ARIZONA
INDEPENDENT OVERSIGHT COMMITTEE

INDEPENDENT OVERSIGHT COMMITTEE MEETING NOTES & ACTION ITEMS

IOC Name: ____ DHS ASH IOC**_____ Meeting Date: 11/18/2021**
Meeting Location: _Conf Call (remote)__ Meeting Time: ___18:05-19:00pm____

Members Present: Laurie Goldstein, Ashley Oddo, Dee Putty, Melissa Farling, Barb Honiberg, Leon Canty, Kim Scherek
Members Absent: Alyce Klein
Other Attendees: Mohave, Sago, Charles Goldstein, Larry Allen, Dorothy O'Brien

Agenda Items (Enter the related topic from the IOC's agenda)	**General Description of Matters Discussed & Motions Made** (Enter the related topic from the IOC's agenda)	**Action Item/Assigned To/Due Date** (Indicate the specific follow-up task/s or actions that need to be completed; include the name of the member assigned to the item, next steps to be taken, and the anticipated due date)
Welcome - disclosure of conflict of interest	None	
Review and approve meeting minutes	Approved Typo in minutes noted	Motion, Dee Second, Leon Roll Call, unanimous
ADOA update	No new business from ADOA No timeline for a new director or candidates at this time; Larry will share info as it comes in. Ask Larry to set up a meeting with the interim director and a small group from the IOC	 Motion, Natalie Second, Dee Roll Call, unanimous
Report from Other IOCs	Dorothy O'Brien, Chairperson of Northern AZ IOC- reports stalls with reviews, continue to	

	work on it- continues to support vulnerable groups, appreciates the networking All-state chair committee meeting recently was productive; meetings are quarterly, discussions and support is valuable	
Review Action Items	Review concerns about administrative separation and responses from ASH again say that the space meets requirements, requirements they follow is unclear ASH outlines the regulations about progressions and outings during COVID; Laurie shared percentage positive rates data from ASU where they do perform routine random testing of employees and on and off-campus students vs. the AZ dept of health is positive testing for people seeking testing (likely since they do not feel well or they were exposed.) This may indicate that the AZ dept of health positivity rates may be skewed; ASH described a number of patients who are eligible for outings Meetings held this month with Dr. Bowen, Woods, and Christina (Ashley reported) discussed passes and progression and the hopelessness in the patients, possible sub-committee to brainstorm ideas for passes, PSRB described the criteria for different groups, it was mentioned that doctors had recommended progression despite the COVID regulations, IOC suggests communicating this with patients and giving patients literature about progression and requirements, Bowen asked IOC to not relate recent suicides to the progression issues and hopelessness- he believes there isn't a direct correlation and the discussion is non-helpful ASH updated Laurie that they are working on a pet therapy contract and making progress to allowing pet therapy- great news!	Motion, Dee Second, Laurie Roll Call, unanimous
Patient Visit Reports	First- main issue discussed was level system, outings vs. visitation, issue with ASH saying outings is restricted despite PSRB order, recent tragedy discussed, the patient felt tragedy was a	What is the procedure for when staff impeded the patient's ability to make a

	direct result of the level progression issue, the patient commented that the person involved in tragedy was not attending groups and was depressed. Second- described emotional abuse from staff, alleged staff was being punitive, they were ordered to do things that made no sense to the patients, ASH staff member took off badge so the patient could not write an incident report (or see the name) and another staff member also refused to share name information, service animal lawsuit progressing but difficulty getting the animal procedure set up, discussed lack of access to the law library (computers in this case) and access being taken away due to behavior consequences, consequences for others affecting patients who did not cause the issue, also discussed the patient who committed suicide and how the patient was not supported, police came to address concern during call and police said that it was an administrative issue, not a law enforcement issue The third patient- sounded terrible/sad, discussed neurological visit and medication issues- it wasn't working or adjusting, concerned constant pain in the shoulder, changing units over and over led to changes in staff and care and lack of consistency, did not meet the team in 72 hours and still had not met team, the patient was concerned that two transport staff and a unit staff must go to appointments leaving too few staff at the unit which restricts other patients- he feels bad he's affecting others, says he's not planning to run away, he has a walker, concern over security person being changed to BHT	report (such as hiding name tag)? What is the procedure for legal library access when computer privileges are revoked or limited? How are patients provided with an unimpeded law library? Motion, Ashley Second, Dee Roll Call, Unanimous Why do 3 staff need to attend appointments? How can we ensure staffing at the unit when appointments happen? Is this an issue? Motion, Ashley Second, Dee Roll Call, Unanimous CRU only has ten patients but has 23 beds. ASH has also reported more patients are eligible. Can ASH allow more patients to move to CRU? Motion, Dee Second, Ashley Roll Call, Unanimous
Overview of incident and accident reports	Noted that incidents are mostly civil, and there are only occasional reports for forensic ASH-2021-4255: patient in art rehab checked out supplies (including scissors) to use, staff was monitoring the use of scissors due to hand tremors, the patient asked to use the restroom, after checks were unresponsive staff entered restroom and scissors were on the floor next to	Does IOC want to know if reports of scissors being lodged in the neck were accurate? Did a nurse remove them as staff and patients reported? What is the investigation protocol for this type of

	the patient, code blue called, responders came to assist, emergency services were called and responded, the patient was in the restroom for 25-26 minutes. Phoenix police came and took a report, took pictures, took possession of the scissors. ASH-2021-4431: code blue on civil, has a monitor 1:1, monitor called the nurse and reported the patient had shoved a whole burrito down his throat and was choking, shoving more food, tears running down the face, staff attempted Heimlich, the patient stopped breathing, compressions and rescue breathes were initiated until responders arrived, wheels fell off the crash cart during movement, there were TV reports about this incident, patient taken to hospital and days later taken off life support ASH-2021-4119: patient threatening another patient, incident in the day room, assault using a chair to hit peer, lack of staff could have avoided the issue ASH-2021-4172: patient threatens another patient physically ASH-2021-4293: patient attempted to harm self-using a bra ASH-2021-4310: patient self-harming, bleeding from the face, had put batteries in the nose and was banging on the toilet to push batteries further in nostrils, was transported to the hospital; Laurie suggested charging stations rather than batteries ASH-2021-4315: patient swallowed six batteries and a toothbrush ASH-2021-2127: patient returned from Valleywise trying to bite ASH staff, yelling, and the nurse suggested PRNs, communication about the patient was not clear between ASH/Valleywise, so it was an unsafe situation	incident? Will more training be provided? Will new policies be written to prevent future incidents? Was there a police investigation? Motion, Dee Second, Natalie Roll Call, unanimous Is ASH doing a formal investigation into the mental health of the patient? Are they addressing the health issues before incidents? Can ASH share reports and procedures? Motion, Ashley Second, Barb Roll Call, unanimous

	ASH-2021-4099: the civil patient being treated on forensic More Forensic incidents Overall, many incidents could be avoided if fully staffed	
Patient Forum	Guidelines: Don't use providers' names IOC will get details later if they need ID Public can ask questions 3-minute limit Bobby Blancett: staff shortage leading to issues on unit, recent code greys called or needed, described patient favoritism, moving patients around to accommodate others, a patient (who was convicted of murder) threated to murder him and explained his plan to another patient and staff minimized it and blew him off, feels punished when he advocates for self, patient seemed to cry, constantly told no and told to wait, uneven application of processes, feels he cannot escalate the issue of feeling unsafe and staff is not recognizing his need for support, cancelled IDTP despite mother driving up from Tucson- opportunity to talk out was taken away, not therapeutic, said that if he went to other staff to escalate they would tell him he was "staff splitting", reports sexual assault and abuse, staff victim blames him when he makes a complaint, feels he has no recourse to advocate for self, said other patients have the same feelings and its not just an isolated issue, committee member suggested the grievance process to patient, Bobby said that they take too long to process and there is retaliation but he will do it Kay Kunes- techs/nurses/staff shortages leading to an unsafe environment, ASH does not work to retain staff, two people for a unit of 16 is not enough (limits mall walks, outings, safety), described violence on the unit when staff is short, ASH cut hazard pay, why can they cut hazard pay but still restrict community outings?	Motion, Dee Second, Ashley Roll Call, unanimous Motion, Dee Second, Melissa Roll Call, unanimous

	Seems to only benefit ASH. Outside time is limited- missing a therapeutic opportunity. Karim- echoing short staff issue, 1:1s are often used to double up to watch individual and a duty, patients can't attend IOC meetings due to supervision issue, reports that more patients would like to attend/participate, volume in the unit is too loud, not therapeutic Kay asked about IOC participation, Laurie said she would follow up Tim Bribiesco- discussed poor climate on the unit, discussed assault with the violent patient, described how this patient has a full-length pencil despite it not being allowed for others. Tables were removed from the day room, and patients were told to eat in the kitchen, but code was called on him- why are codes called on him but not others, even when patients assault staff? Said he prays every night for a heart attack, got bad news about his mom, is asking for support and not getting it, feels hopeless and does not know what to do, likes to be at Mojave with his friends but is often moved units to "focus on the self" forgets what unit he's on, does talk to a therapist but needs more support, the patient was crying, no follow up or grief counselors offered after incidents, said he requested an IOC visit and would like some notice before visits Anonymous patient- curious about IOC, what they can offer, what can be done? Laurie described IOCs role in monitoring for patient rights, care, and safety. They asked if the IOC could be more aggressive and recognize that the same complaints come up and resolutions often do not occur. Laurie described plans to meet with the Governor's office and the Dept of Health. Patients want more information about what the IOC is doing, IOC will take better notes and investigate if minutes can be posted on units with agendas; the patient did say that typically the agendas are posted	Laurie to follow up with Jackie and Kay

Other Business	Meeting with the interim director to include: Progressions/passes Staff shortage, review staff numbers ASH participation in IOC meetings Staff member sent a letter to Larry; Larry shared it with IOC. There was also a new report where staff discussed staff shortage in the news. Staff is reporting that ASH is not a safe environment for staff or patients. Letter included: Written regarding forensic suicide in October, said that no staff went to help the patient during the incident, the patient had spoken to staff seeking help and support, but nobody listened, the current staff is not always paying attention. The nurse responding to code pulled out the scissors, causing the patient to "bleed out," and the staff brought in drugs. If staff were available and trained, this patient could still have been alive.	IOC would like to know plans and use for the CRU. Motion, Dee Second, Melissa Roll Call, unanimous IOC would like to meet with the interim director Motion, Dee Second, Melissa Roll Call, unanimous IOC would like to have the staff numbers for the last six months to investigate what's ideal and effective, what's actually happening, and how we can possibly remedy the situation. Motion, Laurie Second, Dee Roll Call, unanimous
Member recruitment	The forensic patient would like to join, Laurie reached out to Jackie Another individual would like to join in the near future	
Public Comment (3-minute limit per person)/Call to the Public	No additional comments	
Adjournment		Motion, Dee Second, Barb Roll Call, unanimous
Executive Session	No notes on executive session	