesses, also present added safety and risk concerns to the facility.

Discharges

To facilitate successful discharge planning, CCCA works collaboratively with the patients and their families, CSBs, and private providers to coordinate and facilitate continued treatment after discharge. In all of the records reviewed (10) and during the observations of the treatment teams, OSIG staff was able to confirm that active discharge planning was occurring at the facility that included CSBs and family members or authorized legal representatives.

The table below shows the settings to which children were discharged during FY2015.

CCCA DISCHARGE PLACEMENTS FOR FY15		
Discharge Setting	**Number of Placements**	**Percentage of Total Discharges**
Family	510	66%
Mental Health Residential	132	17%
Jail or Detention	58	7.4%
Mental Health Group Home	21	2.7%
Mental Health Specialized Foster Care	14	1.8%
Other	13	1.6%
Out of State	10	1.2%
Home of Non-Relative	6	0.7%
Corrections	4	0.5%
Boarding Home	3	0.3%
Mental Health Residential Respite/Emergency Shelter	2	0.2%
Substance Use Group Home	1	0.1%
Other State Facility	1	0.1%
Unknown	1	0.1%
TOTAL DISCHARGES	**776**	**100%**

Source: CCCA

The number of children readmitted to the facility within 30 days of discharge was 79 (10.4% of the total number of discharges in FY 2015). The number of children readmitted to the facility within 12 months of discharge was 194 (25.6%). Interviews with administrative and clinical staff identified three primary challenges to effective discharge planning: limited community capacity to provide longer-term intensive services, limited access to crisis-stabilization programs that could be used as step-up or step-down programs, and delays in resource attainment, such as funding or transportation for a child or adolescent to return to their home communities or alternate placements.

Review Methodology

The FY 2015 unannounced inspection was designed to ascertain the impact of the safety net law that went into effect on July 1, 2014, on operations at CCCA and to follow up on open findings and recommendations from previous OSIG reports. The design for the inspection was created following an extensive review of the following:

1. Gubernatorial, legislative, and DBHDS initiatives that have occurred since November 2013.
2. Current evidence-based treatment programs for the inpatient treatment of children and adolescents, the history of treatment programs at CCCA, and the implementation of the safety net law at CCCA.
3. Accreditation and certification standards from The Joint Commission (TJC) and Centers for Medicare and Medicaid Coverage (CMS).
4. Evidence-based practice standards from the SAMHSA.
5. DBHDS Offices of Children's Services and Licensure requirements.

Over the course of the inspection, the OSIG team engaged in the following activities:

- Interviews with members of the senior management, clinical and direct care staff, including:
  - Facility Director
  - Chief Nurse Executive
  - Medical Director
  - Team Psychologist
  - Director of Social Work
  - Admissions Coordinator
  - Director of Risk Management
  - Sixteen members of the direct care staff, including nurses and direct service associates.
- Environmental walk through of the physical plant.
- Observations of staff and patient interactions.
- Observations of two comprehensive treatment team meetings.
- Review of policies and procedures related to, but not limited to admissions, discharges, performance improvement, risk management, peer-to-peer aggression, and staff injuries.
- Clinical record reviews of 10 selected current and discharged individuals.

Review Results

Observation No. 1:

Virginia lacks adequate community-based services, supports, and appropriate treatment settings to serve children and adolescents with intellectual and developmental disabilities (ID/DD), Autism Spectrum Disorder (ASD), and forensic involvement. Until adequate programs are operational in the community, CCCA will continue to face challenges with bed capacity and possession of the staffing and programmatic resources necessary to provide quality services to diverse populations.

- DBHDS' 2011 *Final Report: A Plan for Community Based Children's Behavioral Health Services in Virginia*[6] highlighted the lack of comprehensive services for children and adolescents across the Commonwealth. Among the most significant challenges for the system identified in the report are the following:
    - Inadequate capacity resulting in children and families waiting for services, for many of the available services.
    - Inconsistency across the state in the array and capacity of services.
    - Because of the incomplete array, inadequate capacity, and inconsistency, many of the children and adolescents do not receive services early enough, which may mean a worsening of their conditions. This results in delayed, more restrictive, and more costly interventions. Many other children, who do not meet the eligibility of services definition of the predominant funding streams, Medicaid and the Comprehensive Services Act, simply cannot find access to services to meet their needs.
- Since 2011, there has been an increase in the array of crisis response services for children and adolescents in each HPR. However, according to the Report on Funding for Child Psychiatry and Children's Crisis Response Services[7] there remains an inconsistent array of community-based services across the community based system of care.
- If unnecessary institutionalization of children and adolescents is occurring due to a lack of alternative treatment settings, it is in conflict with the provisions of 1999 Supreme Court *Olmstead* decision that requires that individuals seeking services are to be treated in the least restrictive setting[8].
- The June 2015 Report of the Independent Reviewer on Compliance with the Settlement Agreement[9] highlighted DBHDS' non-compliance in implementing crisis response services for children with intellectual disabilities. In the Settlement Agreement between the DOJ and DBHDS, June 2012 was the agreed-upon deadline for these services to be implemented. Children with ID/DD and ASD are the fastest-growing special population being admitted to CCCA with approximately 27 percent of the total admissions.

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6 DBHDS, *Final Report: A Plan for Community Based Children's Behavioral Health Services in Virginia*, November 2011.

7 DBHDS, *Report on Funding for Child Psychiatry and Children's Response Services*, November 2014.

8 Olmstead v. L.C., 527 U.S. 581 (1999).

9 Donald Fletcher, Independent Reviewer, *Report of the Independent Review on Compliance with the Settlement Agreement*, June 2015.

OBSERVATION NO. 1 RECOMMENDATION

The Virginia General Assembly should approve funding for the development of community-based child and adolescent treatment programs including crisis services, integrated treatment for children and adolescents with co-occurring needs (including ID/DD, ASD), and the forensically involved. DBHDS should publish a plan for development of such services on their website and require updates semi-annually and include targeted outcomes, dates, and responsible parties.

Observation No. 2:

CCCA's physical plant and unit design is not suited to effectively manage the treatment needs of the diverse populations admitted for care and treatment. CCCA's facility is divided into four treatment units. Placement on the units occurs according to the patient's age and developmental level. Two units (C and D) serve primarily adolescents while two (A and B) typically serve children under the age of 13. All units are co-ed, with the patients having a mix of functioning levels, diagnoses, and behavioral considerations.

Interviews and documentation reviews revealed that members of the clinical and senior management team meet daily to discuss housing options for new admissions and other patients so that the clinical mix is based on treatment concerns, age and gender considerations, cognitive and behavioral functioning, and other diagnostic and safety concerns. When the facility is operating at or near capacity, which is frequently the case, there is limited flexibility in making appropriate housing assignments based upon the above considerations, often resulting in an increased use of one-to-one or two-to-one staffing to ensure safety.

The physical layout for each unit consists of a small dayroom area surrounded by individual offices, treatment rooms, and at least one seclusion room. There is an area adjoining the dayroom that contains single bedrooms to accommodate the eight patients per unit. The nursing station typically separates male and female bedroom areas.

The unit layout is not conducive to providing children one-to-one or two-to-one staffing with the space needed to find an area of decreased stimulation when needed, creating risk for more restrictive interventions (seclusion or restraint) to be required. The option of removing a child who is experiencing behavioral or psychological dysregulation from the treatment unit to a less stimulating and populated environment is prohibited by staffing availability.

A member of facility leadership disclosed that there were occasions during FY 2015 when children had to be temporarily housed in the unit dayroom (an open, common area) or in a seclusion room (a segregated lockable room, containing only a mattress) because of either overcrowding or for safety needs because of the population of children on the unit at the time.

Because facility units are composed of limited beds organized primarily by age/gender, and the overall physical environment, CCCA treatment units were not designed for the exceptional care needs of the ID/DD/ASD population.

OBSERVATION NO. 2 RECOMMENDATION

DBHDS and the State Board of Behavioral Health and Developmental Disabilities in collaboration with the CSBs and the Virginia Hospital and Healthcare Association (VHHA) should review and revise the mission of the CCCA and define the patient population best served at CCCA and those best served in other settings. They should also develop short term alternative treatment settings for children and adolescents with co-occurring special needs until such time as alternative settings are fully funded and operational.

Observation No. 3:

Staff overtime hours and costs, high turnover rates, position vacancies, and increased incidents of aggression by the patients are significant human resources risks. Data provided by DBHDS showed that the turnover rate for the majority of direct care staff positions was significantly higher during FY 2015 than the two previous fiscal years. The following table shows the percentage of total staff turnover rates.

TURNOVER RATES FOR RNS AND DIRECT CARE STAFF				
Fiscal Year	RN Managers	RNs	Direct Care Associate III	Direct Case Associate II
2015	54.5%	72.7%	33.3%	80.3%
2014	0.0%	20.5%	12.9%	56.1%
2013	22.2%	12.1%	45%	59.6%

On the date of the inspection, CCCA had eight contract nurses working on the treatment units. Because of position vacancies in core nursing staffing positions (72% turnover rate for RNs) at CCCA in FY2015, there has been an increased reliance on contract nurses in order to assure adequate staffing patterns. Contract nurses are a valuable resource for bridging temporary vacancies in core staffing. However, an over-reliance on contract nurses potentially erodes core staff morale as contract nurses often receive higher compensation and are not required to do overtime, resulting in fewer staff available to meet the demand for rotating overtime hours.

Overtime hours for RNs and direct care staff increased between FY 2014 and FY 2015. The number of overtime hours for RNs and direct care staff for the past 3 fiscal years are noted in the table below.

OVERTIME HOURS FOR RNSs AND DIRECT CARE STAFF		
Fiscal Year	Registered Nurses	Direct Care Staff
2015	2,058.2	14,104.5

2014	1,451.9	12,206.4
2013	2,343.1	10,297.6

The overtime cost during FY2015 was $78,767.82 for RNs and $271,593.25 for direct care staff.

The number of staff injuries related to interventions with patients has increased significantly over the past three fiscal years:

- In FY 2015, there were 280 incidents
- In FY 2013, there were 154 incidents
- In FY 2014, there were 184 incidents

There were 713 incidents of peer-to-peer aggression in FY 2015 compared to 393 incidents in FY2014 and 242 incidents in FY2013.

Incidents of Seclusion and Restraint increased during FY 2015. The table below shows the incidents of seclusion and restraint for the past 3 fiscal years.

Incidents of Seclusion and Restraint			
Fiscal Year	**Seclusion**	**Physical Restraint**	**Mechanical Restraint**
2015	1,034	344	706*
2014	742	228	248
2013	681	337	210
**CCCA began using an emergency restraint chair November 6, 2014*			

While administrative staff reported a number of new direct care and nursing positions were authorized for CCCA in the past year, in part as a consequence of the changing population and system demands, the facility has not revised its Master Staffing Plan following in response to changes in patient mix, position vacancies, over time hours, and increases in aggressive behaviors on units Master Staffing Plans must reflect current patient mix, staffing competencies, and programming requirements. Staffing a facility based upon history presents challenges for staff and administration and impacting outcomes.

OBSERVATION NO. 3 RECOMMENDATION

CCCA develop a revised Master Staffing Plan to address current facility need based upon patient mix, skill sets needed, and programming needs. The revised Master Staffing Plan should be utilized to determine current nursing position needs and guide recruitment and retention efforts.

Observation No. 4:

CCCA staff are not receiving adequate training related to the care of the diverse populations being treated at the facility. The presence of sufficiently trained and qualified staff is fundamental to the

successful operation of any organization. Staff must have a level of confidence in their skills in order to provide quality care to patients entrusted to their care. Nursing and direct care staff reported not receiving adequate training in the treatment of children and adolescents with ID/DD or ASD, medically involved clients, as well as the forensic population.

Training concerns were echoed by members of the senior leadership team acknowledging the facility's awareness that more rigorous training programs are needed. The facility reports planning to contract with Commonwealth Autism to receive training in the treatment of ASD. Commonwealth Autism is a Richmond-based program that has reportedly entered into a partnership with DBHDS to increase community capacity for serving the ID/DD and ASD special-needs population.

A member of CCCA senior leadership confirmed that the staff were not sufficiently trained to work with children with ID/DD or cognitive deficits and reported that the facility has hired a training coordinator, a position that had been vacant since 2006. This position has recently been filled.

A review of training provided during new employee orientation revealed that there were no specific training modules on treatment approaches with persons with co-occurring mental health and ID/DD or ASD.

OBSERVATION NO. 4 RECOMMENDATION

CCCA develop and implement a training curriculum for new and existing staff at all levels that addresses skills in treating children and adolescents with ID/DD, ASD, medically complex presentations, and forensic involvement.

Follow-up of Open Recommendations

A follow-up to open recommendations of OSIG Report 2014-BHDS-010 Review of Critical Events: Environmental Safety at the Commonwealth Center for Children and Adolescents occurred during the FY 2015 unannounced inspection. The results of the follow-up are as follows:

Observation #1:

There is a significant difference between facility management and direct care staff perceptions regarding environmental safety.

OBSERVATION NO. 1 RECOMMENDATION:

That CCCA work to increase communication between direct care staff and facility management to help mitigate differing perceptions between direct care staff and facility management.

FOLLOW UP:

Interviews revealed that CCCA leadership have opened communication channels with staff around staffing concerns. Direct care staff indicated in surveys completed that senior leadership has a greater understanding of their concerns and has been actively attempting to address these.

Direct care staff on evening shifts report that there has been increased contact with midlevel management and members of nursing senior leadership.

This recommendation may be considered CLOSED at this time.

Appendix I – Management Response

January 6, 2014

To: June Jennings
Inspector General
Office of the State Inspector General

From: Jack Barber, M.D.
DBHDS Interim Commissioner

Subject: DBHDS Response to Draft OSIG Report 2015-BHDS-004 FY2015 Unannounced Inspection of CCCA

Thank you for this opportunity to review the OSIG's Draft Report on the Unannounced Inspection of CCCA. I regret our delayed response to this report. I appreciate the OSIG's thoughtful review of the role of CCCA within Virginia's systems of care for children and adolescents and for recognizing the work that CCCA's leadership has done to increase communication channels and engage with direct care staff.