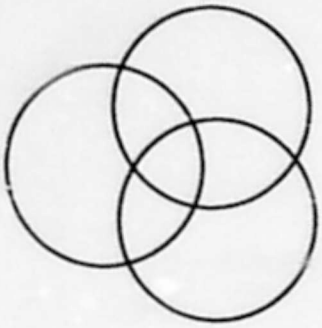
Office of the Ombudsman for Mental Health and Mental Retardation

ANNUAL REPORT

TO THE GOVERNOR

1990

Submitted by the Ombudsman
for Mental Health and Mental Retardation,
Pursuant to Minn. Stat. §245.95, Subd. 2
January, 1991



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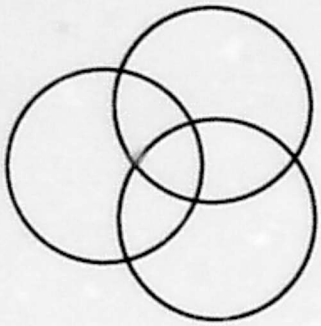


Introduction

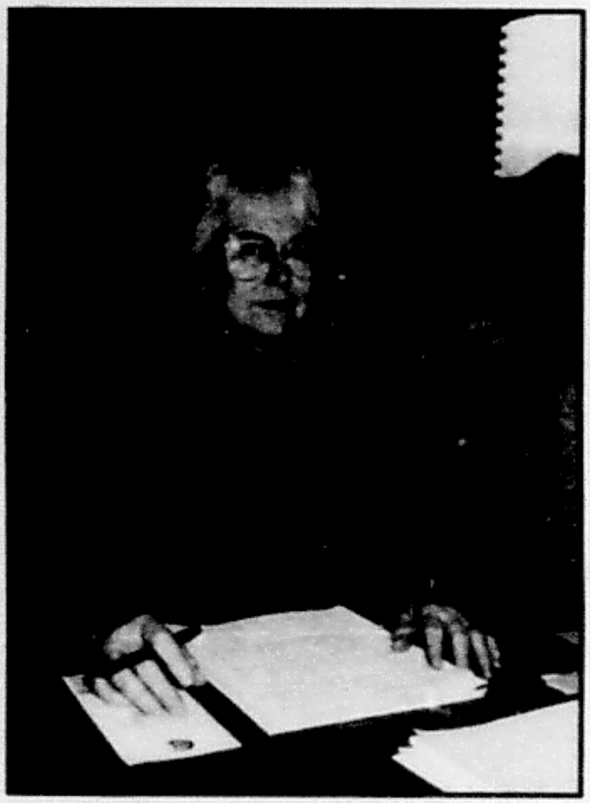
The Office of the Ombudsman for Mental Health and Mental Retardation was created by the 1987 Minnesota Legislature. (Minn. Stat. §245.91 et. seq.).

The Ombudsman has been given a broad mandate to "promote the highest attainable standards of treatment, competence, efficiency, and justice for all people receiving care and treatment for mental illness, mental retardation, chemical dependency, or emotional disturbance."

To carry out the statutory mandate, the Ombudsman has been given the power to:

- prescribe the methods by which complaints to the office are made, reviewed, and acted upon;
- mediate or advocate on behalf of clients;
- investigate the quality of services provided to clients;
- determine the extent to which quality assurance mechanisms work to promote the health, safety, and welfare of clients;
- gather information about and analyze the actions of an agency, facility, or program;
- enter and view premises of an agency, facility, or program;
- examine records of an agency, facility, or program on behalf of a client;
- subpoena a person to appear, give testimony, or produce documents relevant to a matter under inquiry;
- attend Department of Human Services Review Board and Special Review Board proceedings.

The following report, submitted pursuant to Minn. Stat. §245.95, Subd. 2, describes the activities undertaken by the Office of the Ombudsman during 1990.

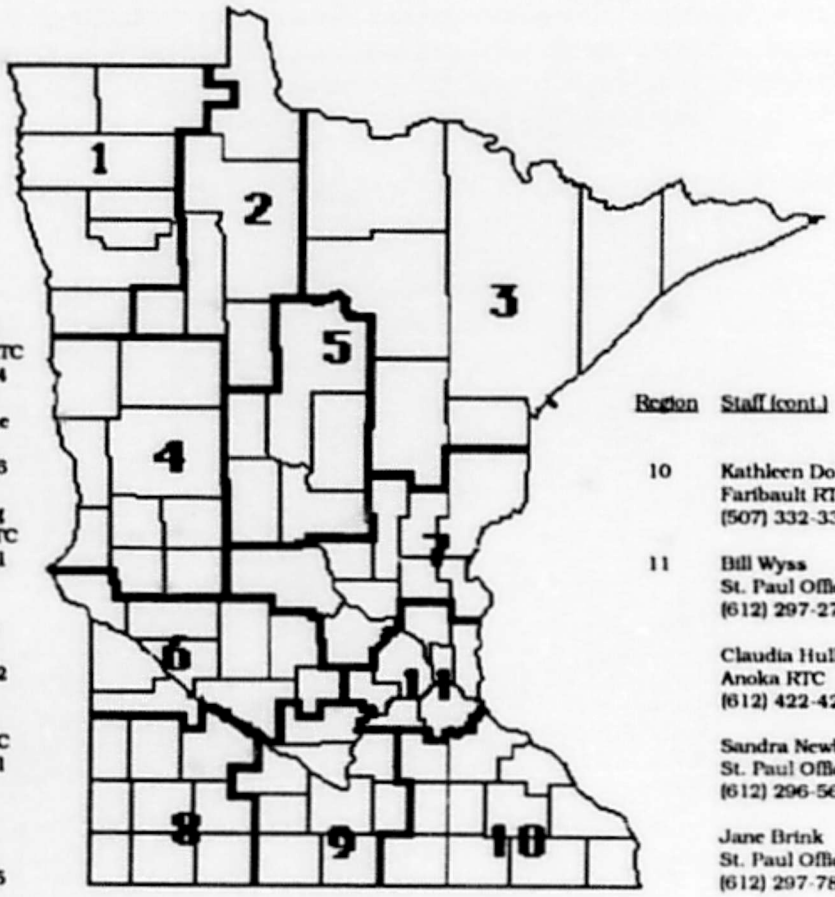


Shirley Hokanson, Ombudsman

Organization of the Office

The Office of the Ombudsman for Mental Health and Mental Retardation consists of a central office in St. Paul and regional offices throughout the state. The regional offices, which are each staffed by a regional client advocate, are located in the Regional Treatment Centers in Anoka, Brainerd, Cambridge, Faribault, Fergus Falls, Moose Lake, St. Peter, and Willmar. The St. Paul staff consists of the Ombudsman, Deputy Ombudsman, a Director of Planning, a Client Mediation and Advocacy Services Coordinator, a Medical Review Coordinator, a Metropolitan Client Advocate Supervisor, two metropolitan client advocates, a student paraprofessional, an office manager, and two secretaries. A strong, cohesive relationship exists between the central office staff and the regional client advocates. Common goals and coordinated work encourages and enhances cooperation in resolving both individual and system complaints.

The client advocates and their respective service areas are delineated below.



Region	Staff
1 & 4	Jerry Hanson Fergus Falls RTC (218) 739-7364
2 & 5	Cheryl Turcotte Brainerd RTC (218) 828-2366
3	Joyce Hultberg Moose Lake RTC (218) 485-4411 Ext. 302
6	Roger Schwab Willmar RTC (612) 231-5962
7	Jim Tausch Cambridge RTC (612) 689-2121 Ext. 337
8 & 9	Glenda Bode St. Peter RTC (507) 931-7105

Region	Staff (cont.)
10	Kathleen Dohmeier Faribault RTC (507) 332-3380
11	Bill Wyss St. Paul Office (612) 297-2762
	Claudia Hulleman Anoka RTC (612) 422-4269
	Sandra Newbauer St. Paul Office (612) 296-5687
	Jane Brink St. Paul Office (612) 297-7853

NOTE: *Although the offices of the regional client advocates are located in the regional treatment centers, staff respond to complaints from the communities, as well as from the regional treatment centers.*

Ombudsman Advisory Committee

At a public meeting in Duluth on October 5, 1990, the Ombudsman Advisory Committee listens to testimony on case management services.

Overview

The Ombudsman Advisory Committee consists of 15 members appointed by the governor to staggered three-year terms. All members of the Committee have a special knowledge of and interest in facilities and programs serving persons with mental illness, mental retardation or related conditions, chemical dependency, or emotional disturbance. The Committee meets on a quarterly basis to advise and assist the Ombudsman.

The Committee's major focus for Fiscal Year 1991 has been an in-depth examination of the issues surrounding the provision of case management services to persons with mental illness, mental retardation, chemical dependency, and emotional disturbance. As part of this review, Committee members held public meetings in Duluth, Moorhead, Minneapolis, Winona, and Marshall to solicit opinions from clients, family members, providers, social service staff, and other interested parties. A report summarizing the issues raised in the public meetings was issued in January, 1991.

Committee Members

The Ombudsman Advisory Committee consisted of the following members in 1990:

Gary Berg

Dr. John Bergstrom (appointed 9/17/90)

Louise Brown

Barbara Case

James Dahlquist

Rebecca Fink

Melvin Goldberg, Chair

Dr. Carl Hansen

Katie O'Brien

Genevieve O'Grady

Rodney Otterness

Terry Schneider

Dorothy Skarnulis

Dr. Lindsey Thomas

James Tweedy

Dr. Ruth Viste (resigned 7/16/90)

Medical Review Subcommittee (MRS)

Medical Review Subcommittee members (L-R): Dr. Carl Hansen, Dr. Lindsey Thomas, Dr. Ruth Viste, Mel Goldberg, and Becky Fink (not pictured Jim Tweedy and Dr. John Bergstrom).

Overview

The Medical Review Subcommittee (MRS) currently consists of six members of the Ombudsman Advisory Committee. The MRS meets on a regular basis to review the causes and circumstances surrounding the deaths of clients. The MRS makes a preliminary determination as to whether each death is unusual or appears to have resulted from other than natural causes. The MRS then aids the Ombudsman in the review of the deaths. Special attention is given to client deaths by suicide and accident. When appropriate, the MRS makes recommendations to the Ombudsman in an effort to improve the quality of care and prevent deaths under similar circumstances. The MRS also reviews selected serious injuries when requested by the Medical Review Coordinator.

Summary of Client Deaths Reported to the Office in 1990

One hundred sixty-nine (169) client deaths were reported to the Office of the Ombudsman in 1990. Ninety-seven (97) of those deaths were of persons with developmental disabilities, 62 were of persons with mental illness, eight were of persons with chemical dependency, and two were of children with emotional disturbance. Most of the deaths were from natural causes; however 15 suicides and two homicides were reported to the Office.

The chart on the following page provides a more detailed breakdown of the 169 deaths reported.

CLIENT DEATHS REPORTED TO THE OFFICE OF THE OMBUDSMAN FOR MENTAL HEALTH AND MENTAL RETARDATION IN 1990

DISABILITY GROUP	SEX		AGE							CAUSE OF DEATH				
	M	F	0-18	19-29	30-39	40-49	50-59	60-69	70 -	N	S	H	A	U
Developmentally Disabled (97)	49	48	10	11	11	12	12	19	22	84	0	1	3	9
Mentally Ill (62)	38	24	3	4	14	6	9	6	20	34	15	1	3	9
Chemically Dependent (8)	6	2	0	2	0	2	2	1	1	6	0	0	0	2
Emotionally Disturbed (2)	1	1	2	0	0	0	0	0	0	0	0	0	1	1
TOTAL (169)	94	75	15	17	25	20	23	26	43	124	15	2	7	21

N = Natural
S = Suicide
H = Homicide
A = Accidental
U = Undetermined

Examples of Cases Reviewed by the Medical Review Subcommittee (MRS)

MRS Concludes Client Had Right to Request Ambulance

A 32 year-old man, with mental retardation and a secondary diagnosis of mental illness, was on an outing to a restaurant with four other clients and a staff person. While waiting for the food, the client went downstairs to the bathroom. He indicated to another person that he was having a heart attack and that an ambulance should be called. Restaurant personnel called an ambulance. The facility staff person was apprised of the situation. She indicated that an ambulance need not be called and went to check on the client.

The client returned to the facility, his vital signs were monitored and the physician was called. The client arrested before the physician arrived. CPR was initiated and an ambulance was called. CPR was continued until the local hospital emergency room staff determined that the client could not be resuscitated.

The case was reviewed by a number of agencies prior to the MRS review. The County substantiated neglect. The Office of Health Facility Complaints concluded that neglect could not be determined.

The MRS concluded that the death probably could not have been prevented; however, the client's request for an ambulance should have been honored. To support this conclusion, the MRS noted that the client was considered competent by the facility's staff. (He represented himself at treatment meetings.) The MRS also noted that the client historically had not presented behaviors such as those displayed in the restaurant and that the facility staff person had not examined the client prior to cancelling the ambulance call.

Based on the MRS's conclusions, the Ombudsman recommended that the facility develop and implement a policy that affirms a client's right to request emergency medical care and that any exceptions to the policy and the rationale for such exceptions be noted in the policy.

In a letter to all residential and non-residential facilities providing care, treatment, or programming for persons with mental retardation, the Ombudsman suggested that they too consider developing and implementing such a policy.

MRS Balances Safety and Privacy Needs

A 48 year-old woman died as the result of cardiorespiratory arrest, probably related to seizure. Her diagnosis, aside from the seizure disorder, included profound mental retardation. Staff members in the residential facility where she lived placed her on the commode. For her safety, she was secured to the commode by a safety belt. For reasons of privacy, the client was left alone for 15 minutes. When the staff returned, she was found slumped forward and in cardiorespiratory arrest. The client died in the emergency room.

The MRS review focused on the documentation during the month before the client died. She had sustained several injuries from falls probably related to seizure activity. She also had some behavioral and motor changes which prompted an evaluation by a neurologist. Until the time of her death, the care given the client was appropriate and necessary. However, the MRS concluded that the deteriorating condition of the client and the unpredicability of her seizure activity warranted close supervision by the staff. Leav-

ing her unattended without checking for 15 minutes, when she was secured to one position, was inappropriate. While staff respect for client privacy in the bathroom is most appropriate, the safety and close supervision needs of this client called for a routine and frequent schedule of checking on her while in the bathroom.

The MRS closed the case with the recommendation that the facility carefully balance the need for privacy and the need for safety on an individual basis.

MRS Reviews Death of Client with Multiple Physical Diagnoses and Chemical Dependency

A thirty-three year old woman was committed as chemically dependent and admitted to a treating facility. She had a long history of alcoholism and was in poor general health because of hepatitis. At the time of commitment, the examining physician stated that the client's prognosis would be grave if she were not treated both medically and with respect to her addiction.

At admission, the client was given no physical diagnoses and embarked on the chemical dependency program. The treatment plan, while indicating her chemical use was life threatening, did not elaborate on the seriousness of her medical problems. The client left the program without leave on three occasions, the last time approximately two months before her death. She died in a community acute care hospital. The cause of her death was esophageal varices with a massive gastrointestinal bleed secondary to her alcohol abuse.

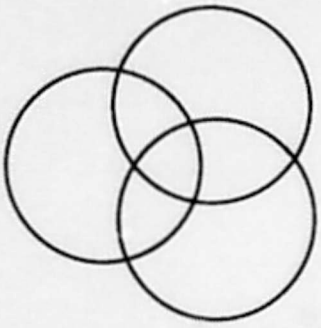
The MRS review indicated that the court physician's assessment of the need for both medical and chemical dependency treatment, was appropriate and that the treatment program seemed unable to provide this. The MRS requested that the treating facility review and evaluate the capability of the Chemical Dependency Program to appropriately treat persons who are committed with both medical and chemical dependency issues.

MRS Reviews Death of Client with Limited Language Skills

A thirty-eight year old man, committed as mentally ill, was admitted for treatment in early 1989. The client, who had immigrated from a Southeast Asian county in 1975, had a history of mental illness that included four serious suicide attempts and paranoid delusions. The client committed suicide while an inpatient in the fall of 1989.

There were numerous references throughout the client's medical record to his isolativeness, his hygiene, his ritualistic behavior and his poor appetite. While problems were identified, the effect of his culture and ethnicity were not considered. The MRS found that the staff failed to assess the client's language barriers and the resultant social isolation; the impact of his separation from his family (His father was still in Southeast Asia.); his inability to fulfill role expectations as the eldest son; cultural dietary preferences (even though the client identified this as a problem); and the client's traditions, beliefs and self-care practices.

Based on these findings, the MRS requested that the treating facility provide educational programs to the staff on assessing and planning care for clients with limited language skills and on traditional cultural beliefs and practices. In addition, an assessment component for interpretive services was requested.



Investigation of Complaints

General Complaint Overview: Matters Appropriate for Review

Pursuant to the Ombudman's power to prescribe the methods by which complaints to the Office are made, reviewed, and acted upon, the Ombudsman Office developed a complaint review protocol. (See Appendix B for full text).

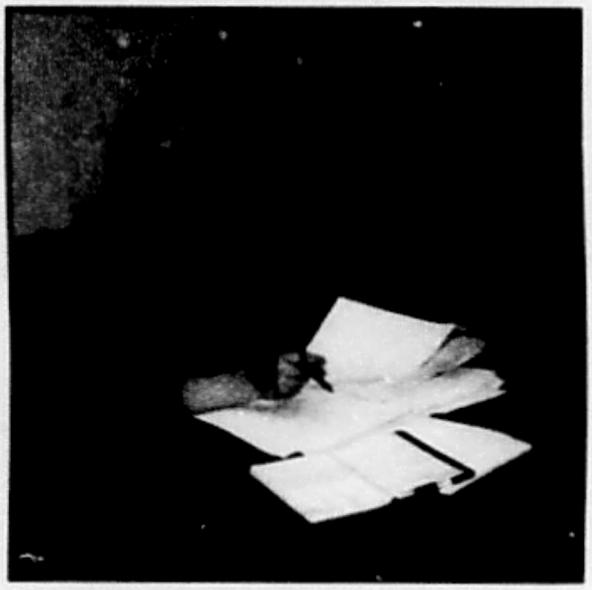
In selecting matters for review by the Office, the Ombudsman is directed to give particular attention to unusual deaths or injuries of a client served by an agency, facility, or program, or actions of an agency, facility, or program that:

- may be contrary to law or rule;
- may be unreasonable, unfair, oppressive, or inconsistent with a policy or order of an agency, facility, or program;
- may be mistaken in law or arbitrary in the ascertainment or facts;
- may be unclear or inadequately explained, when reasons should have been revealed;
- may result in abuse or neglect of a person receiving treatment;
- may disregard the rights of a client or other individual served by an agency or facility;
- may impede or promote independence, community integration, and productivity for clients; or
- may impede or improve the monitoring or evaluation of services provided to clients.

Complaint Statistics

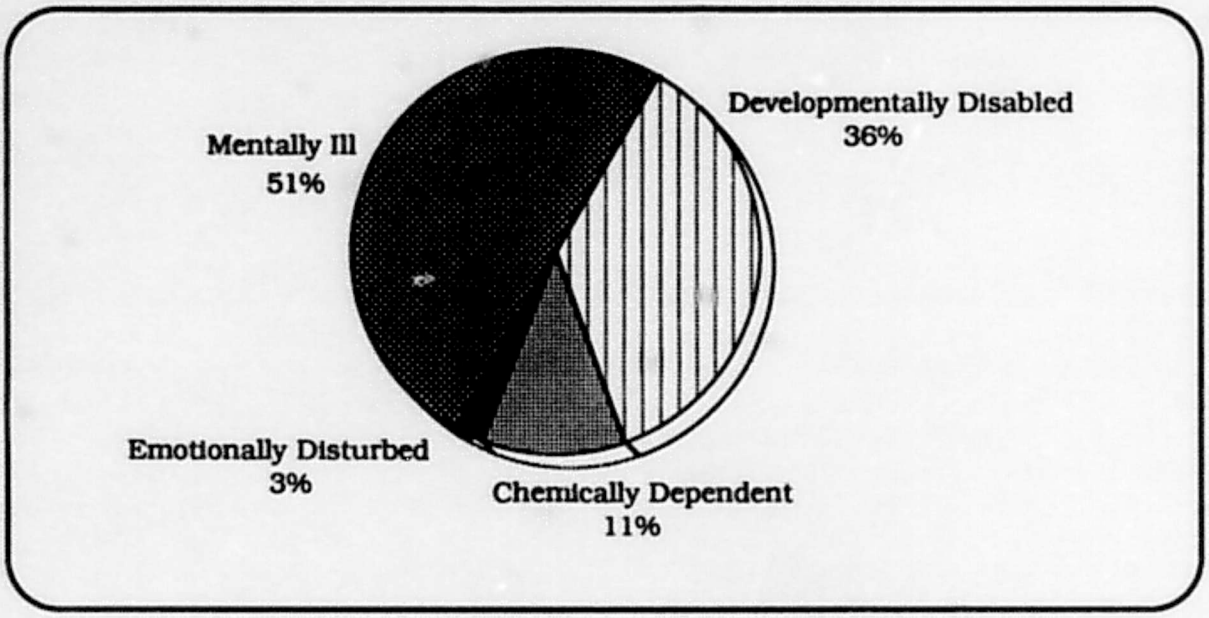
The Office of Ombudsman received over 2,800 complaints during 1990. Most of these complaints were resolved at the local level. Some of the complaints evolved into systemic issues which required a more in-depth review, often resulting in a report or recommendations to the agency, facility, or program affected.

The graphs on the following page detail the nature and substance of the complaints received by the Office during the proceeding year.

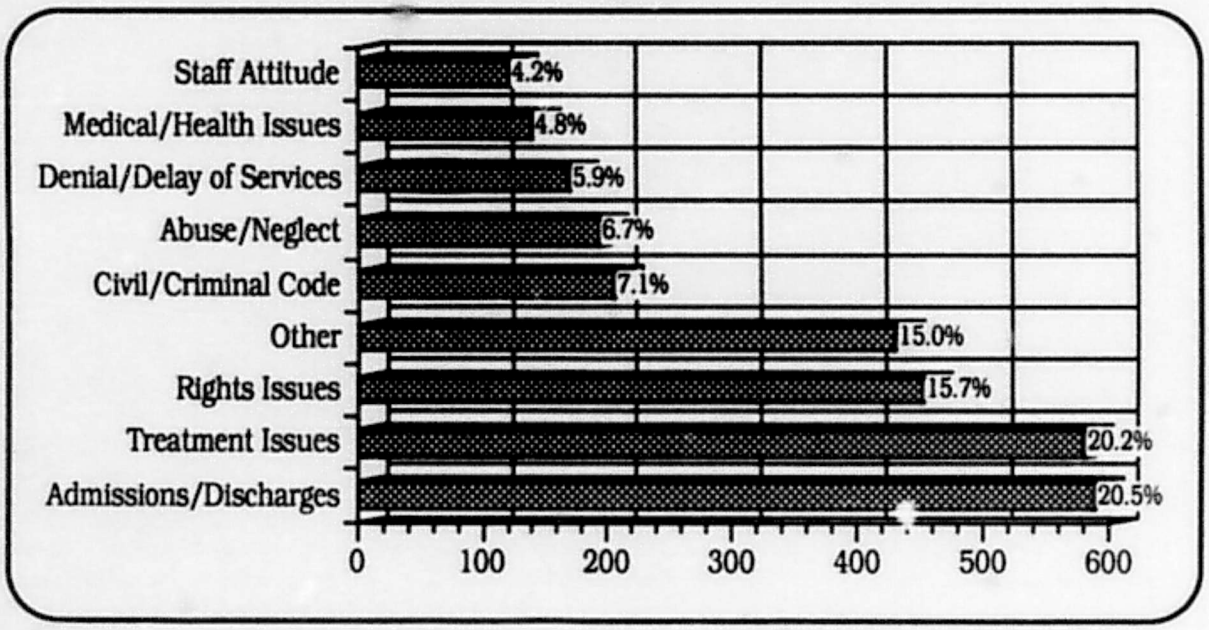


Metro Client Advocates Sandra Newbauer and Jane Brink conferring on a case.

COMPLAINTS BY DISABILITY GROUPS (1990)



NATURE OF THE COMPLAINTS (1990)



Examples of Cases Handled by Client Advocates

A client contacted the regional client advocate with a concern over the reduction in her psychotropic medications. She had experienced emotional and behavioral difficulties in the past when her medications were reduced and was afraid it would happen again. The advocate spoke with the medical staff involved. They were aware of the past difficulties when her medications were reduced. A gradual reduction was appropriate in their opinion, as it had been several years since a reduction had been attempted and the client's circumstances and functioning abilities were improved and stable at this time. The client was to be observed closely for any emotional/behavioral changes during the very gradual reduction. The advocate discussed the reduction plan with the client and although she was still somewhat concerned, she understood the medical reasons and agreed to cooperate with the reduction process.

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A young girl's grandmother sought help for her granddaughter who was living at home with her mother and stepfather. The child was having serious problems within her immediate family's environment and also in school due to her behaviors. The grandmother stated that "no services could be provided because her worker felt there was no problem." The regional client advocate worked with the county case manager and an advocate of the Alliance for the Mentally Ill to facilitate an assessment of the child's difficulties, so that an individual services plan could be developed. The girl will receive a 30 day evaluation with services pending the outcome of the evaluation. The advocate continued to monitor this child's case.

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A client with serious and persistent mental illness who was being discharged from an RTC attempted to rent a mobile home on a lot in a local mobile home park. The manager of the mobile home park refused to let the client move in unless he got a letter from the client's doctor stating that the client would not be a threat to anyone else residing in the park. After consulting with the regional client advocate, the unit director called the manager of the mobile home park. The unit director told the manager he couldn't require the doctor's statement because that would be discrimination based on disability. If he continued to require the statement, a complaint would be filed with the Department of Human Rights. The manager, after consulting his attorney, called the unit director back and assured her that there were spaces available for rent.

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A client who was living at a community Rule 36 facility contacted a metro client advocate. The facility was planning to discharge the client in January, 1990, but the client did not feel she was ready for discharge. To address the client's complaint, the advocate met with the client and staff. All parties agreed to extend the client's treatment until the summer of 1990. The client was satisfied with the extension and a few additional goals were added.

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An 81 year-old client who was mentally ill and dangerous was to be transferred to a Geriatric program at an RTC. The client was very upset over this transfer when informed of it on the day the transfer was to occur. At the client's request, the re-

gional client advocate asked that the Medical Director put the transfer on hold while the advocate worked on an appeal. The transfer was appealed based on the fact that the client had been doing very well on his present unit, and had a job he would lose if he were moved to a different unit. The advocate suggested keeping the client on his present unit, while staff worked on discharge plans. The Medical Director agreed with this plan and the staff are now looking at discharge options.

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The regional client advocate was contacted regarding a client's anxiety over his pending discharge to a community residence. The advocate met with the client and a vocational staff member. The client's feelings about the planned discharge and his current residence at the RTC were discussed. The planning process that occurs prior to a discharge and the protection and monitoring services that are available in the community were described to the client. The client was advised of available community resources and how to access them. The client stated he would give the move a try.

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Metro client advocates were able to help a client with Praider-Willi syndrome move into a community residence rather than go to an RTC. Although the client's psychiatrist did not feel an RTC environment was necessary, a community placement had not been pursued. Client advocates were able to assist the parents in setting up appointments with community proviers, which resulted in two facilities accepting the client. The client is currently in a program in the county of financial responsibility, as the parents pursue placement in an out-of-county facility they feel will better serve their son's needs. Commitment proceedings were halted.

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While responding to a client inquiry, the regional client advocate determined that there was a larger policy issue to be addressed: the process used to decide when a client should appropriately return to his/her vocational/day programming assignment following an illness or injury, and how this process is implemented. The advocate met with the facility's medical director and day program director to review the policy. As a result of this meeting, the policy was amended to clarify and address these concerns.

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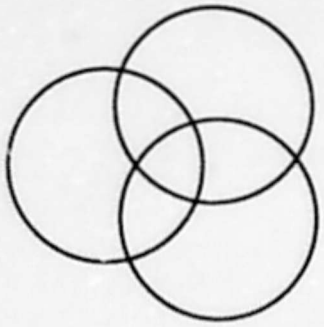
Metro client advocates were contacted by a client who was given a discharge notice to be out of a residential facility in a matter of hours due to a complicated medical situation. Advocates assisted the client in being placed in another chemical dependency treatment setting and in resolving the medical issue, which allowed him to be reinstated in his original treatment program (which he desired). The program is in the process of revising it's discharge policy and notice procedure. The client expressed appreciation with being able to continue treatment without further interruption.



Serious Injury Reports

The law mandating the reporting of all client deaths and serious injuries to the Ombudsman Office, Minn. Stat. §245.94, Subd. 2a, became effective on August 1, 1989. This law has allowed the Office to monitor occurrences of serious injuries in facilities and programs serving clients with mental illness, mental retardation or related conditions, chemical dependency, and emotional disturbance.

One of the purposes of collecting the data is to provide feedback to providers, to help them identify clients at risk of serious injury and to help them identify problem areas in general. This information is intended to enhance providers' perspectives on quality of care for their clients.

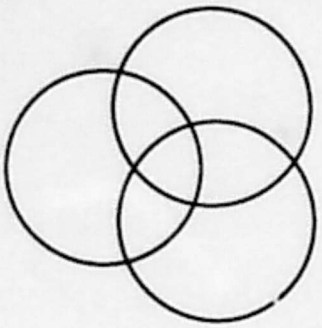
After reviewing the 679 serious injuries that were reported in Fiscal Year 1990 (July 1, 1989 - June 30, 1990), the following trends were identified:

- Sixty-two percent (62%) of all serious injuries reported were fractures. Sixty-four percent (64%) of the fractures occurred in persons with mental retardation or related conditions, 21% occurred among clients with mental illness, 10% among clients with emotional disturbance, and 4% among clients with chemical dependency. The frequency of fractures among persons with mental retardation was consistent with the fact that two-thirds of all serious injuries reported involved this population. A closer examination revealed a common factor within this group: a diagnosed seizure disorder. Forty-eight percent (48%) of the fractures that occurred in persons with mental retardation involved persons who had a seizure disorder.

- Overall, head injuries and dental injuries are the second and third most common types of injuries reported, with each comprising about 5% of the serious injuries reported. A more detailed examination of the injuries among clients who live in community programs revealed that: internal injuries were the second most commonly reported injury among clients with mental illness, while burns were the second most common serious injury to clients with mental retardation. Among clients in the Regional Treatment Centers, the data revealed: ingestion of poison or harmful substances was the second most common injury among clients with mental illness, while dental injuries were the second most common injury among clients with mental retardation. Dental injuries were found primarily in clients with mental retardation or related conditions.

Serious injury reports are reviewed not only as aggregate data but also on an individual basis. For example, quality of care issues affecting an individual client who has sustained an injury are addressed by having a client advocate work with the client and staff to prevent future injuries. Recommendations to change or modify policies or procedures also are often made.

A complete report summarizing the serious injuries reported in Fiscal Year 1990 and the implications of the findings will be available in early 1991. The Ombudsman anticipates that the report will be of assistance to facility and program directors.



Systemic/Focused Reviews

The Office of the Ombudsman for Mental Health and Mental Retardation has taken an in-depth look at several systemic issues in an effort to improve the quality of services and treatment to persons with mental illness, mental retardation or related condition, chemical dependency, and emotional disturbance. The following are some of the issues that were examined in the past year:

Ombudsman Office Conducts Survey of Rule 5 Programs

The Ombudsman Office conducted an in-depth survey of Rule 5 Programs in Minnesota in 1990. Rule 5 is the DHS liscensing rule that licenses facilities for treatment of children/adolescents with emotional disturbances. A report, with findings and recommendations, was made public in December, 1990.

Homeward Bound (New Hope) Review

In response to several complaints regarding quality of care, the Ombudsman Office undertook a thorough review of services provided by Homeward Bound, Inc. of New Hope (HBINH). HBINH is a 52 bed residential facility that provides care for children and young adults with mental retardation. Many of the residents also have multiple physical disabilities.

The Office sent a full report of its investigation, with specific recommendations, to HBINH in August. Since release of the report, new management has been named by the Board of Directors.

Recent monitoring by Ombudsman staff indicates that progress is being made on some of the concerns expressed by the Office.

The Ombudsman Office is continuing to monitor HBINH and do everything possible to assist in resolving the concerns and issues raised in the report.

Ombudsman Writes to County Sheriffs Regarding Transportation of Clients to Regional Treatment Centers

In response to several complaints, the Ombudsman wrote a letter to all County Sheriffs regarding the use of marked police vehicles and uniformed officers.

When a Petition for Commitment is filed, the County Sheriff is generally assigned the responsibility of transporting clients to court hearings and examiner appointments.

Citing several sections of the Minnesota Commitment Act relating to this issue, the Ombudsman urged the assistance of the County Sheriffs "in limiting the use of

uniformed officers and marked police vehicles" to "insure the protection of the rights of people with mental illness, chemical dependency, and developmental disabilities."

Ombudsman Urges Facilities and Programs to Review Water Safety Policies

The Ombudsman wrote a letter to all facilities and programs that provide services to persons with developmental disabilities. The letter reminded the facilities and programs to examine their water safety policies prior to the outdoor swimming season. The letter was written in response to a drowning which the Medical Review Subcommittee (MRS) reviewed last year. At the conclusion of the review, the MRS concluded that adherence to basic swimming safety rules, as well as the facility policy, might have prevented the client's death.

The Ombudsman, in her letter, recommended that facilities: 1) review program policies that cover activities for clients to provide the assurance that facility policies are appropriate to meet the needs of the clients; 2) hold an inservice program that would focus on the topic of water safety for staff members and for clients; and 3) review the individual vulnerability plans of each cleint.

A copy of the Red Cross' Safety Tips for Swimming was enclosed with each letter.

Ombudsman Urges County Sheriffs to Refrain From Using Handcuffs When Transporting Patients to Regional Treatment Centers (RTCs)

In response to a complaint, the Ombudsman urged all County Sheriffs to refrain from handcuffing admittees with mental illness, when at all possible, during their transport to RTCs.

The Ombudsman noted that pursuant to Minn. Stat. §253B.03 Subd. 1, a patient has the right to be free from restraints, with exceptions for the safety of the patient and others. The definition of patient, found in Minn. Stat. §253B.02 Subd. 15, is "any person who is institutionalized or committed under this chapter". Therefore, an admittee who is committed to an RTC appears to have the right to be free from restraints, unless the head of the treatment facility or a member of the medical staff determines that restraints are necessary for the safety of the patient or others.

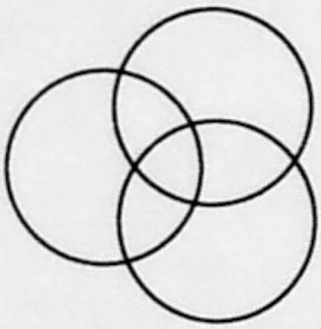
The Ombudsman stressed that, when at all possible, it would seem advisable to transfer admittees without handcuffs, so as to avoid embarrassment and the connotation that they are criminals.

Ombudsman Urges DACs to Protect Clients Against Harmful Noise

In response to a facility visit by a regional Client Advocate to a Developmental Achievement Center (DAC), the Ombudsman has sent a letter to all DAC Program Directors urging them to protect clients against irritating, harmful noise.

In the DAC visited by the regional Client Advocate, the screech of the electric sander caught her attention. When staff were asked why protective devices for ears were not used, responses ranged from acceptance of the noise to "clients don't like to wear the protection."

The Ombudsman urged DAC Program Directors to determine whether their DAC had irritating, harmful noise, and if so, to insist that staff and clients wear protective devices. The Ombudsman stressed that it was crucial that staff model behavior for the clients, to increase client acceptance of the protective devices.



Legislative Efforts

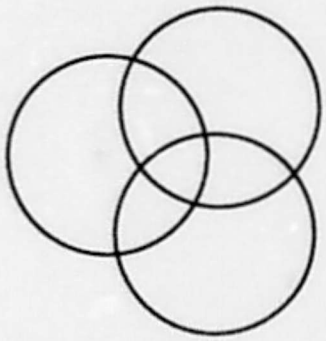
The Office of the Ombudsman for Mental Health and Mental Retardation proposed one legislative initiative in the 1990 Legislative Session. The Office requested a clarification regarding the Ombudsman's right to have access to private data on decedents who were receiving services or treatment for mental illness, mental retardation or related condition, or emotional disturbance. The change was necessary to insure that the Ombudsman Office and the Ombudsman's Medical Review Subcommittee had access to the necessary client records in order to review client deaths. The Legislature passed the bill and it was signed by Governor Perpich on April 5, 1990. The change became effective on August 1, 1990.

The Ombudsman also testified on a bill regarding the use of restrictive techniques and procedures in facilities serving emotionally disturbed children. The bill, as passed by the Legislature and signed into law by the Governor, requires the commissioner of human services to include provisions governing the use of restrictive techniques and procedures when amending the rules governing facilities servicing emotionally disturbed children.

Over 2,800 complaints were handled by the Office during the past year. Some of these complaints evolved into systemic issues which required a more in-depth review, often resulting in a report and recommendations.

Client Advocates participated in the screening process for persons with mental retardation or related conditions leaving the Regional Treatment Centers.

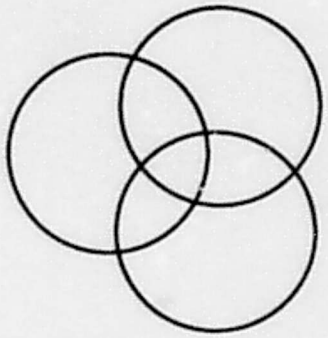
The challenges remain many in the Office's effort to promote the highest standards of treatment, competency, efficiency, and justice for all people receiving care or treatment for mental illness, mental retardation or related condition, chemical dependency, or emotional disturbance. Progress was made in 1990, but many challenges lie ahead in the years to come.



Summary

The past year has been a very busy, active year for the Office of the Ombudsman for Mental Health and Mental Retardation.

Nineteen ninety was the first full year of mandatory reporting of client deaths and serious injuries to the Office. Seven hundred and twenty (720) serious injuries and 169 deaths were reported to the Office in 1990. Death Review and Serious Injury Review Guidelines were developed to efficiently handle these many reports.



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Appendix A

OMBUDSMAN STATUTE: MINN. STAT. §245.91-.97

245.91 DEFINITIONS.

Subdivision 1. **Applicability**. For the purposes of sections 245.91 to 245.97, the following terms have the meanings given them.

Subd. 2. **Agency**. "Agency" means the divisions, officials, or employees of the state departments of human services and health, and of designated county social service agencies as defined in section 256G.02, subdivision 7, that are engaged in monitoring, providing, or regulating services or treatment for mental illness, mental retardation or a related condition, chemical dependency, or emotional disturbance.

Subd. 3. **Client**. "Client" means a person served by an agency, facility, or program, who is receiving services or treatment for mental illness, mental retardation or a related condition, chemical dependency, or emotional disturbance.

Subd. 4. **Facility or program**. "Facility" or "program" means a nonresidential or residential program as defined in section 245A.02, subdivisions 10 and 14, that is required to be licensed by the commissioner of human services, and an acute care inpatient facility that provides services or treatment for mental illness, mental retardation or a related condition, chemical dependency, or emotional disturbance.

Subd. 5. **Regional center.** "Regional center" means a regional center as defined in section 253B.02, subdivision 18.

Subd. 6. **Serious Injury**. "Serious injury" means:

(1) fractures;
(2) dislocations;
(3) evidence of internal injuries;
(4) head injuries with loss of consciousness;
(5) lacerations involving injuries to tendons or organs, and those for which complications are present;
(6) extensive second degree or third degree burns, and other burns for which complications are present;
(7) extensive second degree or third degree frost bite, and others for which complications are present;
(8) irreversible mobility or avulsion of teeth;
(9) injuries to the eyeball;
(10) ingestion of foreign substances and objects that are harmful;
(11) near drowning;
(12) heat exhaustion or sunstroke; and
(13) all other injuries considered serious by a physician.

245.92 OFFICE OF OMBUDSMAN; CREATION; QUALIFICATIONS; FUNCTION.

The ombudsman for persons receiving services or treatment for mental illness, mental retardation or a related condition, chemical dependency, or emotional disturbance shall promote the highest attainable standards of treatment, competence, efficiency, and justice. The ombudsman may gather information about decisions, acts, and other matters of an agency, facility, or program. The ombudsman is appointed by the governor,

serves in the unclassified service, and may be removed only for just cause. The ombudsman must be selected without regard to political affiliation and must be a person who has knowledge and experience concerning the treatment, needs, and rights of clients, and who is highly competent and qualified. No person may serve as ombudsman while holding another public office.

245.93 ORGANIZATION OF OFFICE OF OMBUDSMAN.

Subdivision 1. **Staff**. The ombudsman may appoint a deputy and a confidential secretary in the unclassified service and may appoint other employees as authorized by the legislature. The ombudsman and the full-time staff are members of the Minnesota state retirement association.

Subd. 2. **Advocacy**. The function of mental health and mental retardation client advocacy in the department of human services is transferred to the office of ombudsman according to section 15.039. The ombudsman shall maintain at least one client advocate in each regional center.

Subd. 3. **Delegation**. The ombudsman may delegate to members of the staff any authority or duties of the office except the duty of formally making recommendations to an agency or facility or reports to the governor or the legislature.

245.94 POWERS OF OMBUDSMAN; REVIEWS AND EVALUATIONS; RECOMMENDATIONS.

Subdivision 1. **Powers**. (a) The ombudsman may prescribe the methods by which complaints to the office are to be made, reviewed, and acted upon. The ombudsman may not levy a complaint fee.

(b) The ombudsman may mediate or advocate on behalf of a client.

(c) The ombudsman may investigate the quality of services provided to clients and determine the extent to which quality assurance mechanisms within state and county government work to promote the health, safety, and welfare of clients, other than clients in acute care facilities who are receiving services not paid for by public funds.

(d) At the request of a client, or upon receiving a complaint or other information affording reasonable grounds to believe that the rights of a client who is not capable of requesting assistance have been adversely affected, the ombudsman may gather information about and analyze, on behalf of the client, the actions of an agency, facility, or program.

(e) The ombudsman may examine, on behalf of a client, records of an agency, facility, or program if the records relate to a matter that is within the scope of the ombudsman's authority. If the records are private and the client is capable of providing consent, the ombudsman shall first obtain the client's consent. The ombudsman is not required to obtain consent for access to private data on clients with mental retardation or a related condition. The ombudsman is not required to obtain consent for access to private data on decedents who were receiving services for mental illness, mental retardation or a related condition, or emotional disturbance.

(f) The ombudsman may subpoena a person to appear, give testimony, or produce documents or other evidence that the ombudsman considers relevant to a matter under inquiry. The ombudsman may petition the appropriate court to enforce the subpoena. A witness who is at a hearing or is part of an investigation possesses the same privileges that a witness possesses in the courts or under the law of this state. Data obtained from

a person under this paragraph are private data as defined in section 13.02, subdivision 12.

(g) The ombudsman may, at reasonable times in the course of conducting a review, enter and view premises within the control of an agency, facility, or program.

(h) The ombudsman may attend department of human services review board and special review board proceedings; proceedings regarding the transfer of patients or residents, as defined in section 246.50, subdivisions 4 and 4a, between institutions operated by the department of human services; and, subject to the consent of the affected client, other proceedings affecting the rights of clients. The ombudsman is not required to obtain consent to attend meetings or proceedings and have access to private data on clients with mental retardation or a related condition.

(i) The ombudsman shall have access to data of agencies, facilities, or programs classified as private or confidential as defined in section 13.02, subdivisions 12 and 13, regarding services provided to clients with mental retardation or a related condition.

(j) To avoid duplication and preserve evidence, the ombudsman shall inform relevant licensing or regulatory officials before undertaking a review of an action of the facility or program.

(k) Sections 245.91 to 245.97 are in addition to other provisions of law under which any other remedy or right is provided.

Subd. 2. **Matters appropriate for review.** (a) In selecting matters for review by the office, the ombudsman shall give particular attention to unusual deaths or injuries of a client served by an agency, facility, or program, or actions of an agency, facility, or program that:

(1) may be contrary to law or rule;

(2) may be unreasonable, unfair, oppressive, or inconsistent with a policy or order of an agency, facility, or program;

(3) may be mistaken in law or arbitrary in the ascertainment of facts;

(4) may be unclear or inadequately explained, when reasons should have been revealed;

(5) may result in abuse or neglect of a person receiving treatment;

(6) may disregard the rights of a client or other individual served by an agency or facility;

(7) may impede or promote independence, community integration, and productivity for clients; or

(8) may impede or improve the monitoring or evaluation of services provided to clients.

(b) The ombudsman shall, in selecting matters for review and in the course of the review, avoid duplicating other investigations or regulatory efforts.

Subd. 2a. **Mandatory Reporting**. Within 24 hours after a client suffers death or serious injury, the facility or program director shall notify the ombudsman of the death or serious injury.

Subd. 3. **Complaints**. The ombudsman may receive a complaint from any source concerning an action of an agency, facility, or program. After completing a review, the ombudsman shall inform the complainant and the agency, facility, or program. No client may be punished nor may the general condition of the client's treatment be unfavorably altered as a result of an investigation, a complaint by the client, or by another person on the client's behalf. An agency, facility, or program shall not retaliate or take adverse action, as defined in section 626.557, subdivision 17, paragraph (c), against a client or

other person, who in good faith makes a complaint or assists in an investigation.

Subd. 4. **Recommendations to agency.** (a) If, after reviewing a complaint or conducting an investigation and considering the response of an agency, facility, or program and any other pertinent material, the ombudsman determines that the complaint has merit or the investigation reveals a problem, the ombudsman may recommend that the agency, facility, or program:

(1) consider the matter further;
(2) modify or cancel its actions;
(3) alter a rule, order, or internal policy;
(4) explain more fully the action in question; or
(5) take other action.

(b) At the ombudsman's request, the agency, facility, or program shall, within a reasonable time, inform the ombudsman about the action taken on the recommendation or the reasons for not complying with it.

245.95 RECOMMENDATIONS AND REPORTS TO GOVERNOR.

Subdivision 1. **Specific reports.** The ombudsman may send conclusions and suggestions concerning any matter reviewed to the governor. Before making public a conclusion or recommendation that expressly or implicitly criticizes an agency, facility, program, or any person, the ombudsman shall consult with the governor and the agency, facility, program, or person concerning the conclusion or recommendation. When sending a conclusion or recommendation to the governor that is adverse to an agency, facility, program, or any person, the ombudsman shall include any statement of reasonable length made by that agency, facility, program, or person in defense or mitigation of the office's conclusion or recommendation.

Subd. 2. **General reports.** In addition to whatever conclusions or recommendations the ombudsman may make to the governor on an ad hoc basis, the ombudsman shall at the end of each year report to the governor concerning the exercise of the ombudsman's functions during the preceding year.

245.96 CIVIL ACTIONS.

The ombudsman and his designees are not civilly liable for any action taken under sections 245.91 to 245.97 if the action was taken in good faith, was within the scope of the ombudsman's authority, and did not constitute willful or reckless misconduct.

245.97 OMBUDSMAN COMMITTEE.

Subdivision 1. **Membership.** The ombudsman committee consists of 15 members appointed by the governor to three-year terms. Members shall be appointed on the basis of their knowledge of and interest in the health and human services system subject to the ombudsman's authority. In making the appointments, the governor shall try to ensure that the overall membership of the committee adequately reflects the agencies, facilities, and programs within the ombudsman's authority and that members include consumer representatives, including clients, former clients, and relatives of present or former clients; representatives of advocacy organizations for clients and other individuals served by an agency, facility, or program; human services and health care professionals including specialists in psychiatry, psychology, internal medicine, and forensic pathology; and other providers of services or treatment to clients.

Subd. 2. **Compensation; chair.** Members do not receive compensation, but are entitled to receive reimbursement for reasonable and necessary expenses incurred. The governor shall designate one member of the committee to serve as its chair at the pleasure of the governor.

Subd. 3. **Meetings.** The committee shall meet at least four times a year at the request of its chair or the ombudsman.

Subd. 4. **Duties.** The committee shall advise and assist the ombudsman in selecting matters for attention; developing policies, plans, and programs to carry out the ombudsman's functions and powers; and making reports and recommendations for changes designed to improve standards of competence, efficiency, justice, and protection of rights. The committee shall function as an advisory body.

Subd. 5. **Medical review subcommittee.** At least five members of the committee, including at least three physicians, one of whom is a psychiatrist, must be designated by the governor to serve as a medical review subcommittee. Terms of service, vacancies, and compensation are governed by subdivision 2. The governor shall designate one of the members to serve as chair of the subcommittee. The medical review subcommittee may:

(1) make a preliminary determination of whether the death of a client that has been brought to its attention is unusual or reasonably appears to have resulted from causes other than natural causes and warrants investigation;

(2) review the causes of and circumstances surrounding the death;

(3) request the county coroner or medical examiner to conduct an autopsy;

(4) assist an agency in its investigations of unusual deaths and deaths from causes other than natural causes; and

(5) submit a report regarding the death of a client to the committee, the ombudsman, the client's next-of-kin, and the facility where the death occurred and, where appropriate, make recommendations to prevent recurrence of similar deaths to the head of each affected agency or facility.

Subd. 6. **Terms, compensation, removal and expiration.** The membership terms, compensation, and removal of members of the committee and the filling of membership vacancies are governed by section 15.0575. The ombudsman committee and the medical review subcommittee expire on June 30, 1993.

Appendix B

Process for Handling Complaints Brought to the Office of the Ombudsman

Complaint Intake

1. A complaint may be received from any source concerning an action of an agency, facility, or program. A complaint may be made by telephone, letter, or direct contact with the regional staff or central office staff. The source is strongly encouraged to make the complaint to the regional staff office.

2. The regional staff shall determine if the complaint is an appropriate matter for review. In selecting matters for review, the regional staff shall give particular attention to unusual deaths or injuries of clients, or actions of an agency or facility or program that:

a) may be contrary to law or rule;

b) may be unreasonable, unfair, oppressive, or inconsistent with a policy or order of an agency, facility, or program;

c) may be mistaken in law or arbitrary in the ascertainment of facts;

d) may be unclear or inadequately explained, when reasons should have been revealed;

e) may result in abuse or neglect of a person receiving treatment;

f) may disregard the rights of a client or other individual served by an agency, facility, or program;

g) may impede or promote independence, community integration and productivity for clients; or

h) may impede or improve the monitoring or evaluation of services provided to clients.

Action on Complaint at Regional Level

1. If the regional staff determines that the complaint is not an appropriate matter for review, the regional staff shall so inform the source. If possible, the regional staff should refer the source to an appropriate agency or other resource.

2. If the regional staff determines that the complaint is an appropriate matter for review, and the review does not duplicate other investigations or regulatory efforts, the regional staff shall consult with the source, consult with the client (when appropriate), and consult with other persons (as necessary) to obtain information pertinent to the complaint. The regional staff shall then proceed to:

a. notify the agency, facility or program named in the complaint and mediate or advocate on behalf of the client;

b. refer the complaint regarding the agency, facility, or program to a more appropriate resource for action; or

c. continue to monitor for a reasonable length of time.

3. The regional staff shall notify appropriate parties once all action has been completed.

4. The regional staff may, at any time, refer a complaint directly to the Ombudsman for advice, counsel, or further review and action.

Action by Ombudsman on Complaint

1. Following the receipt and review of a complaint from regional staff, the Ombudsman may notify the source as to the merit of the complaint and may notify the agency, facility, or program, and any other appropriate parties.

2. After reviewing a complaint, the Ombudsman may request a response from the agency, facility or program.

3. After considering the response of an agency, facility, or program and any other pertinent material, the Ombudsman may recommend that the agency, facility, or program do the following:

a) consider the matter further;

b) modify or cancel its actions;

c) alter a rule, order, or internal policy;

d) explain more fully the action in question; or

e) take other action.

4. The agency, facility, or program shall be notified in writing of the Ombudsman's recommendations and, at the Ombudsman's request, shall within a reasonable time inform the Ombudsman of the action taken on the recommendations.

5. If the actions or response from an agency, facility, or program to the Ombudsman's recommendations resolve the complaint in a manner that promotes the highest attainable standards of treatment, competence, efficiency and justice for persons receiving care or treatment for mental illness, mental retardation or related condition, chemical dependency, or emotional disturbance, the Ombudsman shall consider the matter closed and shall so inform the agency, facility, or program.

6. The Ombudsman may send conclusions and recommendations to the Governor as follows:

a) If the conclusions or recommendations to the Governor are adverse, the Ombudsman shall notify the agency, facility, or program in writing;

b) The agency, facility, or program shall be given an opportunity to provide any statement of reasonable length in defense or mitigation of the Ombudsman's conclusions or recommendations;

c) The Ombudsman's conclusions or recommendations and the statement by the agency, facility, or program shall be sent to the Governor.

7. Before making public a report which contains conclusions or recommendations that expresssly or immplicitly criticize an agency, facility, program, or person, the Ombudsman will:

a) Submit a draft report to the agency, facility, program, or person affected;

b) Within ten days of submitting the draft report, meet with the agency, facility, program, or person affected to discuss the draft report;

c) Prepare a final report after discussing the draft report with the agency, facility, program, or person affected;

d) Consult with the governor concerning the conclusions and recommendations contained in the final report; and

e) Remove all private data prior to releasing a written final report or any other information to the public.

Appendix C

Death Review Guidelines
Internal Policy

I. Purpose

The purpose of the guidelines is to describe the procedure for monitoring and reviewing deaths and to describe the role of the Medical Review Subcommittee (MRS).

II. Authority

Minn. Stat. §245.94, Subd. 2 states the "The Ombudsman shall give particular attention to unusual deaths or injuries of a client...." The MRS's authority to review client deaths is found in Minn. Stat. §245.97, Subd. 5.

III. Policy

The Office has determined that an ongoing program designed to objectively and systematically monitor the circumstances surrounding the death of a client can provide an opportunity to evaluate the quality of care and pursue opportunities to improve the quality of such care.

IV. Procedure

The procedure consists of three sequential phases for action: the monitor; the evaluation; and the corrective action.

A. The Monitor

1. The reports of death are initially reviewed by the Medical Review Coordinator or Clinical Reviewer in consultation with the Medical Review Coordinator, based on the following criteria:
   a. The client was 65 years of age or older or the client was under 65 but had a terminal and irreversible illness.
   b. The client died of known and natural causes.
   c. Information indicates the death was not related to:
      1. a complication of treatment;
      2. a complication of surgery;
      3. a complication of a procedure;
      4. a failure to diagnose; and
      5. a failure to treat appropriately.
   d. The death was not reportable to the Medical Examiner or the Coroner.

2. All deaths are entered into the Ombudsman Office data base.

3. Deaths meeting the initial review criteria (all) are considered closed to further review unless additional information indicates the likelihood of a problem or concern regarding the circumstances surrounding the death.

4. Deaths not meeting the initial review criteria are assigned to a client advocate for data collection. The Deputy Ombudsman is advised and consulted regarding death case assignment.

5. Review materials are forwarded to the Medical Review Coordinator and case materials are reviewed and summarized. Materials are prepared for MRS members and distributed at the meeting one month prior to the planned review.

B. The Evaluation

The evaluation provides the review and assessment of the quality of the care and identifies potential problems, and/or opportunities to correct/improve. Evaluation is done on individual cases and aggregated data by the Medical Review Subcommittee (MRS).

1. Individual Case Evaluation
   a. The MRS reviews each case and makes a determination to close the case based on meeting criteria as written in IV, B. 3d, or it determines a quality of care problem exists.
   b. In cases in which quality of care concerns exist, the findings are formulated into conclusions and problems are identified.
   c. Recommendations are forwarded to the Ombudsman for action.

2. Aggregated Data Evaluation
   a. On an annual basis, the MRS reviews the aggregate data prepared by the Ombudsman Office staff, and identifies patterns, trends and areas in which there may be a potential for problems to exist.
   b. On an annual basis, the aggregated data relating to types of problems identified and types of corrective action recommended through the individual case review will be reviewed by the MRS.
   c. The MRS may recommend that the Ombudsman undertake a focused review on areas identified as having a high potential for problems or may recommend that specific corrective action be taken.

3. Role and Responsibility of the MRS
   a. The MRS is advisory to the Ombudsman in matters relating to review and evaluation of client deaths.
   b. The members of the MRS may act as consultants in medical/treatment issues other than those related to death and serious injury of clients when requested by the Ombudsman.
   c. The MRS meets regularly, and the minutes of the meeting reflect the agenda and recommendations forwarded to the Ombudsman for action.
   d. At the conclusion of the review and evaluation of circumstances sur-

rounding the death of a client, the MRS will advise the Ombudsman whether the following criteria were met in each case:

1. The care provided the client was necessary, appropriate, timely and adequate.
2. The policies regarding client safeguards and the clinical practices regarding client care were adequate and sufficient to meet the needs of the client.
3. In retrospect, the death could not reasonably have been prevented.

e. The MRS will identify the problem in cases not meeting the criteria, and recommend corrective action to the Ombudsman.

4. MRS Membership
The MRS is comprised of at least five members of the Ombudsman Advisory Committee, including at least three physicians, one of whom must be a psychiatrist. The MRS members and the chair are designated by the Governor.

C. Corrective Action
The corrective action is based on the identification of a problem or problems and is designed to improve the quality of care. MRS recommendations are forwarded to the Ombudsman and a plan for corrective action is implemented. Included in this phase are the following steps:

1. Assessment of identified problems to determine the correctable factors involved in poor outcomes. These would include:
   a. client factors (self-management factors for which clients are unprepared);
   b provider factors including knowledge, skills and behavior;
   c. organizational factors (policies, procedures, etc.); and
   d. health care systems factors including accessibility and availability of care, socio-economic factors, geographic limitations or those things beyond the scope of an individual facility.

2. Generating the corrective or improvement action. (Communication with the appropriate body)

3. Implementing the corrective or improvement action. (Negotiating the plan)

4. Evaluating the corrective or improvement action. (Monitoring for improvement)

Appendix D

Serious Injury Review Guidelines
Internal Policy

I. Purpose
The purpose of these guidelines is to describe the procedure and process of the serious injury monitor and review.

II. Authority
The definition of serious injury is found in Minn. Stat. §245.91, Subd. 6. The requirements for mandatory reporting of serious injuries are found in Minn. Stat. §245.94, Subd. 2a.

III. Policy
The Office has determined that an ongoing program designed to objectively and systematically monitor incidents of serious injury can provide an opportunity to evaluate the quality of care provided to clients and thereby offer opportunities to make recommendations to improve the quality of such care.

IV. Procedures
The procedure consists of three sequential phases for action: the monitoring phase; the evaluation phase; and the corrective action phase.

A. **The Monitor**
This monitoring phase provides a mechanism to collect data on the circumstances surrounding the injury and the facility response to that injury.

1. *Appropriateness:* The Medical Review Coordinator or the Clinical Reviewer determines if the injury meets the definition.
   - Phone calls not meeting the definition are logged on the flow sheet entitled "No Report Generated".

2. *Data Retrieval:* Information regarding the injury is entered into the Serious Injury Review, Outline for Telephone Report, Data Base Part I.

3. *Data Input:* Data on the injury is entered into the serious injury data base program.

4. *Initial Screen:* All injuries are screened by the Medical Review Coordinator or the Clinical Reviewer in consultation with the Medical Review Coordinator, using criteria that includes but is not limited to the following:

a. Intensity of services:
   At the time of injury, the client was:
   1. In seclusion room;
   2. In a physical hold by staff;
   3. In mechanical restraint;
   4. On a 1:1, arms length, or close supervision, etc.;
   5. Other, please state:
b. Abuse/Neglect Considerations
   1. The facility suspects and is filing a report.
   2. The facility does not suspect, but reviewer has concerns.
c. Severity of Outcome
   1. The injury resulted in major, perhaps permanent injury.
   2. The injury was life threatening.
d. Predictability
   1. The client has had similar incidents/injuries in the past.
   2. The potential for harm had been identified.
   3. There was a known environmental risk.
e. Preventability
   1. There was inadequate assessment of client.
   2. Safety measures were available, but not used.
   3. Safety measures were inadequate.
f. Sentinel Event
   1. A singular occurrence that may not meet the above criteria, but a major concern regarding the quality of care still exists.

5. *Follow-up:* Cases meeting screening criteria will be reviewed monthly by the Deputy Ombudsman, the Medical Review Coordinator and the Clinical Reviewer. If the potential for a quality of care problem is identified, the possible problem/concern is summarized and the appropriate client advocate is assigned by the Deputy Ombudsman to address relevant issues in follow-up.

B. The Evaluation

The evaluation phase provides the review and assessment of the quality of the care and identifies potential problems, and/or opportunities to correct/improve.

1. Individual Case Evaluation
   a. The Regional Client Advocate completes the follow-up review in the manner described in "Process for Handling Complaints Brought to the Office of the Ombudsman."
   b. Interviews with facility staff will be arranged if necessary.
   c. *Consultant review* by the Medical Review Subcommittee (MRS) may be requested. To provide expertise outside of that available in the MRS, an outside consultant may be used. If the problem statement is supported by the MRS

or consultant findings, the case is referred to the Ombudsman for corrective action.

2. Aggregated Evaluation
   a. All serious injury report data will be aggregated on a regular basis. The aggregation report, including identification of patterns, trends, and possible areas of quality of care problems, is prepared by the Clinical Reviewer and the Medical Review Coordinator. The report is forwarded to the Ombudsman, the Deputy Ombudsman and the Quality Assurance Committee.
   b. Based on the identification of possible problem areas, Focused Reviews may be requested and referred to the Quality Assurance Committee for development. Plans for implementing the review are approved by the Ombudsman.
   c. Results of the Focused Review/Study may be presented to the MRS for its review and any recommendations it may have for corrective action will be forwarded to the Ombudsman.

C. The Corrective Action

The corrective action is based on the identification of a problem or problems and is designed to improve the quality of care. Accepting recommendations and implementing a plan for corrective/improvement action is done by the Ombudsman. Included in this phase are the following steps:

1. Assessment of identified problems to determine the correctable factors involved in poor outcomes. These would include; l) client factors (self-management factors for which clients are unprepared); 2) provider factors including knowledge, skills and behavior; 3) organizational factors (policies, procedures, etc.); 4) health care systems factors including accessibility and availability of care, socio-economic factors, geographic limitations factors beyond the scope of an individual facility.

2. Generating the corrective or improvement action. (Communication with the appropriate body.)

3. Implementing the corrective or improvement action. (Negotiating the plan.)

4. Evaluating the corrective or improvement action. (Monitoring for improvement.)

STATE OF MINNESOTA

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