Department of HUMAN SERVICES

Glenwood Resource Center (GRC)
Actions and Improvement

As of December 8, 2021

The following is a high-level summary of actions and improvements at the Glenwood Resource Center following the notification from the Department of Justice (DOJ) of an investigation into the State Resource Centers.

Leadership, Communication and Consistency

- Hired a new Superintendent with experience in intermediate care facilities for individuals with intellectual disabilities (ICF/ID) to oversee both state resource centers.
- Held monthly parent/guardian town halls to provide updates and hear feedback.
- Revised the administrator on duty structure and protocols to increase the level of leadership in charge after hours and on weekends.
- Revised facility supervisory schedules to provide more support in the evenings and on weekends.
- Revised the organizational structure at both state resource centers to provide added support; including adding an assistant superintendent of integrated services to oversee the Psychology Department, Social Services Department, Therapy Services Department, and the pharmacy.
- Increased staff communication through a monthly newsletter.
- Hired an executive officer 2 in the Office of Facility Support who has extensive experience as a health facilities surveyor.
- Began hosting Superintendent-led town halls for more immediate distribution of information and feedback sharing with staff.
- Hired a psychology administrator who started December 6, 2021. Position had been vacant for almost two years.

Addressing Staffing Challenges

- Revised hiring practices to favor direct contact with applicants instead of email or other communication methods to eliminate delays in response, interview scheduling, and subsequent hire.
- Adjusted the frequency of new-hire interviews to weekly instead of bi-weekly to increase the rate of hire.
- Holding new employee orientation more often to ensure staff competency and availability sooner; and expanded the curriculum to include a full day of active treatment training.
- Increased amount of new-hire training from 10 days to 21 days.
- Revised routine training to include reporting an incident, and ensuring follow-up is completed.
- Revised scheduling procedures to ensure consistent staff in homes, which results in better care overall.
- Consolidated houses to ensure staff efficiency and better care overall.
- Transitioned seven individuals to Woodward Resource Center and one to GRC waiver program to ensure staff efficiency and more specialized supports for the individuals.
- Developed a short-term committee for all DHS facilities which met to discuss options for scheduling and overtime. Solicited feedback on scheduling options from residential treatment workers. Looking to pilot 12-hour shifts.
- Increased the contractual agreements rates with staffing agencies to augment state employee staffing.

- Developed and trained psychologists on standard operating procedures consistent between the SRCs.
- Hosted both on- and off-campus job fairs to increase awareness of GRC employment opportunities.
- Open interviews conducted weekly on designated days. Radio advertising is running and future advertising for open positions in targeted television markets is in progress.
- Contracted with a board-certified behavior analyst (Psychologist 2) to provide services to GRC individuals.
- Hired an advanced registered nurse practitioner who will start February 1, 2022. This is vital to basic medical care.
- Trained all qualified intellectual disabilities professionals (QIDP), assistant superintendents, treatment program administrators, psychologists, psychology assistants and other staff on writing and monitoring individual implementation programs (IIP); and the top 10 most frequently cited deficiencies by the Iowa Department of Inspections and Appeals (DIA) and how to prevent them, thereby ensuring the best possible care for individuals served.
- Reviewing options with the Iowa Department of Administrative Services to recruit and retain front-line staff. Options include salary adjustment, recruitment bonuses, and other retention tools.

Clarifying Policy and Direction

- Reviewed all GRC policies to ensure consistency with state and federal requirements but also with WRC. Policy revisions include:
    - The proper monitoring of your loved one in the homes.
    - Ensuring timely emergent medical care.
    - Ensuring adequate safety measures when using lifts and other patient movement devices.
    - How to amend records within the medical record but ensure overall accuracy and integrity.
- Reduced number of GRC policies to ensure staff understanding and compliance with the rules.
- Policies are available for regular review or citation by staff. This ensures individual safety at the SRCs.
- Developed a statewide DHS policy to ensure research conducted is ethically appropriate and systematically approved. The new policy strictly defines the core principles and practices for requesting, conducting, and monitoring research.
- Revised the medical emergency policy and eliminated the nurse stat procedure to promote any staff calling a medical emergency to get not only nurses but the medical provider to the home. This promotes the philosophy that any staff may call 911.
- GRC continues to review and revise all policies at least annually through a policy committee. New policies are also reviewed prior to implementation.
- Reviewed and revised the following policies between January and May 2021:
    - Key management
    - Locating missing persons
    - Employee personal possessions
    - Security cameras and digital recording
- Revised the accountability policy, changing general supervision from 30-minute checks by staff to 15-minute checks to increase oversight and safety of individuals. This policy also increases the quantity and quality of information staff have in a condensed, quick reference format to help them quickly understand what is important to know.
- The Leisure department publishes a monthly calendar of activities to all staff and individuals by the 25th of each month for the following month.

- Revised the transition and discharge planning documentation for interdisciplinary team (IDT) members to contribute ideas based on their area of expertise and include the following information:
    - What is keeping the individual at GRC / why are they here
    - What do individuals need to learn and what do we need to teach them so that they can leave GRC
    - What are the risks the individual faces in everyday life, how do we minimize the risks and what can we teach them to reduce their own risks.
- Added the completion of the Reinforcer Assessment for Individuals with Severe Disability (RAISD) preference assessments prior to an individual's annual individual support plan (ISP) meeting. This assessment addresses what individuals want to work on for goals in the upcoming year.
- Re-established completion of routine monitoring of IIPs to ensure direct support staff are implementing plans as written.
- Began quality assurance review to be completed monthly to ensure the QIDPs and program monitors are done per established timelines. All QIDPs were trained and being held accountable to complete monthly by the tenth calendar day. Program monitors were trained and held accountable to complete progress reports by the fifth calendar day of the month. Both items are to improve quality of services and supports to individuals by providing the IDTs with timely, organized data to help them make more informed decisions.

Mitigating Use of Restraint

- Implemented Mandt training as GRC's behavior intervention technique to replace GRC's homegrown behavior intervention system which relied heavily on restraint, particularly restraint on the ground.
    - Mandt relies on relationship building, prevention, and intervention techniques.
- Behavior support plans and documentation are in the electronic medical record. This allows the IDT to have contemporaneous data which is important to provide the best information for decision making.
- Restraint Review and Reduction Committee continues to monitor restraints and Mandt training and recertification. The committee reviews data, assesses progress and recommends specific follow-up by the IDT.
- Continuing to reduce the number of physical restraints used to manage individual behavior.
    - Prior to adoption of Mandt training: Average of 35-50 physical restraints per month
    - July through December 2020: Average of 7.4 physical restraints per month
    - January through May 2021: Average of 4.2 physical restraints per month.

Improving Medical Care

- Hired an interim medical director to oversee medical staff and care.
- Hired a permanent administrator of nursing to help set standard direction in nursing care.
- Daily medical meetings are held which include multiple disciplines to ensure totality of care.
- Contractual agreements established with University of Iowa Hospitals and Clinics (UIHC) for weekly case consultation, and medical staff peer review.
- Working with UIHC to develop a relationship and contract for a permanent medical director.
- Working with the UIHC to develop a contract for training and consultation on ethics in medical decision-making.
- Enhanced communication with outside providers by providing standardized information focused on the patient's concerns and why they need to be seen. This also provides a framework for provider communication back to the facility.
- Improved tracking of medication variances by the staff member responsible; as well as tracking and trending to determine appropriate follow-up.

- Revised and trained the peri-care and skin assessment process for individuals who wear an adult brief resulting in a reduction in urinary tract infections.
- All nurses were trained on recognizing and treating (or when to seek emergency medical care) the fatal five: bowel obstruction, aspiration/GERD, dehydration, infection/sepsis, and seizures.
- Expanded partnership with UIHC for the hiring of a chief medical officer.

Continued Compliance/Oversight

- Contracted with a vendor to complete an assessment of SRC operations.
- Contracted with UIHC for medical care, peer review, and other services to enhance care.
- Continued CMS oversight resulted in no deficiencies in February 2020.
- DIA investigations and oversight resulted in full licensure as of December 4, 2020, after having conditional license for the preceding 12 months. All outstanding re-visits on plans of correction were met.
- DIA annual survey completed in May 2021 with deficiencies noted and plans of correction in progress.
- All recommendations by third party mortality reviewer were addressed with appropriate follow-up completed.
- All GRC investigators and the director of quality management completed labor relations training and certification on conducting investigations.
- CMS Federal Comparative Look Behind Survey exited on August 27, 2021, with no condition level deficiencies and with overall positive comments regarding service provision.