MENTAL HEALTH CRISIS CENTER OF LANCASTER COUNTY
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Scott Etherton
Director

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Medical Director

1/2/2019

CARF International
6951 E. Southpoint Road
Tucson, AZ 85756-9407

Dear Sirs:

I am writing regarding our organizational survey conducted October 29-30, 2018. I believe the survey was not conducted in a manner consistent with your standards. This opinion is based upon our review of the Accreditation Report, our participation in the onsite survey and our collective knowledge of the organization's policies, procedures and program.

The Accreditation Report we received following the survey came as a shock to us. It contains numerous recommendations in areas we do not believe were discussed during the survey but for which documentation was available. Other recommendations were from areas in which staff showed the surveyors standard supporting evidence and discussed the material. Staff offered to provide other evidence of meeting the standard but were informed it was not necessary or the surveyor would get back to them if needed, but the areas were then included as recommendations. Further recommendations came from misapplied standards, which did not take into account the nature of the program and the flexibility that your standards allow in their application. There were also areas in which every item in the standard was listed as a recommendation, when our understanding was that we may have only been lacking wording in one area to be inclusive for a policy.

Understanding what went wrong with this survey has been paramount to me and I am including some thoughts. I do not believe there was an intention of the surveyors to be unfair in their assessment of the program. They were cordial, respectful and conducted themselves professionally. I believe the standards that allow flexibility due to the short term and legal nature of facilities were not considered, and thus we were made to adhere to the highest possible standard. As your records will indicate, we have participated in CARF surveys for a number of years at this facility. Past surveyors have both verbally stated the flexibility noted above, and, taken that flexibility into account in our accreditation surveys. Apparently that was not the case in this survey however we were not informed of any change in the survey process at the time of our survey.

I also believe time constraints were or became a factor. Numerous documents, paper and electronic, were given to the surveyors upon their arrival at their hotel prior to initiation of the survey. Explanation of our operation as a governmental agency of Lancaster County of Nebraska were included. As a governmental agency we are also covered significantly by all the functions of Lancaster County. Human Resources, Accounting, Risk Management, County Attorney, Treasurer and other departments all have functions, policies & procedures that we follow which cover some of the functions that CARF addresses as standards. I do not believe this was fully understood by the surveyors.

As stated above, this was not the first CARF survey for our organization and most of our staff, myself included, have participated in previous surveys. We believed that the documentation was available at the time of the survey & our experience should have helped the process. At the time of the exit interview, there were some things reported as not being met, that we knew we had evidence of and were available. I reached out by email asking about sending that documentation but did not get a response. As with past exit interviews, we were told by the surveyors that we should know at the end of the exit interview how we faired in the survey process and that we should not be surprised when receiving our Accreditation Report. This was not the case with this survey.

We believe the Accreditation Report contains multiple recommendations which never should have been a factor in your Accreditation decision. I am sending our review of your report via the postal service but wanted you to be aware of our concerns prior to receiving that review. The report details most of the areas of concern that I have expressed and includes the supporting documentation showing that the standards were met and were available at the time of our survey.

Your process allows for an on-site review of the accreditation decision. I do not believe this should be required. I am asking for a review of our file and that your accreditation decision be reviewed based on the documentation.

We value our long standing relationship with CARF and the improvements to all functions of our agency as a result of our collaboration. I look forward to our communication regarding this matter.

Sincerely

Scott E. Etherton
Director
Mental Health Crisis Center
Company ID # 32766
Survey # 110193

carf INTERNATIONAL

CARF Accreditation Report

for

Mental Health Crisis Center of Lancaster County

One-Year Accreditation

CARF International Headquarters
6951 E. Southpoint Road
Tucson, AZ 85756-9407, USA

www.carf.org

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About CARF

CARF is an independent, nonprofit accreditor of health and human services, enhancing the lives of persons served worldwide.

The accreditation process applies CARF's internationally recognized standards during an on-site survey conducted by peer surveyors. Accreditation, however, is an ongoing process that distinguishes a provider's service delivery and signals to the public that the provider is committed to continuous performance improvement, responsive to feedback, and accountable to the community and its other stakeholders.

CARF accreditation promotes providers' demonstration of value and Quality Across the Lifespan® of millions of persons served through application of rigorous organizational and program standards organized around the ASPIRE to Excellence® continuous quality improvement framework. CARF accreditation has been the recognized benchmark of quality health and human services for more than 50 years.

For more information or to contact CARF, please visit www.carf.org/contact-us.

Organization

Mental Health Crisis Center of Lancaster County
825 J Street
Lincoln, NE 68508

Organizational Leadership

Jareth Kaup, Business Manager
Scott E. Etherton, Director

Survey Date(s)

October 29, 2018–October 30, 2018

Surveyor(s)

Teresa J. Galutia, Administrative
Coralee Schmitz, M.S., LAC, MAC, Program

Program(s)/Service(s) Surveyed

Crisis Stabilization: Mental Health (Adults)

Previous Survey

Three-Year Accreditation
October 19, 2015–October 20, 2015

Accreditation Decision

One-Year Accreditation
Expiration: October 31, 2019

Executive Summary

This report contains the findings of CARF's on-site survey of Mental Health Crisis Center of Lancaster County conducted October 29, 2018–October 30, 2018. This report includes the following information:

- Documentation of the accreditation decision and the basis for the decision as determined by CARF's consideration of the survey findings.
- Identification of the specific program(s)/service(s) and location(s) to which this accreditation decision applies.
- Identification of the CARF surveyor(s) who conducted the survey and an overview of the CARF survey process and how conformance to the standards was determined.
- Feedback on the organization's strengths and recognition of any areas where the organization demonstrated exemplary conformance to the standards.
- Documentation of the specific sections of the CARF standards that were applied on the survey.
- Recommendations for improvement in any areas where the organization did not meet the minimum requirements to demonstrate full conformance to the standards.
- Any consultative suggestions documented by the surveyor(s) to help the organization improve its program(s)/service(s) and business operations.

Accreditation Decision

On balance, Mental Health Crisis Center of Lancaster County demonstrated conformance to many of the standards. Mental Health Crisis Center of Lancaster County (MHCC) provides a highly valued service in a section of Nebraska that is in serious need. These services are underfunded and not readily available in all areas. MHCC provides these mental health crisis services regardless of the clients' ability to pay, further limiting its overall budget. There are significant opportunities for improvement in the recommendations in this report, which relate to inclusion of the client in support planning, treatment, transition, and the debriefing process; client rights; client orientation; client safety planning; health and safety planning and education; information trending and use in planning processes; policy and procedure refinement; succession planning; performance measurement and management; and other areas. MHCC does have a significant desire to meet the standards and to serve a vulnerable population with limited resources. MHCC is urged to continue to use its resources to address these standards and to explore additional opportunities for improvement. Despite numerous recommendations in health and safety and other areas, it appears that clients are benefiting from the services provided and that their general health, safety, and welfare are protected.

Mental Health Crisis Center of Lancaster County appears to have the capability and commitment to address the recommendations identified in this report. Mental Health Crisis Center of Lancaster County is required to submit a post-survey Quality Improvement Plan (QIP) that addresses all recommendations identified in this report.

Mental Health Crisis Center of Lancaster County has earned a One-Year Accreditation. The leadership team and staff are complimented and congratulated for this achievement. In order to maintain this accreditation, throughout the term of accreditation, the organization is required to:

- Submit required information to CARF, as detailed in the Accreditation Policies and Procedures section in the standards manual.
- Maintain ongoing conformance to CARF's standards, satisfy all accreditation conditions, and comply with all accreditation policies and procedures, as they are published and made effective by CARF.

Survey Details

Survey Participants

The survey of Mental Health Crisis Center of Lancaster County was conducted by the following CARF surveyor(s):

- Teresa J. Galutia, Administrative
- Coralee Schmitz, M.S., LAC, MAC, Program

CARF considers the involvement of persons served to be vital to the survey process. As part of the accreditation survey for all organizations, CARF surveyors interact with and conduct direct, confidential interviews with consenting current and former persons served in the program(s)/service(s) for which the organization is seeking accreditation. In addition, as applicable and available, interviews may be conducted with family members and/or representatives of the persons served such as guardians, advocates, or members of their support system.

Interviews are also conducted with individuals associated with the organization, as applicable, which may include:

- The organization's leadership, such as board members, executives, owners, and managers.
- Business unit resources, such as finance and human resources.
- Personnel who serve and directly interact with persons served in the program(s)/service(s) for which the organization is seeking accreditation.
- Other stakeholders, such as referral sources, payers, insurers, and fiscal intermediaries.
- Community constituents and governmental representatives.

Survey Activities

Achieving CARF accreditation involves demonstrating conformance to the applicable CARF standards, evidenced through observable practices, verifiable results over time, and comprehensive supporting documentation. The survey of Mental Health Crisis Center of Lancaster County and its program(s)/service(s) consisted of the following activities:

- Confidential interviews and direct interactions, as outlined in the previous section.
- Direct observation of the organization's operations and service delivery practices.
- Observation of the organization's location(s) where services are delivered.
- Review of organizational documents, which may include policies; plans; written procedures; promotional materials; governing documents, such as articles of incorporation and bylaws; financial statements; and other documents necessary to determine conformance to standards.
- Review of documents related to program/service design, delivery, outcomes, and improvement, such as program descriptions, records of services provided, documentation of reviews of program resources and services conducted, and program evaluations.
- Review of records of current and former persons served.

Program(s)/Service(s) Surveyed

The survey addressed by this report is specific to the following program(s)/service(s):

- Crisis Stabilization: Mental Health (Adults)

A list of the organization's accredited program(s)/service(s) by location is included at the end of this report.

Representations and Constraints

The accreditation decision and survey findings contained in this report are based on an on-balance consideration of the information obtained by the surveyor(s) during the on-site survey. Any information that was unavailable, not presented, or outside the scope of the survey was not considered and, had it been considered, may have affected the contents of this report. If at any time CARF subsequently learns or has reason to believe that the organization did not participate in the accreditation process in good faith or that any information presented was not accurate, truthful, or complete, CARF may modify the accreditation decision, up to and including revocation of accreditation.

Survey Findings

This report provides a summary of the organization's strengths and identifies the sections of the CARF standards that were applied on the survey and the findings in each area. In conjunction with its evaluation of conformance to the specific program/service standards, CARF assessed conformance to its business practice standards, referred to as Section 1. ASPIRE to Excellence, which are designed to support the delivery of the program(s)/service(s) within a sound business operating framework to promote long-term success.

The specific standards applied from each section vary based on a variety of factors, including, but not limited to, the scope(s) of the program(s)/service(s), population(s) served, location(s), methods of service delivery, and survey type. Information about the specific standards applied on each survey is included in the standards manual and other instructions that may be provided by CARF.

Areas of Strength

CARF found that Mental Health Crisis Center of Lancaster County demonstrated the following strengths:

- MHCC provides a much-needed service in a regional area that has recently lost needed mental health services. The organization provides supports at a critical time for the neediest of citizens, and it does this on an extremely limited budget and without reimbursement for a large number of clients.
- As a part of Lancaster County's government, MHCC must work cooperatively with Region V officials and other local community stakeholders. These stakeholders speak positively about MHCC, indicating that the organization builds on its own strength and that of the community, resulting in persons being served close to home. Stakeholders report that the MHCC listens very well to feedback and seriously considers all input when deciding on a course of action. They report that MHCC gives back to the community by facilitating training with community partners, which has contributed to a reduction in involuntary commitments and negative stigma for clients. Several of these clients are encouraged to present some of the training themselves, speaking to what works and what doesn't work for them. This personalized approach provides much-needed awareness and education for community partners.

- MHCC receives direction and input from a community advisory committee that meets monthly to provide input and direction to the organization. MHCC is described as being transparent in its communications by the committee. Additionally, the committee believes that its input is valued and utilized.
- MHCC's physical facility is specially designed to provide for the safety of staff and clients. The organization has given significant attention to balance both safety and personal privacy of each client through specially designed door handles and hinges, windows that can be opened or closed as needs change, and gentle lights that can be activated from outside the room.
- MHCC collects a large variety of demographic data on the population served. These data demonstrate a wide diversity in the types of clients served and are helpful with future planning.
- MHCC engages in an annual audit, and it also goes through a second annual audit through Lancaster County, ensuring solid accounting practices.
- The organization's staff members are enthusiastic about what they do and have clearly developed a culture of welcoming and comfort. The family style lunches are a nice touch, and everyone seems to contribute. The organization's culture has resulted in low turnover and high staff retention.
- The setup and organization of the building seems to meet the needs of the clients, community, and staff. It provides for administrative and clinical functions, as well as external meetings that will not interrupt client care.

Opportunities for Quality Improvement

The CARF survey process identifies opportunities for continuous improvement, a core concept of "aspiring to excellence." This section of the report lists the sections of the CARF standards that were applied on the survey, including a description of the business practice area and/or the specific program(s)/service(s) surveyed and a summary of the key areas addressed in that section of the standards.

In this section of the report, a recommendation identifies any standard for which CARF determined that the organization did not meet the minimum requirements to demonstrate full conformance. All recommendations must be addressed in a QIP submitted to CARF.

In addition, consultation may be provided for areas of or specific standards where the surveyor(s) documented suggestions that the organization may consider to improve its business or service delivery practices. Note that consultation may be offered for areas of specific standards that do not have any recommendations. Such consultation does not indicate nonconformance to the standards; it is intended to offer ideas that the organization might find helpful in its ongoing quality improvement efforts. The organization is not required to address consultation.

When CARF surveyors visit an organization, their role is that of independent peer reviewers, and their goal is not only to gather an assess information to determine conformance to the standards, but also to engage in relevant and meaningful consultative dialogue. Not all consultation or suggestions discussed during the survey are noted in this report. The organization is encouraged to review any notes made during the survey and consider the consultation or suggestions that were discussed.

During the process of preparing for a CARF accreditation survey, an organization may conduct a detailed self-assessment and engage in deliberations and discussions within the organization as well as with external stakeholders as it considers ways to implement and use the standards to guide its quality improvement efforts. The organization is encouraged to review these discussions and deliberations as it considers ways to implement innovative changes and further advance its business and service delivery practices.

Section 1. ASPIRE to Excellence®

1.A. Leadership

Description

CARF-accredited organizations identify leadership that embraces the values of accountability and responsibility to the individual organization's stated mission. The leadership demonstrates corporate social responsibility.

Key Areas Addressed

- Leadership structure and responsibilities
- Person-centered philosophy
- Organizational guidance
- Leadership accessibility
- Cultural competency and diversity
- Corporate responsibility
- Organizational fundraising, if applicable

Recommendations

1.A.5.b.(6)
1.A.5.b.(7)
1.A.5.c.
1.A.5.d.
It is recommended that the organization implement its cultural competency and diversity plan and expand it so that it is also based on consideration of socioeconomic status and language. The plan should be reviewed at least annually and be updated as needed.

1.A.6.a.(6)(a)(i)
1.A.6.a.(6)(a)(iii)
1.A.6.a.(6)(e)
It is recommended that the organization's written ethical codes of conduct include direction on the exchange of gifts and gratuities and the witnessing of legal documents.

1.A.7.d.(1)
It is recommended that the organization provide training of personnel on corporate compliance and the role of the compliance officer.

1.C. Strategic Planning

Description

CARF-accredited organizations establish a foundation for success through strategic planning focused on taking advantage of strengths and opportunities and addressing weaknesses and threats.

Key Areas Addressed

- Environmental considerations
- Strategic plan development, implementation, and periodic review

Recommendations

1.C.2.a.(1)
It is recommended that the organization develop its strategic plan with input from the persons served.

1.C.3.a.
It is recommended that the strategic plan be shared with the persons served, as relevant to their needs.

1.D. Input from Persons Served and Other Stakeholders

Description

CARF-accredited organizations continually focus on the expectations of the persons served and other stakeholders. The standards in this subsection direct the organization's focus to soliciting, collecting, analyzing, and using input from all stakeholders to create services that meet or exceed the expectations of the persons served, the community, and other stakeholders.

Key Areas Addressed

- Collection of input
- Integration of input into business practices and planning

Recommendations

There are no recommendations in this area.

Consultation

- Although MHCC collects data from clients via the BASIS-24® survey and the Care Perceptions document, the qualitative data containing feedback in the client's own words are not trended or used to influence planning. MHCC may want to consider analyzing and using this information, along with the other data collected, when planning for the organization (i.e., program planning, performance improvement, and strategic planning).

1.E. Legal Requirements

Description

CARF-accredited organizations comply with all legal and regulatory requirements.

Key Areas Addressed

- Compliance with obligations
- Response to legal action
- Confidentiality and security of records

Recommendations

There are no recommendations in this area.

1.F. Financial Planning and Management

Description

CARF-accredited organizations strive to be financially responsible and solvent, conducting fiscal management in a manner that supports their mission, values, and performance objectives. Fiscal practices adhere to established accounting principles and business practices. Fiscal management covers daily operational cost management and incorporates plans for long-term solvency.

Key Areas Addressed

- Budgets
- Review of financial results and relevant factors
- Fiscal policies and procedures
- Reviews of bills for services and fee structures, if applicable
- Safeguarding funds of persons served, if applicable
- Review/audit of financial statements

Recommendations

1.F.7.a.
1.F.7.b.(1)
1.F.7.b.(2)
Because the organization bills for services, it is recommended that a review of a representative sample of bills be conducted at least quarterly to determine that the bills are accurate and to identify necessary corrective action.

1.G. Risk Management

Description

CARF-accredited organizations engage in a coordinated set of activities designed to control threats to their people, property, income, goodwill, and ability to accomplish goals.

Key Areas Addressed

- Risk management plan implementation and periodic review
- Adequate insurance coverage
- Media relations and social media procedures
- Reviews of contract services

Recommendations

1.G.1.a.(3)
1.G.1.a.(4)
1.G.1.a.(5)
1.G.1.a.(6)
1.G.1.a.(7)
Although the organization implements a risk management plan, it is recommended that it also include identification of how to rectify identified exposures, implementation of actions to reduce risk, monitoring of actions to reduce risk, and inclusion of risk reduction in performance improvement activities.

1.H. Health and Safety

Description

CARF-accredited organizations maintain healthy, safe, and clean environments that support quality services and minimize risk of harm to persons served, personnel, and other stakeholders.

Key Areas Addressed

- Competency-based training on safety procedures and practices
- Emergency procedures
- Access to first aid and emergency information
- Critical incidents
- Infection control
- Health and safety inspections

Recommendations

1.H.5.a.(6)
1.H.5.c.(6)
1.H.5.c.(7)
1.H.5.c.(8)
1.H.5.c.(9)
It is recommended that the written emergency procedures also address violent or other threatening situations; temporary shelter, when applicable; identification of essential services; continuation of essential services; and emergency phone numbers.

1.H.6.a.
1.H.6.b.(1)
1.H.6.b.(2)
1.H.6.b.(3)
It is recommended that the organization have evacuation routes that are accessible and understandable to persons served; personnel; and other stakeholders, including visitors.

1.H.7.a.(1)
1.H.7.c.(1)
1.H.7.c.(2)
1.H.7.c.(3)
1.H.7.c.(4)
1.H.7.d.
It is recommended that the organization hold unannounced tests of all emergency procedures at least annually on each shift. Actual or simulated drills should be analyzed for performance, including areas needing improvement, actions to be taken, results of performance improvement plans, and necessary education and training of personnel. Tests should be evidenced in writing, including the analysis.

1.H.9.f.(4)
1.H.9.f.(5)
1.H.9.f.(6)
1.H.9.f.(7)
1.H.9.f.(9)
1.H.9.f.(10)
1.H.9.f.(12)
1.H.9.f.(16)
It is recommended that the organization include incidents involving injury, communicable disease, infection control, aggression or violence, wandering, elopement, biohazardous accidents, and suicide and attempted suicide in its written critical incident procedures.

1.H.10.a.
1.H.10.b.(1)
1.H.10.b.(2)
1.H.10.b.(3)
1.H.10.b.(4)
1.H.10.b.(5)
1.H.10.b.(6)
1.H.10.b.(7)
1.H.10.b.(8)
Although the organization compiles an annual list of critical incidents, it is recommended that a written analysis of all critical incidents be provided to or conducted by the leadership at least annually that addresses causes, trends, actions for improvement, the results of performance improvement plans, any necessary education and training of personnel, prevention of recurrence, internal reporting requirements, and external reporting requirements.

1.H.11.b.(3)(a)
It is recommended that the organization implement guidelines for addressing infection control and prevention procedures with the persons served.

1.H.13.b.(3)
It is recommended that the comprehensive health and safety inspections result in a written report that identifies actions taken to respond to recommendations.

1.H.14.b.(2)
1.H.14.b.(3)
It is recommended that the comprehensive health and safety self-inspections result in a written report that identifies recommendations for areas needing improvement and actions taken to respond to the recommendations.

1.H.15.a.
1.H.15.b.
1.H.15.c.
It is recommended that MHCC implement written procedures concerning hazardous materials that provide for safe handling, storage, and disposal.

Consultation

- MHCC might want to consider adding additional detail to its written emergency procedure concerning medical emergencies to ensure enhanced understanding of its intent.

1.I. Workforce Development and Management

Description

CARF-accredited organizations demonstrate that they value their human resources and focus on aligning and linking human resources processes, procedures, and initiatives with the strategic objectives of the organization. Organizational effectiveness depends on the organization's ability to develop and manage the knowledge, skills, abilities, and behavioral expectations of its workforce. The organization describes its workforce, which is often composed of a diverse blend of human resources. Effective workforce development and management promote engagement and organizational sustainability and foster an environment that promotes the provision of services that center on enhancing the lives of persons served.

Key Areas Addressed

- Composition of workforce
- Ongoing workforce planning
- Verification of background/credentials/fitness for duty
- Workforce engagement and development
- Performance appraisals
- Succession planning

Recommendations

1.I.4.a.(1)(a)
1.I.4.b.(1)
1.I.4.b.(2)
1.I.4.b.(3)
1.I.4.c.(1)
1.I.4.c.(2)
Although the organization completes criminal background checks on all new employees, this practice is not documented in written procedure. It is recommended that the organization implement written procedures that address verification of backgrounds of the workforce in criminal checks and actions to be taken in response to the information received concerning background checks, credentials verification, and fitness for duty. It should also implement procedures that address timeframes for verification of backgrounds, credentials, and fitness for duty, both prior to the delivery of services and throughout employment.

1.I.8.a.
1.I.8.b.
1.I.8.c.
1.I.8.d.
1.I.8.e.
1.I.8.f.
1.I.8.g.
1.I.8.h.
It is recommended that the organization implement written procedures for performance appraisal that address the identified workforce, the criteria against which people are being appraised, involvement of the person being appraised, documentation requirements, timeframes/frequencies related to the performance appraisal process, measurable goals, sources of input, and opportunities for development.

1.I.11.a.
1.I.11.b.
1.I.11.c.
1.I.11.d.
1.I.11.e.
1.I.11.f.
1.I.11.g.
Although Lancaster County protocol outlines a general practice to be followed in any county situation that requires succession attention, it is recommended that MHCC's succession planning address, at a minimum, its future workforce needs, identification of key positions, identification of the competencies required by key positions, review of talent in the current workforce, identification of workforce readiness, gap analysis, and strategic development.

1.J. Technology

Description

CARF-accredited organizations plan for the use of technology to support and advance effective and efficient service and business practices.

Key Areas Addressed

- Technology and system plan implementation and periodic review
- Written procedures for the use of information and communication technologies (ICT) in service delivery, if applicable
- ICT instruction and training, if applicable
- Access to ICT information and assistance, if applicable
- Maintenance of ICT equipment, if applicable
- Emergency procedures that address unique aspects of service delivery via ICT, if applicable

Recommendations

There are no recommendations in this area.

1.K. Rights of Persons Served

Description

CARF-accredited organizations protect and promote the rights of all persons served. This commitment guides the delivery of services and ongoing interactions with the persons served.

Key Areas Addressed

- Policies that promote rights of persons served
- Communication of rights to persons served
- Formal complaints by persons served

Recommendations

1.K.1.c.(2)
1.K.1.c.(3)
1.K.1.e.(4)
1.K.1.f.(1)
It is recommended that the organization include the right to be free from financial or other exploitation and retaliation, the right to informed consent or refusal or expression of choice in the composition of the service delivery team, and access or referral to legal entities for appropriate representation in its policies promoting the rights of persons served.

1.K.4.b.(3)
1.K.4.b.(4)
1.K.4.b.(5)
It is recommended that the organization include areas needing improvement, actions to be taken to address the improvements needed, and actions taken or changes made to improve performance in its annual analysis of all formal complaints.

Consultation

- Although the organization includes one timeline in its formal complaint procedure that ensures a three-day turnaround timeline, it may want to consider including additional timelines to ensure that the complaint is timely in its initial filing.
- Although the organization includes a process for written notification regarding the actions to be taken to address the complaint, it also includes the option of a verbal notification. The organization may want to consider making the written notification mandatory and the verbal notification optional, depending on the communication needs of the client.

1.L. Accessibility

Description

CARF-accredited organizations promote accessibility and the removal of barriers for the persons served and other stakeholders.

Key Areas Addressed

- Assessment of accessibility needs and identification of barriers
- Accessibility plan implementation and periodic review
- Requests for reasonable accommodations

Recommendations

1.L.1.b.(7)
1.L.1.b.(9)
It is recommended that the organization's leadership implement an ongoing process for identification of barriers in technology and community integration, when appropriate.

1.L.2.a.(2)
It is recommended that the organization include a timeline for remediation of all identified barriers in its accessibility plan.

1.M. Performance Measurement and Management

Description

CARF-accredited organizations are committed to continually improving their organizations and service delivery to the persons served. Data are collected and analyzed, and information is used to manage and improve service delivery.

Key Areas Addressed

- Data collection
- Establishment and measurement of performance indicators

Recommendations

1.M.2.a.
1.M.2.b.
1.M.2.c.
1.M.2.d.
The organization should demonstrate how its data collection system addresses reliability, validity, completeness, and accuracy.

1.M.3.b.(1)
1.M.3.b.(2)
1.M.3.b.(3)
1.M.3.c.
1.M.3.d.(2)(a)
1.M.3.d.(2)(b)
1.M.3.d.(2)(c)
It is recommended that the performance measurement and management data collected by the organization address the needs of persons served, the needs of the stakeholders, and the business needs of the organization and allow for comparative analysis. It is also recommended that the performance measurement and management data collected be used to set written service delivery objectives, performance indicators, and performance targets for each program seeking accreditation.

1.M.5.d.
The organization should also collect data about the persons served at a point or at points in time following services.

1.M.6.b.(2)
1.M.6.b.(3)
1.M.6.b.(4)(b)
It is recommended that the organization measure service delivery performance indicators for each program/service seeking accreditation, including the efficiency of services and service access and satisfaction and other feedback from other stakeholders.

1.M.7.a.
1.M.7.c.
1.M.7.d.
For each service delivery performance indicator, it is recommended that the organization determine to whom the indicator will be applied; the source from which data will be collected; and a performance target based on an industry benchmark, based on the organization's performance history, or established by the organization or other stakeholder.

1.N. Performance Improvement

Description

The dynamic nature of continuous improvement in a CARF-accredited organization sets it apart from other organizations providing similar services. CARF-accredited organizations share and provide the persons served and other interested stakeholders with ongoing information about their actual performance as a business entity and their ability to achieve optimal outcomes for the persons served through their programs and services.

Key Areas Addressed

- Analysis of performance indicators in relation to performance targets
- Use of performance analysis for quality improvement and organizational decision making
- Communication of performance information

Recommendations

1.N.1.a.
1.N.1.b.(1)
1.N.1.b.(2)(a)
1.N.1.b.(2)(b)
1.N.1.b.(2)(c)
1.N.1.b.(2)(d)(i)
1.N.1.b.(2)(d)(ii)
1.N.1.b.(3)
1.N.1.c.(1)
1.N.1.c.(2)
1.N.1.c.(3)
It is recommended that the organization complete a written analysis at least annually that analyzes performance indicators in relationship to performance targets, including business functions and service delivery of each program seeking accreditation, including the effectiveness of services, the efficiency of services, service access, and satisfaction and other feedback from the persons served and other stakeholders, and extenuating or influencing factors. In addition, the performance analysis should identify areas needing performance improvement, result in an action plan to address improvements needed to reach established or revised performance targets, and outline actions taken or changes made to improve performance.

1.N.2.a.(1)
1.N.2.a.(2)
1.N.2.b.
1.N.2.c.
1.N.2.d.
The analysis of performance indicators should be used to review the implementation of the mission and the core values of the organization, improve the quality of programs and services, facilitate organizational decision making, and review or update the organization's strategic plan.

1.N.3.a.(1)
1.N.3.a.(2)
1.N.3.a.(3)
1.N.3.b.(1)
1.N.3.b.(2)
1.N.3.b.(3)
1.N.3.c.
The organization is urged to communicate accurate performance information to persons served, personnel, and other stakeholders according to the needs of the specific group, including the format of the information communicated, the content of the information communicated, and the timeliness of the information communicated.

Section 2. General Program Standards

Description

For an organization to achieve quality services, the persons served are active participants in the planning, prioritization, implementation, and ongoing evaluation of the services offered. A commitment to quality and the involvement of the persons served span the entire time that the persons served are involved with the organization. The service planning process is individualized, establishing goals and objectives that incorporate the unique strengths, needs, abilities, and preferences of the persons served. The persons served have the opportunity to transition easily through a system of care.

2.A. Program/Service Structure

Description

A fundamental responsibility of the organization is to provide a comprehensive program structure. The staffing is designed to maximize opportunities for the persons served to obtain and participate in the services provided.

Key Areas Addressed

- Written program plan
- Team composition/duties
- Crisis intervention provided
- Relevant education
- Medical consultation
- Clinical supervision
- Services relevant to diversity
- Family participation encouraged
- Assistance with advocacy and support groups

Recommendations

2.A.21.c.
2.A.21.d.
2.A.21.f.(1)
2.A.21.f.(2)
2.A.21.f.(3)
MHCC offers monthly training for staff; however, this training is not competency based and does not cover person-centered plan development; interviewing skills; and identification of clinical risk factors, including suicide, violence, and other risky behaviors. It is recommended that, for personnel providing direct services, the organization include competency-based training in these areas.

2.A.25.a.
2.A.25.b.
2.A.25.c.
2.A.25.d.
2.A.25.e.
2.A.25.f.
2.A.25.g.
2.A.25.h.
2.A.25.i.

Although there are three team supervisors who have quarterly staff meetings, there are no documented supervision logs. It is recommended that MHCC have documented ongoing supervision of clinical or direct service personnel that addresses the accuracy of assessment and referral skills; the appropriateness of the treatment or service intervention selected relative to the specific needs of each person served; treatment/service effectiveness as reflected by the person served meeting his or her individual goals; risk factors for suicide and other dangerous behaviors; the provision of feedback that enhances the skills of direct service personnel; issues of ethics, legal aspects of clinical practice, and professional standards, including boundaries; clinical documentation issues identified through ongoing compliance review; cultural competency issues; and model fidelity, when implementing evidence-based practices.

2.A.26.a.(1)
2.A.26.a.(2)
2.A.26.b.(1)
2.A.26.b.(2)
2.A.26.b.(3)
2.A.26.b.(4)
2.A.26.b.(5)

Although the organization has secure practices for searches upon arrival at the facility, there are no policies regarding contraband brought into the facility. It is recommended that the organization implement policies and procedures for both persons served and personnel that address the handling of items brought into the program, including illegal drugs, legal drugs, prescription medication, weapons, and tobacco products.

Consultation

- Although the program plan appears to cover all areas, it is suggested that the organization consider elaborating on its philosophy in the program description in order to clearly demonstrate its program philosophy.

2.B. Screening and Access to Services

Description

The process of screening and assessment is designed to determine a person's eligibility for services and the organization's ability to provide those services. A person-centered assessment process helps to maximize opportunities for the persons served to gain access to the organization's programs and services. Each person served is actively involved in, and has a significant role in, the assessment process. Assessments are conducted in a manner that identifies the historical and current information of the person served as well as his or her strengths, needs, abilities, and preferences. Assessment data may be gathered through various means including face-to-face contact, telehealth, or written material; and from various sources including the person served, his or her family or significant others, or from external resources.

Key Areas Addressed

- Screening process described in policies and procedures
- Waiting list
- Ineligibility for services
- Primary and ongoing assessments
- Admission criteria
- Reassessments
- Orientation information provided regarding rights, grievances, services, fees, etc.

Recommendations

2.B.8.a.(1)
2.B.8.a.(2)
2.B.8.b.
2.B.8.d.(1)(c)
2.B.8.d.(1)(d)(iv)
2.B.8.d.(1)(d)(v)
2.B.8.d.(1)(d)(ix)
2.B.8.d.(1)(f)(iii)
2.B.8.d.(1)(f)(iv)
2.B.8.d.(1)(f)(v)
2.B.8.d.(1)(g)(i)
2.B.8.d.(1)(g)(ii)
2.B.8.d.(1)(g)(iii)
2.B.8.d.(2)
2.B.8.d.(3)
2.B.8.d.(4)
2.B.8.d.(5)(a)
2.B.8.d.(5)(b)
2.B.8.d.(5)(c)
2.B.8.d.(5)(d)
2.B.8.d.(5)(e)

Although there is signed confirmation of the orientation process in the record, clients reported that they did not receive an orientation. It is recommended that the orientation be provided in a way that the client understands and that the orientation include the client's presenting condition and the types of services provided. The orientation should include ways in which input can be given and the organization's transition criteria and procedures; discharge criteria; and requirements for reporting and/or follow-up for the mandated person served, regardless of his or her discharge outcome. The orientation should also include the program's health and safety policies regarding illegal or legal substances brought into the program, prescription medication brought into the program, and weapons brought into the program. The orientation should include the program rules and expectations of the person served, which identify any restrictions the program may place on the person served; events, behaviors, or attitudes and their likely consequences; and means by which the person served may regain rights or privileges that have been restricted. Additionally, the orientation should include familiarization with the premises, including emergency exits and/or shelters, fire suppression equipment and first aid kits; education regarding advance directives when indicated; and identification of the purpose and process of the assessment. It is also recommended that the orientation include how the person-centered plan will be developed; the person's participation in goal development and achievement; the potential course of treatment/services; how motivational incentives may be used; and expectations for legally required appointments, sanctions, or court notifications.

2.B.13.b.
2.B.13.c.
2.B.13.d.
2.B.13.e.
2.B.13.h.(1)
2.B.13.h.(2)
2.B.13.j.
2.B.13.m.(4)
2.B.13.n.(1)(b)
2.B.13.n.(2)(a)
2.B.13.n.(2)(b)
2.B.13.n.(2)(c)
2.B.13.n.(2)(d)
2.B.13.q.
2.B.13.r.
2.B.13.t.
Although the assessment process gathers much of the necessary information, it is recommended that it also include the client's strengths; needs; abilities; preferences; medication history and current use profile; efficacy of current or previously used medication; use of complementary health approaches; gender identity; history of witnessed trauma, including abuse, neglect, violence, and sexual assault; literacy level; need for assistive technology in the provision of services; and advance directives.

2.B.14.a.
2.B.14.b.
2.B.14.c.
Although the assessment outlines the client's historical information, there is no interpretive summary that could integrate and interpret from a broader perspective, all history and assessment information collected. The assessment process should include the preparation of a written interpretive summary that is based on the assessment data; identifies any co-occurring disabilities, comorbidities, and/or disorders; and is used in the development of the person-centered plan.

Consultation

- The language used in the orientation does not appear to be understandable to the persons served. The organization may want to modify wording in the orientation materials in order to help make it understandable.
- Although there is a spot for strengths in the assessment, many of the clients stated that they don't have any strengths. It is suggested that staff use this opportunity to help the client identify individual strengths as a way to build rapport and empowerment with the client.

2.C. Person-Centered Plan

Description

Each person served is actively involved in and has a significant role in the person-centered planning process and determining the direction of his or her plan. The person-centered plan contains goals and objectives that incorporate the unique strengths, needs, abilities, and preferences of the person served, as well as identified challenges and potential solutions. The planning process is person-directed and person-centered. The person-centered plan may also be referred to as an individual service plan, treatment plan, or plan of care. In a family-centered program, the plan may be for the family and identified as a family-centered plan.

Key Areas Addressed

- Development of person-centered plan
- Co-occurring disabilities/disorders
- Person-centered plan goals and objectives
- Designated person coordinates services

Recommendations

2.C.1.a.(1)
2.C.1.a.(2)
2.C.1.b.
Although the person-centered plan is developed and in the record, the client's only input into the plan includes his/her strengths, needs, abilities, and preferences. Further, the family/guardian is not involved in the plan, and it is prepared using only limited information from the assessment. It is recommended that the person-centered plan be developed with the active participation of the client; involvement of family/legal guardian of the client, when applicable and permitted; and information from the assessment process.

2.C.2.e.(1)
2.C.2.e.(2)
2.C.2.e.(3)
2.C.2.e.(5)
2.C.2.f.(1)
2.C.2.f.(2)
Although the organization identifies client need for follow-up care and services outside the scope of the organization, the person-centered plan does not address these needs. It is recommended that the plan address any needs beyond the scope of the program, referrals needed for additional services, transition to other community services, and/or available aftercare options. Additionally, many of the clients are legally mandated for services as identified in the assessment; however, legal concerns are not included in the person-centered plan. It is recommended that legal requirements and/or legally imposed fees be included in the person-centered plan.

2.C.3.a.
2.C.3.b.
Although the person-centered plan appears to be completed in a timely manner, there are no procedures identifying the required timeframes. It is recommended that the program implement written procedures identifying timeframes for reviewing and modifying person-centered plans to ensure that the plan for each person served reflects current issues and maintains relevance.

2.C.4.a.(1)
2.C.4.a.(2)
2.C.4.b.(1)
2.C.4.b.(2)
2.C.4.b.(3)
2.C.4.b.(4)
2.C.4.b.(5)(a)
2.C.4.b.(5)(b)
2.C.4.b.(6)
Although the organization conducts a brief risk assessment, there is no safety plan developed for those clients identified as having a potential risk for suicide, violence, or other risky behaviors. It is recommended that a safety plan be developed with these clients as soon as possible that includes triggers; current coping skills; warning signs; actions to be taken; preferred interventions necessary for personal and public safety; and advance directives, when available.

2.C.5.a.
Although the person-centered plan indicates that a client will meet with a psychiatrist or psychologist, there are no specific objectives or interventions related to the specific co-morbidity. When the person served has concurrent disorders or disabilities and/or comorbidities, it is recommended that the person-centered plan specifically address these conditions in an integrated manner.

2.C.6.a.
Although the organization provides services to persons who have intensive medical needs, interventions and objectives do not reflect the integration of these needs into the person-centered plan. If services are provided to persons who have intensive medical needs, the person-centered plan should specifically address how services will be provided in a manner that ensures the safety of the person served.

2.D. Transition/Discharge

Description

Transition, continuing care, or discharge planning assists the persons served to move from one level of care to another within the organization or to obtain services that are needed but are not available within the organization. The transition process is planned with the active participation of each person served. Transition may include planned discharge, placement on inactive status, movement to a different level of service or intensity of contact, or a re-entry program in a criminal justice system.

The transition plan is a document developed with and for the person served and other interested participants to guide the person served in activities following transition/discharge to support the gains made during program participation. It is prepared with the active participation of person served when he or she moves to another level of care, after-care program, or community-based services. The transition plan is meant to be a plan that the person served uses to identify the support that is needed to prevent a recurrence of symptoms or reduction in functioning. It is expected that the person served receives a copy of the transition plan.

A discharge summary is a clinical document written by the program personnel who are involved in the services provided to the person served and is completed when the person leaves the organization (planned or unplanned). It is a document that is intended for the record of the person served and released, with appropriate authorization, to describe the course of services that the organization provided and the response by the person served.

Just as the assessment is critical to the success of treatment, the transition services are critical for the support of the individual's ongoing recovery or well-being. The organization proactively attempts to connect the persons served with the receiving service provider and contact the persons served after formal transition or discharge to gather needed information related to their post-discharge status. Discharge information is reviewed to determine the effectiveness of its services and whether additional services were needed.

Transition planning may be included as part of the person-centered plan. The transition plan and/or discharge summary may be a combined document or part of the plan for the person served as long as it is clear whether the information relates to transition or pre-discharge planning or identifies the person's discharge or departure from the program.

Key Areas Addressed

- Referral or transition to other services
- Unplanned discharge referrals
- Active participation of persons served

- Plan addresses strengths, needs, abilities, preferences
- Transition planning at earliest point
- Follow up for persons discharged for aggressiveness

Recommendations

2.D.1.b.
2.D.1.c.
2.D.1.d.
2.D.1.f.
2.D.1.g.(1)
2.D.1.g.(2)(a)
2.D.1.g.(2)(b)
Although the program offers written procedures for discharge, there does not appear to be written procedures regarding the transfer or transition to another level of care or other services, or for discharge follow-up with clients. It is recommended that the organization develop and implement written procedures for transfer to another level of care, when applicable; transfer to other services; inactive status, if appropriate; follow-up; and identification of when transition planning will occur and where the transitional planning and discharge summary are documented.

2.D.3.e.
2.D.3.f.
2.D.3.g.(1)
2.D.3.g.(2)
2.D.3.g.(3)
2.D.3.g.(4)
The staffing note serves as the transition plan; however, this does not include information on options and resources available if symptoms recur or additional services are needed. It is recommended that the written transition plan include communication of information on options and resources available if symptoms recur or additional services are needed, when applicable. It should also include referral information, such as contact name, telephone number, locations, hours, and days of services, when applicable. MHCC prepares a staffing note that is multidisciplinary and identifies client behaviors, but it does not identify client strengths, needs, abilities, and preferences. It is recommended that strengths, needs, abilities, and preferences be included in the staffing transition note.

2.D.4.a.(1)
2.D.4.a.(2)
2.D.4.a.(3)
Although there are staff and community members who are involved in the transition plan, there is no apparent input from the person served, his/her family/legal guardian, or legally authorized representative. It is recommended that the written transition plan be consistently developed with the input and participation of the person served; the family/legal guardian, when applicable and permitted; and a legally authorized representative, when appropriate.

2.D.5.a.
2.D.5.b.
2.D.5.c.
2.D.5.d.
2.D.5.e.
2.D.5.f.
It is recommended that the program complete a discharge summary for all persons leaving services to ensure that the person served has documented treatment episodes and results of treatment. The discharge summary should include the date of admission, describe the services provided, identify the presenting condition, describe the extent to which established goals and objectives were achieved, describe the reasons for discharge, and identify the status of the person served at last contact.

2.E. Medication Use

Description

Medication use is the practice of controlling, administering, and/or prescribing medications to persons served in response to specific symptoms, behaviors, or conditions for which the use of medications is indicated and deemed efficacious. The use of medication is one component of treatment directed toward maximizing the functioning of the persons served while reducing their specific symptoms. Prior to the use of medications other therapeutic interventions should be considered, except in circumstances that call for a more urgent intervention.

Medication use includes all prescribed medications, whether or not the program is involved in prescribing, and may include over-the-counter or alternative medications. Alternative medications can include herbal or mineral supplements, vitamins, homeopathic remedies, hormone therapy, or culturally specific treatments.

Medication control is identified as the process of physically controlling, storing, transporting, and disposing of medications, including those self-administered by the person served.

Medication administration is the preparing and giving of prescription and nonprescription medications by authorized and trained personnel to the person served. Self-administration is the application of a medication (whether by oral ingestion, injection, inhalation, or other means) by the person served to his/her own body. This may include the program storing the medication for the person served, personnel handing the bottle or prepackaged medication dose to the person served, instructing or verbally prompting the person served to take the medication, coaching the person served through the steps to ensure proper adherence, and/or closely observing the person served self-administering the medication.

Prescribing is the result of an evaluation that determines if there is a need for medication and what medication is to be used in the treatment of the person served. Prior to providing a prescription for medication, the prescriber obtains the informed consent of the individual authorized to consent to treatment and, if applicable, the assent of the person served. Prescription orders may be verbal or written and detail what medication should be given to whom, in what formulation and dose, by what route, when, how frequently, and for what length of time.

Key Areas Addressed

- Scope of medication services provided by the program(s) seeking accreditation
- Education and training provided to direct service personnel at orientation and at least annually
- Education and training provided to persons served, family members, and others identified by the persons served, in accordance with identified needs
- Written procedures that address medication control, administration, and/or prescribing, as applicable to the program
- Use of treatment guidelines and protocols to promote prescribing consistent with standards of care, if applicable to the program
- Peer review of prescribing practices, if applicable to the program

Recommendations

2.E.2.a.(2)
2.E.2.c.(1)
2.E.2.c.(2)
2.E.2.c.(3)
2.E.2.c.(4)
2.E.2.c.(5)
2.E.2.c.(6)
2.E.2.c.(7)
2.E.2.c.(8)
2.E.2.c.(9)
2.E.2.c.(10)
2.E.2.c.(11)
2.E.2.c.(12)
2.E.2.c.(13)
2.E.2.c.(14)
2.E.2.c.(15)
2.E.2.c.(16)

Although MHCC offers training at orientation and annually thereafter, this training does not include the required training for medication control, administering, and/or prescribing. It is recommended that MHCC provide documented annual training and education regarding medications to appropriate direct service personnel that include the purpose of the medication; the benefits and risks associated with medication use; contraindications; side effects; missed doses; potential implications of diet and exercise when using medications; risks associated with medication use during pregnancy; the importance of taking medications as prescribed, including, when applicable, the identification of potential obstacles to adherence; the need for laboratory studies, tests, or other monitoring procedures; early signs that medication efficacy is diminishing; signs of nonadherence to medication prescriptions; potential drug reactions when combining prescription and nonprescription medications; instructions on self-administration, when applicable; the expected course of use of medication, including discontinuation; the availability of financial supports and resources to assist the persons served to obtain needed medications; and what to do in the event there is a question or concern about a medication the person served is taking or has been prescribed.

2.E.4.g.
2.E.4.h.

MHCC reports that it documents medication reactions; however, there were none documented to review and verify. It is recommended that, when the program provides medication control, administering, or prescribing, documentation of all medications for each person served, including prescription and nonprescription medications, include observed and reported medication reactions. Additionally, when PRN medication is administered, the reason that it is administered to the client is not documented. It is recommended that documentation include the reason the medication was administered.

2.E.5.a.
2.E.5.b.

Although the program indicates that it looks up the poison control number on the internet, if needed, it is not readily available. When the program provides medication control or administering, it should provide ready access to the telephone number of a poison control center to program personnel and the persons served.

2.E.6.a.
2.E.6.b.
2.E.6.d.(1)
2.E.6.d.(2)
2.E.6.d.(3)
2.E.6.e.
2.E.6.f.
2.E.6.h.
2.E.6.i.
2.E.6.k.
2.E.6.l.(2)
2.E.6.n.
2.E.6.o.
2.E.6.p.
2.E.6.q.
2.E.6.s.

The organization has implemented a written procedure that addresses assessment of abnormal involuntary movements in clients receiving antipsychotic medication; however, this procedure does not include the frequency of these assessments. It is recommended that written procedures address how medications are integrated into the individualized plan of the person served; the active involvement of the persons served, when able, or members of the family when appropriate, in making decisions related to the use of medications; review of past medication use, including efficacy, side effects, and adverse reactions; identification of alcohol, tobacco, and other drug use; use of over-the-counter medications; use of medications by women of childbearing age, if applicable; use of medications during pregnancy, if applicable; necessary laboratory studies, tests, or other monitoring procedures; documented assessment of abnormal involuntary movements in persons served receiving antipsychotic medications, if applicable, at a frequency that meets the needs of the persons served; review of medication use activities as part of the performance measurement and management system; an evaluation of the risk of diversion; behaviors related to stockpiling of medication; actions to be taken in case of emergencies related to the use of medications; and management of biohazards associated with the administration of medications.

2.E.8.a.
2.E.8.b.
2.E.8.d.(1)
2.E.8.d.(2)
2.E.8.f.
2.E.8.g.

MHCC has procedures for prescribing medications; however, these are limited. It is recommended that written procedures address screening for common medical comorbidities; evaluation of coexisting medical conditions for potential medication impact; documentation of informed consent for each medication prescribed and assent for each medication prescribed, when possible; ongoing reassessment of the current medication profile; and use of a Prescription Drug Monitoring Program (PDMP), when available.

2.E.9.a.(1)
2.E.9.a.(2)
2.E.9.a.(3)
2.E.9.a.(4)(a)
2.E.9.a.(4)(b)
2.E.9.a.(4)(c)
2.E.9.a.(4)(d)
2.E.9.a.(4)(e)
2.E.9.a.(5)(a)(i)
2.E.9.a.(5)(a)(ii)
2.E.9.a.(5)(a)(iii)
2.E.9.a.(5)(b)
2.E.9.a.(5)(c)(i)
2.E.9.a.(5)(c)(ii)
2.E.9.b.(1)
2.E.9.b.(2)
2.E.9.b.(3)

Although MHCC provides medication prescribing, there is no evidence of a documented peer review. A documented peer review should be conducted at least annually by a qualified professional licensed to prescribe or a pharmacist. The peer review should be completed on the records of a representative sample of persons for whom prescriptions were provided to assess the appropriateness of each medication, as determined by the needs and preferences of the person served; the condition for which the medication is prescribed; dosage; periodic reevaluation of continued use related to the primary condition being treated; and the efficacy of the medication. The peer review should determine whether contraindications, side effects, and adverse reactions were identified and, if needed, addressed; whether necessary monitoring protocols were implemented; and whether there was simultaneous use of multiple medications, including polypharmacy and co-pharmacy. The information collected from the peer review process should be reported to appropriate personnel, used to improve the quality of services provided, and incorporated into the performance measurement and management system.

2.F. Promoting Nonviolent Practices

Description

CARF-accredited programs strive to create learning environments for the persons served and to support the development of skills that build and strengthen resiliency and well-being. The establishment of quality relationships between personnel and the persons served provides the foundation for a safe and nurturing environment. Providers are mindful of creating an environment that cultivates:

- Engagement.
- Partnership.
- Holistic approaches.
- Nurturance.
- Respect.
- Hope.
- Self direction.

It is recognized that persons served may require support to fully benefit from their services. This may include, but is not limited to, praise and encouragement, verbal prompts, written expectations, clarity of rules and expectations, or environmental supports.

Even with support there are times when persons served may demonstrate signs of fear, anger, or pain that could lead to unsafe behaviors. Personnel are trained to recognize and respond to these behaviors through various interventions, such as changes to the physical environment, sensory-based calming strategies, engagement in meaningful activities, redirection, active listening, approaches that have been effective for the individual in the past, etc. When these interventions are not effective in de-escalating a situation and there is imminent risk to the person served or others, seclusion or restraint may be used to ensure safety. Seclusion and restraint are never considered treatment interventions; they are always considered actions of last resort.

As the use of seclusion or restraint creates potential physical and psychological risks to the persons subject to the interventions, to the personnel who administer them, and to those who witness the practice, an organization that utilizes seclusion or restraint should have the elimination thereof as its goal.

Seclusion refers to restriction of the person served to a segregated room or space with the person's freedom to leave physically restricted. Voluntary time out is not considered seclusion, even though the voluntary time out may occur in response to verbal direction; the person served is considered in seclusion only if freedom to leave the segregated room or space is denied.

Restraint is the use of physical force or mechanical means to temporarily limit a person's freedom of movement; chemical restraint is the involuntary emergency administration of medication as an immediate response to a dangerous behavior. The following are not considered restraints for the purposes of this section of standards:

- Assistive devices used for persons with physical or medical needs.
- Briefly holding a person served, without undue force, for the purpose of comforting him or her or to prevent self-injurious behavior or injury to others.
- Holding a person's hand or arm to safely guide him or her from one area to another or away from another person.
- Security doors designed to prevent elopement or wandering.
- Security measures for forensic purposes, such as the use of handcuffs instituted by law enforcement personnel. When permissible, consideration is given to removal of physical restraints while the person is receiving services in the behavioral healthcare setting.
- In a correctional setting, the use of seclusion or restraint for purposes of security.

Seclusion or restraint by trained and competent personnel is used only when other, less restrictive measures have been ineffective to protect the person served or others from unsafe behavior. Peer restraint is not an acceptable alternative to restraint by personnel. Seclusion or restraint is not used as a means of coercion, discipline, convenience, or retaliation or in lieu of adequate programming or staffing.

Key Areas Addressed

- Policy addressing how the program will respond to unsafe behaviors of persons served
- Competency-based training for direct service personnel on the prevention of unsafe behaviors
- Policies on the program's use of seclusion and restraint, if applicable
- Competency-based training for personnel involved in the direct administration of seclusion and restraint, if applicable
- Plan for elimination of the use of seclusion and restraint, if applicable
- Written procedures regarding orders for and the use of seclusion and restraint, if applicable
- Review and analysis of the use of seclusion and restraint, if applicable

Recommendations

2.F.4.c.(1)
2.F.4.c.(2)(a)
2.F.4.c.(2)(b)
2.F.4.c.(3)
2.F.4.c.(4)(c)(i)
2.F.4.c.(4)(c)(ii)
2.F.4.c.(7)
Although the organization provides Crisis Prevention Institute (CPI) training, as well as restraint (mechanical) and seclusion training, it does not consider CPI physical restraint techniques as a restraint. It therefore only considers mechanical restraint with respect to restraint standards. It is recommended that all personnel involved in the direct administration of seclusion or restraint, both physical and mechanical, receive documented, competency-based training that is provided by persons or entities qualified to conduct such training and that the training address the circumstances under which seclusion or restraint are indicated; interventions to be used for seclusion or restraint that minimize harm, including interventions done by an individual or those done by a team; signs of physical distress in a person who is being secluded or restrained, including physical risks and psychological risks; and how to continually assess for the earliest release of the seclusion or restraint.

2.F.5.a.(4)(a)
2.F.5.a.(4)(b)
2.F.5.a.(4)(c)
2.F.5.b.(2)
Although the program has developed a plan to eliminate the use of seclusion and/or restraint, it does not include input from persons served, families, or advocates. It is recommended that the program include input regarding the use of seclusion and/or restraint from persons served, families, and advocates into its plan to eliminate the use of seclusion and/or restraint. This plan should be shared with the persons served.

2.F.7.a.(1)(a)
2.F.7.a.(1)(b)
2.F.7.a.(1)(c)
2.F.7.a.(1)(d)
2.F.7.a.(2)(a)
2.F.7.a.(2)(b)
Although there is a risk assessment in the client record, there are no written procedures outlining this process. It is recommended that written procedures be implemented that address risk assessment of each person served, including medical history; trauma history; history of unsafe behaviors resulting in seclusion or restraint; and identification of interventions that have been successful in interrupting unsafe behaviors, when applicable. The risk assessment should result in identification of risks associated with the potential use of seclusion or restraint and precautions to be taken.

2.F.8.c.
2.F.8.h.(1)
Although there is documentation that staff attempted interventions prior to enforcing seclusion, there is no documentation that the personnel indicate the purpose of seclusion and restraint, or that family was notified. It is recommended that when seclusion or restraint is used, documentation in the record of the person served demonstrate that personnel communicate to the person served that the purpose of the seclusion or restraint is to keep him/her and others safe and that in addition to notifying the practitioner, the family is also notified.

2.F.11.b.(3)
2.F.11.c.(1)
2.F.11.c.(2)
2.F.11.c.(6)
2.F.11.c.(7)
2.F.11.c.(8)
2.F.11.c.(9)
2.F.11.c.(10)
Although there is a debriefing process with the client, the family is not included in this process. It is recommended that following the use of seclusion or restraint, a debriefing process include family members, unless contraindicated. The debriefing process should be documented, including a description of the incident, from the perspective of the person served of what he/she experienced; the reasons for the use of seclusion or restraint; the specific intervention used; the person's reaction to the intervention; actions that could make the future use of seclusion or restraint unnecessary; and modifications made to the individualized plan to address issues or behaviors that impact the need to use seclusion or restraint, as applicable.

Consultation

- MHCC may want to consider documenting the demonstration of physical skills associated with CPI physical restraint training as a competency-based element. Similarly, a demonstration of competency with regard to mechanical restraints could serve the same documentation purpose.

2.G. Records of the Persons Served

Description

A complete and accurate record is developed to ensure that all appropriate individuals have access to relevant clinical and other information regarding each person served.

Key Areas Addressed

- Confidentiality
- Timeframes for entries to records
- Individual record requirements
- Duplicate records

Recommendations

2.G.1.a.
Although the organization has appropriate release-of-information forms, it does not appear to have policies or procedures regarding information that can be shared without an authorization. It is recommended that MHCC implement policies and procedures regarding information to be transmitted to other individuals or agencies that include the identification of information that can legally be shared without an authorization for release of information.

2.H. Quality Records Management

Description

The organization implements systems and procedures that provide for the ongoing monitoring of the quality, appropriateness, and utilization of the services provided. This is largely accomplished through a systematic review of the records of the persons served. The review assists the organization in improving the quality of services provided to each person served.

Key Areas Addressed

- Quarterly professional review
- Review current and closed records
- Items addressed in quarterly review
- Use of information to improve quality of services

Recommendations

2.H.1.b.(2)
2.H.1.b.(3)
2.H.1.b.(4)
Although the program provides a review of the records, the review does not address appropriateness of services; patterns of service utilization; and model fidelity, when an evidence-based practice is identified. It is recommended that the program conduct a documented review of the services provided that addresses these topics.

2.H.2.a.
Although the quarterly review is conducted, the staff conducting the review may not be qualified to review provider records. It is recommended that the personnel reviewing provider records be trained and qualified.

2.H.4.d.(1)
2.H.4.d.(2)
Although the organization reviews client records, the review does not address if risk factors were adequately addressed. It is recommended that the records review address whether risk factors were adequately assessed and resulted in safety plans, when appropriate.

2.H.5.a.
2.H.5.b.
2.H.5.c.
Although there is an established review process, the information is not used to enhance services or further train personnel. It is recommended that the organization demonstrate that the information collected from its established review process is used to improve the quality of its services through performance improvement activities, used to identify personnel training needs, and reported to personnel.

Consultation

- Although there are chart reviews that have a check-off for notes as thorough, complete, and timely, the staff members reviewing these notes may not have the skill set to review a psychiatrist's notes. The organization may want to consider selecting someone to review the records who is trained more specifically in this area.
- Although the chart reviewed indicates that the person-centered plan was updated in accordance with the policy, there is no policy on updating person-centered plans. A consultation was given that the organization may want to consider developing a policy that outlines frequency of treatment plan reviews.

Section 3. Core Treatment Program Standards

Description

The standards in this section address the unique characteristics of each type of core program area. Behavioral health programs are organized and designed to provide services for persons who have or who are at risk of having psychiatric disorders, harmful involvement with alcohol or other drugs, or other addictions or who have other behavioral health needs. Through a team approach, and with the active and ongoing participation of the persons

served, the overall goal of each program is to improve the quality of life and the functional abilities of the persons served. Each program selected for accreditation demonstrates cultural competency and relevance. Family members and significant others are involved in the programs of the persons served as appropriate and to the extent possible.

3.F. Crisis Stabilization (CS)

Description

Crisis stabilization programs are organized and staffed to provide the availability of overnight residential services 24 hours a day, 7 days a week for a limited duration to stabilize acute psychiatric or behavioral symptoms, evaluate treatment needs, and develop plans to meet the needs of the persons served. Often crisis stabilization programs are used as a preemptive measure to deter unnecessary inpatient hospitalization.

Key Areas Addressed

- Limited duration overnight residential services 24 hours a day, 7 days a week
- Crisis stabilization plan
- Licensed medical personnel are available 24 hours a day, 7 days a week.
- Referral and linkage to needed services

Recommendations

3.F.2.c.
It is recommended that an initial crisis stabilization plan identify any directives from the person served and/or legal guardian.

Program(s)/Service(s) by Location

Mental Health Crisis Center of Lancaster County

825 J Street
Lincoln, NE 68508

Crisis Stabilization: Mental Health (Adults)

Scott Etherton

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