



# STATE OF IOWA

CHESTER J. CULVER, GOVERNOR  
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES  
CHARLES J. KROGMEIER, DIRECTOR

November 27, 2009

## GENERAL LETTER NO. 3-B-8

ISSUED BY: Office of Deputy Director for Field Operations

SUBJECT: Employees' Manual, Title 3, Chapter B, **STATE RESOURCE CENTERS**, Title page, revised; Contents (page 1 through 5), revised; pages 1 through 115, revised; and pages 116 through 123, new.

### Summary

This chapter is revised to:

- ◆ Change language of some definitions,
- ◆ Incorporate revised administrative rules on human rights,
- ◆ Reflect change in state law on next of kin,
- ◆ Update reporting requirements to the deputy director,
- ◆ Change policy on elopements,
- ◆ Change training requirements,
- ◆ Add some general language clean-up, and
- ◆ Change the style and format.

### Effective Date

Upon receipt.

### Material Superseded

This material supersedes the entire Chapter B from Employees' Manual, Title 3, which includes the following pages:

<u>Page</u>	<u>Date</u>
Title (page)	September 22, 2006
Contents (pages 1, 2)	September 22, 2006
Contents (page 3)	July 27, 2007
Contents (pages 4, 5)	October 31, 2008
1	September 22, 2006
2, 3	October 31, 2008
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5-15	October 31, 2008
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96-101	October 31, 2008
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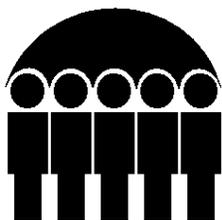
**Additional Information**

Refer questions about this general letter to deputy director for field operations.

Revised November 27, 2009

Employees' Manual  
Title 3  
Chapter B

# STATE RESOURCE CENTERS



Iowa  
Department  
of  
Human Services

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## **Overview**

The purpose of each state resource center is to provide individuals with developmental disabilities opportunities to live and develop independent living skills in a safe and humane environment where the individual's rights are protected with the end goal of assisting the individual to return to and live in the community.

This is best achieved when the resource center works to develop competency-based trained staff who work cooperatively with the individual to develop an individual support plan based on an assessment of the individual's preferences, strengths to build on, and needed supports. The plan also assesses the diverse risk issues affecting the individual's quality of life and develops supports to minimize the impact risks have on the individual.

The individual's served by the resource center usually have many medical needs that requires the services of professional clinical staff who are committed to providing treatment services in the most integrated manner possible to maximize good health and well being.

To assure that services comply with current professional standards and are maintained, it is essential that an ongoing process be in place to evaluate clinical judgment against practice standards along with the implementation of processes that continuously seek to improve the quality of the services provided.

In November 2704, the state of Iowa entered into a settlement agreement with the United States Department of Justice relating to the state resource centers. Effective October 1, 2004, the Iowa Department of Human Services and the state resource centers agreed to the Iowa State Resource Centers Plan. The policies in this chapter are part of the state's good-faith effort to implement the provisions of the agreement and the plan.

Each resource center shall establish, maintain, and adhere to written policies and procedures that comply with applicable federal and state law, policy, regulations, and ensure that policies and procedures reflect a commitment to quality through integrated teamwork. Each facility's policy shall be subject to the review and approval of the deputy director.

### **Legal Basis**

Iowa Code section 218.1 provides that the director of the Department of Human Services has full authority to control, manage, direct and operate the Department's institutions and may assign this authority to the superintendents at the resource centers.

Iowa Code section 218.13 requires the Department to conduct background checks of any person who is:

- ◆ Being considered for employment involving direct responsibility for an individual or with access to an individual when the individual is alone; or
- ◆ Requesting permission to reside on the grounds of the resource center.

The purpose of the background check is to determine whether the person has been convicted of a crime or has a founded child abuse or dependent adult abuse record. If so, the Department is required to determine if the conviction or founded abuse warrants prohibition of the person from employment or residing on grounds.

Iowa Code section 218.64(2) requires the county medical examiner to conduct a preliminary investigation of all deaths at institutions covered by Iowa Code Chapter 218. Iowa Code section 218.65 governs the handling of the property of an individual who dies at a state institution.

Iowa Code Chapter 222 outlines the authority and responsibilities of the state resource centers. Iowa Code section 222.12 requires the county medical examiner to conduct a preliminary investigation of all deaths at the state resource centers.

Iowa Code sections 232.67 through 232.77, Iowa Code Chapter 235A, and 441 Iowa Administrative Code Chapter 175 define child abuse and require reporting, investigation, and actions to be taken to protect children from abuse.

Iowa Code Chapter 235B and 441 Iowa Administrative Code Chapter 176 define dependent adult abuse and require reporting, investigation, and actions to be taken to protect dependent adults from abuse.

Iowa Code sections 225C.25 through 225C.32 provide that persons with mental retardation, developmental disabilities, brain injury, or chronic mental illness retain the same rights granted to all other persons and cannot be denied these rights without due process.

Iowa Code sections 331.802 and 331.805 detail the responsibilities of the county medical examiner in deaths of public interest and define all deaths at an institution governed by Iowa Code Chapter 218 as deaths of public interest.

Iowa Code section 709.1 defines sexual abuse.

Title XIX of the Social Security Act and 42 Code of Federal Regulations §483.420(a) require facilities to ensure the rights of clients as a condition of participation in the Medicaid ICF/MR program.

Civil Rights of Institutionalized Person Act (CRIPA) at 42 USC §§1997j requires the United States Attorney General to investigate conditions of egregious or flagrant deprivation of rights of persons residing in public institutions.

Public Law 106-402, the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (DD Act), codified at 42 USC 15001, provides that programs, projects, and activities for persons with developmental disabilities shall be carried out in a manner consistent with supporting the rights of the persons served.

### **Definitions**

**“Abuse”** occurs when a caretaker intends to inflict harm on an individual or, where the caretaker fails to act or acts in a reckless manner, which has the consequence of causing that individual harm, or has the potential to cause such harm. Abuse may also occur when a caretaker threatens harm in a manner that a reasonable person believes that the harm might occur. Types of abuse include:

- ◆ **Physical abuse:** An act that causes, or may have caused an injury to an individual. Physical abuse includes but is not limited to:
  - Hitting, slapping, pushing, pinching, throwing objects directed at the individual or otherwise striking an individual,
  - Physical assault,
  - Corporal punishment (physical punishment for an individual’s actions),
  - Use of excessive force (failure to use least restrictive interventions),
  - Unauthorized use of restrictive interventions including restraint, seclusion, aversive conditioning, time out or punishment, and
  - Incitement to act, which includes circumstances where caretakers instigate individuals to inflict harm on another individual.

- ◆ **Sexual abuse:** Any sexual contact between an individual and a caretaker is sexual abuse. Sexual abuse occurs when there is any sexual contact with a minor. Sexual abuse includes but is not limited to:
  - Inappropriate touching,
  - Attempted or actual sexual relations,
  - Penetration,
  - Solicitation,
  - Indecent exposure,
  - Sexual assault,
  - Invasion of privacy for sexual gratification,
  - Use of sexually explicit language to harass or suggest sexual activity, or
  - Sexual exploitation (having individuals perform sexual acts with other individuals for the employee's benefit or sexual gratification)
  
- ◆ **Verbal abuse:** An oral (including tone of voice), written or gestured language to belittle, ridicule, scorn, assault, dehumanize, otherwise denigrate, socially stigmatize, or show contempt for an individual. Such behaviors include but are not limited to:
  - Yelling,
  - Swearing,
  - Name-calling,
  - Teasing,
  - Insulting, or
  - Use of disrespectful or derogatory terms to describe an individual.
  
- ◆ **Mental or psychological abuse:** Actions that result or may result in a negative impact on an individual's sense of well-being, safety, integrity, or self-esteem. The impact may be recognized by an individual's expression of anxiety, depression, withdrawal, or by aggressive behaviors. Such abuse includes but is not limited to:
  - Intimidation,
  - Withholding attention,
  - Threat to physically harm, or
  - Taunting or harassment

- ◆ **Neglect or denial of critical care:** Actions or inactions that result in the failure to provide food, shelter, clothing, physical or mental health, supervision, or any other care necessary to prevent imminent risk of or potential risk for harm or death. Neglect or denial of critical care includes but is not limited to:
  - Lack of appropriate supervision of individuals which result in an elopement,
  - Withholding of food or clothing or other activities to punish an individual or any other such action which is not included in the individual's Individual Support Plan,
  - A medication error when it results in an immediate or imminent health risk,
  - Lack of appropriate supervision of individuals which results in sexual contact between minors,
  - Lack of appropriate supervision of individuals which results in non-consensual sexual contact between adult individuals or when one of the adults is incapable of giving consent, or
  - Lack of appropriate supervision which results in assault.
- ◆ **Exploitation:** An act or process of taking advantage of an individual or an individual's physical or financial resources for personal gain. Exploitation includes but is not limited to:
  - Misleading or deceiving an individual to gain access to personal resources,
  - Stealing an individual's personal property, or
  - Requests for or using individuals to perform work duties for the caretaker or to perform services for the state resource center that are not in accordance with the individual's support plan.

**"Active treatment"** means continuous training to assist individuals acquire their maximal independence through formal and informal activities enhancing their optimal physical, emotional, social, intellectual, and vocational levels of development and functioning.

**"Admission"** means the acceptance of an individual for full residence at a resource center on either a voluntary or involuntary basis.

**"Adult"** means an individual 18 years of age or older.

**“Adverse drug reaction”** means an unexpected and untoward reaction to medication.

**“Allegation”** means an assertion of misconduct or wrongdoing that has yet to be proven or confirmed by supporting evidence.

**“Allied health services”** means a group of diverse providers responsible for a portion of integrated healthcare that directly or indirectly impact services to individuals or facilities along the chain of service delivery.

**“Aspiration pneumonia”** means an inflammation of the lungs and bronchial tubes caused by inhaling foreign material, usually food, drink, vomit, or secretions from the mouth into the lungs.

**“Assault”** means the actual physical or sexual attack of an individual or threat of a physical or sexual attack. Sexual assault occurs between individuals when one of the individuals has not given consent or when one of the individuals is incapable of giving consent. See [Iowa Code section 708.1](#).

**“Behavior support plan”** or **“BSP”** means a component of the individual support plan that is a comprehensive, individualized plan outlining behavioral issues impacting a person’s life and interventions for addressing those behaviors.

**“Bio-psycho-social”** means a philosophy identifying the inter-relatedness and interdependence of the biological, psychological, and social components of a human being.

**“Board of supervisors”** means the elected governing body of a county as defined in [Iowa Code Chapter 331](#).

**“Bowel obstruction”** means an intestinal obstruction involving a partial or complete blockage of the bowel that results in the failure of the intestinal contents to pass through.

**“Business day”** means a working day in the usual Monday-through-Friday workweek. A holiday falling within this workweek shall not be counted as a business day.

**“Caretaker”** means an employee, contractor, or volunteer of a resource center.

**“Catchment area”** means the group of counties, designated by the deputy director, that each resource center is assigned to serve.

**“Central point of coordination process”** means the process defined in [Iowa Code section 331.440\(1\)\(a\)](#).

**“Child”** means an individual under the age of 18.

**“Choking”** means a blockage of the upper airway by food or other objects, preventing an individual from breathing effectively. Choking occurs when physical intervention, such as the abdominal thrust, is needed.

**“Clinical indicator”** means a measure assessing a particular health care outcome determined to have a clinical significance or correlation to the quality of care.

**“Clinical services”** means a group of specialized practices addressing the bio-psycho-social needs of an individual. For the purposes of this policy, these practices include the specialized care provided by licensed practitioners in the fields of dentistry, medicine, neurology, neuropsychiatry, nursing, nutrition, occupational therapy, pharmacology, physical therapy, psychiatry, psychology, and speech and language pathology.

**“Community integration”** means the process of including persons with disabilities in the environments, activities, and social networks of typical persons. This term is also used interchangeably with “inclusion.”

**“Competency-based training”** means a type of training in which the student must demonstrate, through testing or observed practicum, a clear understanding of the learning material presented.

**“Comprehensive functional assessment”** or **“CFA”** means a set of evaluations identifying an individual’s strengths and preferences; functional and adaptive skill levels; disabilities and possible causes; and needs.

**“Contractor”** means a person employed under a personal services contract by the facility that has direct personal contact with an individual.

**“Corporal punishment”** means the use of any physical force to inflict punishment for an individual’s actions.

**“Corrective action”** means action to correct a situation and prevent reoccurrence of the situation. Corrective action may include but is not limited to, program change, system change such as an environmental improvement, or disciplinary action.

**“County board of supervisors”** means the elected board of supervisors of an Iowa county.

**“Date of application”** means the date that the Department’s Field Operations Support Unit receives the application by the county board of supervisors or the court’s request for a diagnostic evaluation.

**“Department”** means the Iowa Department of Human Services.

**“Deputy director”** means the Department’s deputy director for field operations.

**“Dignity of risk”** means the concept that individuals, having the right to self-determination, also have the right to expose themselves to experiences which, while posing some risk, open doors to learning and growth that would have remained closed had the risk not been taken.

**“Discharge”** means another provider has accepted responsibility for providing services and supports to an individual and the resource center no longer has legal responsibility for providing direct services to the individual.

**“Discharge plan”** means the plan developed for an individual that identifies the major barriers to discharge and the strategies that will be developed and implemented to overcome the barriers to enable the individual to move to the most integrated setting appropriate to the individual’s needs.

**“Due process”** means assuring that an individual’s rights are not limited unless done so by court order through a process defined by law or through an individual’s approved program plan process that includes informed consent.

**“Elopement”** occurs when:

- ◆ An individual’s location is unknown by staff who are assigned responsibility for oversight; or
- ◆ An individual who is allowed to travel independently on campus does not arrive or return when expected; or
- ◆ An individual who is either on or off campus leaves without permission and is no longer in continuous oversight.

**“Employee”** means a full-time, part-time, or temporary person on the payroll of the facility.

**“Entities responsible for funding”** means the individual’s county of legal settlement or the Iowa Department of Human Services.

**“Essential supports”** means the medical, mobility, nutritional, and behavioral supports that are essential to an individual’s health and safety. Absence of an essential support would immediately negatively compromise the individual’s health, safety, or behavior. Essential supports are to be in place before an individual is placed.

**“Evidence-based practice”** means the integration of best research evidence with clinical expertise and patient values.

**“Expected death”** means the death of an individual who is diagnosed with a terminal illness or condition and whose health status, based on current medical knowledge, is not expected to improve but likely to deteriorate. The illness or condition is expected to be fatal within a reasonable period, and the determination is supported by the individual’s treatment record and course of treatment.

**“External review”** means a review conducted by persons from outside the resource center who represent the specialties that are required to be reviewed.

**“Facility risk data profile”** means the aggregate data collected on the type of risks experienced by individuals who reside at a resource center which is used for identifying trends, patterns, quality management and performance improvement.

**“Fall”** means unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of syncope or overwhelming external force. The following are **not** to be classified as falls:

- ◆ An individual being pushed, shoved, or aggressed against causing him to go to the ground, floor, etc. This is an incident of **aggression**.
- ◆ An individual intentionally sitting on the ground, floor, pavement, etc. This is most likely either the individual choosing to rest or behaviorally communicating that he does not want to participate in what is being asked or suggested of him.

**“Family contact”** means:

- ◆ The parent of a minor individual, or
- ◆ The family member an adult individual has designated in writing to receive information concerning the individual's services at the resource center, or
- ◆ A person who has been legally authorized to make care decisions for the individual if the individual loses decision-making capacity, often referred to as a surrogate decision-maker.

**“Full residence”** means the determination that the individual meets all the admission requirements and has been admitted for an ongoing stay to receive support and treatment services.

**“Grievance”** means a written or oral complaint by an individual involving a rights violation, or unfairness to the individual, or any aspect of the individual's life that the individual does not agree with.

**“Guardian”** means the person other than a parent of a child who has been appointed by the court to have custody of person of the individual as provided under [Iowa Code section 232.2\(21\)](#) or [633.3\(20\)](#).

**“Health care professional”** means a physician, nurse practitioner, physician's assistant, or a registered nurse.

**“High risk or dangerous behavior”** means a behavior or action on the part of an individual that a reasonable and prudent person would deem as of immediate danger to the individual's health or safety or the health or safety of another person. This includes threatened behavior when the individual has the immediate opportunity and capacity to carry out the behavior.

**“Immediate clinical review”** means a review initiated by a treatment program manager or QMRP by the end of the next business day from when a problem is identified to address:

- ◆ Whether appropriate treatment and supports were in place, and
- ◆ What changes are needed to appropriately address the problem.

The clinician or a group of clinicians appropriate to evaluate the cause of the problem shall conduct the review. The treatment program manager or QMRP shall determine the participation of other members of the individual’s interdisciplinary team based on the individual and the problem involved.

**“Incident”** means any action, situation, behavior, or occurrence that is not consistent with the care, treatment, or habilitation plan of an individual or that may affect the health or safety of the individual.

**“Incident review committee”** means the committee responsible for the overall monitoring, reviewing, and determining the effectiveness of a resource center’s implementation of incident management policies and corrective actions. At a minimum, the committee shall include the superintendent, the persons directly responsible for the program and treatment services, representatives from psychology and nursing, and the director of quality management.

**“Independent physician”** means a licensed physician who is not an employee of the resource center and who has no personal or professional connections to the individual who died.

**“Individual”** means any child or dependent adult residing at and receiving services from a resource center. For the policies on human rights and abuse, it also includes any child or dependent adult not residing but receiving services from a resource center.

**“Individual education plan”** or **“IEP”** means the primary document outlining an individual’s educational needs and the services and supports required for the individual to receive a free appropriate public education in the least restrictive environment.

**“Individual support plan”** or **“ISP”** means the plan of treatment, education, and support services developed for each individual to address the individual’s identified needs.

**“Informed consent”** means an agreement to participate in an activity by an individual or the individual’s parent, guardian, or legal representative based upon an understanding of:

- ◆ A full explanation of the procedures to be followed, including an identification of those that are experimental.
- ◆ A description of the attendant discomforts and risks.
- ◆ A description of the benefits to be expected.
- ◆ A disclosure of appropriate alternative procedures that would be advantageous for the individual.
- ◆ Assurance that the consent is given freely and voluntarily without fear of retribution or withdrawal of services.

**“Injury of unknown origin”** means an injury whose source was not observed by any person or cannot be explained by the individual and which is suspicious because of:

- ◆ The extent of the injury,
- ◆ The location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma),
- ◆ The number of injuries observed at one particular point in time, or
- ◆ The incidence of injuries over time.

**“Interdisciplinary team”** or **“IDT”** means a collection of people with varied professional backgrounds who develop one plan of care to meet an individual’s need for services.

**“Leave”** means any status where the individual is not physically present in the resource center but has not been discharged and the resource center retains some responsibility for the care, oversight, or treatment of the individual.

**“Legal representative”** means a person, including an attorney, who is authorized by law to act on behalf of an individual.

**“Legal settlement”** means the determination made under [Iowa Code sections 252.16](#) and [252.17](#) to identify whether one of the 99 Iowa counties has a legal obligation to provide financial support for an individual.

**“Mandatory reporter”** means:

- ◆ For adult abuse, a person as defined in the [Iowa Code section 235B.3\(2\)](#).
- ◆ For child abuse, a person as defined in the [Iowa Code section 232.69\(1\)](#).

**“Medical emergency”** means a change in an individual’s health status that requires emergency medical intervention, including but not limited to use of the abdominal thrust maneuver, use of CPR, defibrillation, calling 911 for emergency medical services, or hospitalization.

**“Medication variance”** means any preventable event that may cause or lead to inappropriate medication use or individual harm while the medication is in the control of the health care professional, the medication aide, or the individual.

**“Mental retardation”** means a condition where all of these factors are present:

- ◆ Significantly subaverage intellectual functioning: an intelligence quotient (IQ) of approximately 70 or below on an individually administered IQ test (for infants, a clinical judgment of significantly subaverage intellectual functioning) as defined by the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, American Psychiatric Association.
- ◆ Concurrent deficits or impairments in present adaptive functioning (i.e., the person’s effectiveness in meeting the standards expected for the person’s age by the person’s cultural group) in at least two of the following areas: communication, self-care, home living, social and interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety.
- ◆ Onset before the age of 18. (Criteria from *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (DSM IV-TR), 2000 revision, American Psychiatric Association)

**“Next of kin,”** as defined in [Iowa Code section 144C.5](#), means the following persons in descending order:

- ◆ A designee or alternative designee appointed under Iowa Code section 144C.3, acting pursuant to the decedent’s declaration.
- ◆ The surviving spouse, if not legally separated from the decedent, whose whereabouts is reasonably ascertainable.
- ◆ A surviving child, or if there is more than one, a majority of the surviving children whose whereabouts are reasonably ascertainable.

- ◆ The surviving parents whose whereabouts are reasonably ascertainable.
- ◆ A surviving grandchild, or, if there is more than one, a majority of the surviving grandchildren whose whereabouts are reasonably ascertainable.
- ◆ A surviving sibling, or, if there is more than one, a majority of the surviving siblings whose whereabouts are reasonably ascertainable.
- ◆ A surviving grandparent, or if there is more than one, a majority of the surviving grandparents whose whereabouts are reasonably ascertainable.
- ◆ A person in the next degree of kinship in the order named by law to inherit the estate of the decedent under the rules of inheritance of intestate succession or, if there is more than one, a majority of such surviving persons whose whereabouts are reasonably ascertainable.
- ◆ A persons who represents that the person knows the identity of the decedent and who signs an affidavit warranting the identity of the decedent and assuming the right to control final disposition of the decedent's remains and the responsibility to pay any expense attendant to such final disposition.
- ◆ The county medical examiner, if responsible for the decedent's remains.

**“Nonessential supports”** means those supports that are a necessary part of a complete individual support plan for an individual but their short-term absence is not an immediate threat to the individual's health or safety. Nonessential supports are to be in place no later than 60 days after the individual is placed.

**“Official designated agent”** means a person designated to act on behalf of a board of supervisors by a recorded vote of the board of supervisors.

**“Outpatient admission”** means a person is provided a service but is not admitted to residence, except the term includes individuals admitted to residence for a diagnostic evaluation for determining the appropriateness of a court ordered admission.

**“Parent”** means a natural or adoptive mother or father of a child but does not include a mother or father whose parental rights have been terminated.

**“Performance measure”** means a type of indicator assessing a particular process determined to affect quality of care or compliance.

**“Perpetrator”** means a person who has been found, under the law, to be responsible for the abuse of a child or a dependent adult.

**“Physical injury”** means:

- ◆ Damage to any bodily tissue to the extent that the tissue must undergo a healing process in order to be restored to a sound and healthy condition, or
- ◆ Damage to any bodily tissue that results in the death of the person who has sustained the damage.

**“Pica”** means the intentional swallowing of all or part of an inedible substance or foreign body.

**“Profession”** for a professional peer review means medicine and surgery, podiatry, osteopathy, osteopathic medicine and surgery, practice as a physician assistant, psychology, chiropractic, nursing, dentistry, dental hygiene, speech pathology, audiology, pharmacy, physical therapy, occupational therapy, respiratory care, mental health counseling, social work, and dietetics.

**“Professional standards”** means those as contemporary, accepted professional judgment, and practice standards that are recognized by a profession.

**“Programmatic restrictive intervention”** means a planned act, program, process, method, or response infringing upon an individual’s rights that has been approved by the human rights committee and for which informed consent has been obtained.

**“Qualified mental retardation professional”** or **“QMRP”** means the leader of the interdisciplinary team (IDT), also referred to as the treatment program manager (TPM). The qualified mental retardation professional is ultimately responsible for ensuring individuals receive all needed bio-psycho-social services and supports in an integrated and coordinated fashion.

**“Quality assurance”** means all activities that contribute to defining, designing, assessing, monitoring, and improving the quality of healthcare. (Source: The Quality Assurance Project funded through USAID)

**“Quality council”** means the group of key employee leaders in administration, clinical services, and direct service management that is responsible for oversight of the quality management and performance improvement practices facility-wide.

**“Quality improvement”** means using collaborative efforts and teams to study and improve specific existing processes at all levels in an organization. (Source: JB Quality Solutions, Inc., *The Healthcare Quality Handbook* 2005)

**“Quality management”** means a planned, systematic, organization-wide approach to the monitoring, analysis, and improvement of organization performance, thereby continuously improving the quality of patient care and services provided and the likelihood of desired patient outcomes. (Source: JB Quality Solutions, Inc., *The Healthcare Quality Handbook* 2005)

**“Quality of care”** means the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

**“Residence”** means an overnight stay at a resource center.

**“Residential technical assistance team”** or **“RTAT”** means the identified field and central office employees designated to review all voluntary applications or court orders for admission to a state resource center to assure that all reasonable community based options have been considered before an application for admission to a resource center is approved.

**“Restrictive intervention”** means an act, program, process, method, or response limiting or infringing upon an individual’s rights.

**“Rights”** means the human, civil, and constitutional liberties an individual possesses through federal and state constitutions and laws.

**“Rights violation”** means any act, program, process, method or response, either through commission or omission, infringing upon or limiting an individual’s rights, as defined in this chapter, without due process or without adherence to the emergency restriction policy in this chapter.

**“Risk”** means an actual or likely condition, injury, or predisposition posing the possibility of danger or loss to an individual.

**“Risk/benefit analysis”** means weighing the negative impact on the individual’s rights against the expected benefit of a rights limitation to determine if the individual’s expected outcome, with the rights limitation, is of more value to the individual than the outcome of not limiting the individual’s rights.

**“Risk management plan”** means an individualized interdisciplinary plan that addresses an individual’s identified risks and is incorporated into the individual support plan.

**“Risk status”** means the level of risk severity to the individual.

**“Serious injury”** means injury, self-inflicted or inflicted by another, resulting in significant impairment of a person’s physical condition, as determined by qualified medical personnel. Serious injuries include but are not limited to, injuries that:

- ◆ Are to the genitals, perineum, or anus,
- ◆ Result in bone fractures,
- ◆ Result in an altered state of consciousness,
- ◆ Require a resuscitation procedure including CPR or abdominal thrust maneuver,
- ◆ Result in full thickness lacerations with damage to deep structures,
- ◆ Result in injuries to internal organs,
- ◆ Result in a substantial hematoma that causes functional impairment,
- ◆ Result in a second degree burn involving over 20% of total body surface area,
- ◆ Result in a second degree burn with secondary cellulitis,
- ◆ Result in a third degree burn involving more than 10% total body surface area,
- ◆ Require emergency hospitalization, or
- ◆ Result in death.

**“Significant weight change”** means an unplanned change in body weight (more than a 10% increase or decrease) during report month.

**“Skin breakdown”** means a Stage 2, 3, or 4 pressure sore or decubitus ulcer, as identified by a health care professional.

**“Specialty peer review”** means professional or clinical assessments of care conducted by like professionals for the purposes of improving client outcomes.

**“State case”** means the determination made under [Iowa Code section 252.16](#) that identifies an individual as not having legal settlement in an Iowa county and places funding responsibility with the state.

**“Status epilepticus”** means ten or more minutes of continuous seizure activity or two or more sequential seizures without full recovery of consciousness between seizures.

**“Suicide attempt”** means self-injurious behavior with a nonfatal outcome accompanied by evidence (either explicit or implicit) that the person intended to die.

**“Suicide threat”** means verbally expressing the intent to harm but not having attempted to harm oneself.

**“Suspension or termination”** means the involuntary removal, dismissal, or termination from an educational, vocational, or occupational program in which the individual regularly participates.

**“Suspicious injury”** means:

- ◆ An injury where the initial explanation of the injury appears inconsistent with the injury sustained, or
- ◆ Other injuries that may be questionable as to how they happened, which might include, but are not limited to, unexplained black eyes, bruises around the neck or on inner thighs, or any patterned injuries regardless of the area of the body.

**“Temporary admission”** means the voluntary admission of an individual to residence on a time-limited basis for evaluation or treatment.

**“Transition plan”** means the plan developed when an appropriate discharge setting has been identified for an individual that specifies the actions needed to be taken by the resource center to accomplish the discharge and assure success. The plan:

- ◆ Identifies the appropriate county central point of coordination, Department, and provider staff who will be involved in implementation of the plan; and
- ◆ Specifies the required resource center actions and the staff and timelines for completion of the required actions.

**“Unexpected death”** means a death that was not the result of a known and documented terminal illness or condition and was not anticipated until the onset of the acute terminal episode.

**“Volunteer”** means an unpaid person registered with the resource center who has direct contact with an individual.

## **Policy on Admissions**

It is the policy of the Department that admission to a resource center shall be made only for individuals for whom community-based resources are not adequate to meet the individual's current needs. Admission is available only to persons with mental retardation.

All applications for voluntary admissions are screened to assure that community resources have been considered and it has been determined that, based on generally accepted professional standards of care, the resource center is determined to be the most integrated setting based on the individual's current needs.

Applications for voluntary admission of adults shall be made through the central point of coordination process. Applications for minors shall be made through the county board of supervisors.

Involuntary commitments are evaluated before a commitment order is issued to determine if the commitment would be appropriate and if the resource center has adequate facilities to care for the individual.

## **General Principles**

Resource center written policies and procedures shall assure that:

- ◆ Voluntary or involuntary admission is authorized only after it has been determined that community-based resources are not adequate to meet the individual's current needs.
- ◆ Voluntary or involuntary admission is authorized only after it has been determined that the resource center has adequate facilities to serve the individual and the admission will not result in over-crowding.
- ◆ The voluntary admission of an adult individual is made only with:
  - An application from and the consent of a county board of supervisors through the central point of coordination process; and
  - A diagnostic evaluation that determines the individual's need for and eligibility for admission based on generally accepted professional standards of care.

- ◆ The voluntary admission of a minor individual is made only with:
  - An application from and the consent of a county board of supervisors; and
  - A diagnostic evaluation that determines the individual's need for and eligibility for admission based on generally accepted professional standards of care.
- ◆ Minor individuals are admitted voluntarily only after the individual has been informed of the individual's right to object to a voluntary admission and, if the minor objects, a court has authorized the individual's admission.
- ◆ Involuntary admissions are made only after a diagnostic evaluation indicates that an admission is appropriate and a court has issued an order for commitment.
- ◆ Legal settlement of the individual has been determined or the dispute resolution process has been initiated if necessary.
- ◆ The individual's rights are protected throughout the admission process.
- ◆ The individual or the individual's parent, guardian, or legal representative is involved in the admission process.
- ◆ The individual or the individual's guardian understands that the resource center's goal will be to return the individual to community services and that the discharge process begins with admission.
- ◆ The local state and county employees involved in the admission:
  - Understand that the resource center's goal will be to return the individual to community services and that the discharge process begins with admission and
  - Agree to this understanding in writing.
- ◆ The local state and county employees who are responsible for assisting in developing the appropriate community resources for the individual are strongly encouraged to be a part of the individual's individual support plan process.

### **Application Submittal Process**

Resource center written policies and procedures shall assure that:

- ◆ Applications for admission, temporary admission, or outpatient admission shall be accepted only from counties in the resource center's catchment area as defined in [441 IAC 28.11\(218\)](#) unless the deputy director grants an exception.

- ◆ The applicant submits adequate information to determine that:
  - The individual for whom application is made is a person with mental retardation,
  - All reasonable community resources have been considered and it has been professionally determined that the resource center is the most integrated setting to meet the individual's current needs, and
  - Appropriate information regarding the individual's history, previous services and supports, and current service and support needs has been provided.

### **Legal Settlement**

Resource center written policies and procedures shall assure that:

- ◆ The county of application makes a legal settlement determination under [Iowa Code section 252.16](#) and [441 IAC 30.3\(222\)](#), using form 470-3439, *Legal Settlement Worksheet*, before an admission is approved.
- ◆ When legal settlement or state case status is in dispute, admission shall be approved only after the county of application has given the notices required in [Iowa Code sections 252.22](#) and [252.23](#) to all potential counties of legal settlement and when appropriate, to the deputy director.
- ◆ Following admission of a minor, and at least annually until the individual reaches majority, the legal settlement of the minor's parents shall be reviewed to determine whether:
  - The parents have acquired legal settlement,
  - The parents' county of legal settlement has changed, or
  - The parents have lost legal settlement.

If any of these changes appears to have occurred, notice of the possible change shall be sent to the currently identified county of legal settlement and:

- In the case of potential loss of legal settlement, to the deputy director.
- In the case of a current state case, to any potential new county of legal settlement.
- ◆ All legal settlement determinations submitted shall be reviewed to determine if the resource center agrees with the determination.
- ◆ When the resource center disagrees with the determination, notice shall be given to the deputy director.

### **Individuals Without Legal Settlement**

Resource center written policies and procedures for individuals without legal settlement shall assure that:

- ◆ The application shall be made in the same manner as an application for an individual with legal settlement.
- ◆ The deputy director or the deputy director's designee shall approve the application.

### **Voluntary Residential Admission for Adult**

Resource center written policies and procedures shall assure that:

- ◆ All applications for admission shall be approved as appropriate for admission by the residential technical assistance team before the resource center processes the application.
- ◆ An application for admission shall be accepted only when the application has been made through the central point of coordination by the board of supervisors of either the individual's county of residence or the individual's county of legal settlement.
- ◆ The application shall be made using form 470-4402, *Application for Admission to a State Resource Center*.
- ◆ The applicant or the applicant's guardian consents to release of all information the resource center needs to determine the appropriateness of the admission, using form 470-4402, *Application for Admission to a State Resource Center*.
- ◆ The board of supervisors or the board's officially designated agent shall sign the application.
- ◆ When the individual has been determined or alleged to be a state case, the deputy director or the deputy director's designee shall also sign the application.
- ◆ The application shall provide information supporting a diagnosis or possible diagnosis of mental retardation.
- ◆ When the individual for whom application is made is not competent to give consent to admission or treatment, the individual's guardian or legal representative shall give consent.

### **Voluntary Residential Admission for Minor**

Resource center written policies and procedures shall assure that:

- ◆ Before the resource center processes an application for admission, the residential technical assistance team shall approve the application as appropriate for admission.
- ◆ An application shall be accepted only when the application has been made by the board of supervisors of either the individual's county of residence or the individual's county of legal settlement.
- ◆ An application shall be made using form 470-4402, *Application for Admission to a State Resource Center*.
- ◆ The board of supervisors or the board's officially designated agent shall sign the application.
- ◆ When the individual has been determined or alleged to be a state case, the deputy director or the deputy director's designee shall also sign the application.
- ◆ The application provides information supporting a diagnosis or possible diagnosis of mental retardation.

### **Involuntary Residential Admission**

Resource center written policies and procedures shall assure that:

- ◆ The residential technical assistance team shall approve all court orders for admission as appropriate for admission before the resource center recommends the admission.
- ◆ Before accepting a court ordered admission:
  - A diagnostic evaluation of the individual has been made either by the superintendent or the superintendent's designee; and
  - The superintendent has recommended that the order be issued and that the resource center has adequate facilities for the care of the individual.

- ◆ A diagnostic evaluation is conducted only if the applicant or the applicant's guardian consents to the submittal of all background materials on the individual necessary to determine the appropriate service and support needs of the individual.
- ◆ Form 470-4402, *Application for Admission to a State Resource Center*, is not required for an involuntary admission but may be used informally to assure that a county board of supervisors is aware of the admission. When used, the resource center shall note on the form that it is for an involuntary admission.

### **Temporary Admission**

Resource center written policies and procedures shall assure that:

- ◆ Voluntary application for a temporary admission shall be made in the same way as an application for a voluntary admission except:
  - The application is exempt from the residential technical assistance team process; and
  - A diagnostic evaluation is not required.
- ◆ The person or agency seeking temporary admission for an individual shall provide a written and signed understanding that:
  - The request is for a temporary admission for a specified limited period;
  - The person or agency agrees to take the individual back; and
  - Application for full resident admission requires a separate process.

### **Outpatient Admission**

Resource center written policies and procedures shall assure that:

- ◆ Voluntary application for an outpatient admission shall be made in the same way as an application for a voluntary admission but is exempt from the residential technical assistance team process.
- ◆ Referrals from a district court for a diagnostic evaluation before issuing an order of commitment shall be referred through the residential technical assistance team process.

## **Admission Approval**

### **Residential Admission Approval**

Resource center written policies and procedures shall assure that residential admission approval is given only when:

- ◆ The individual clearly meets the definition of mental retardation;
- ◆ The preadmission diagnostic evaluation clearly shows that community resources have been considered and it has been determined that the Resource Center is determined to be the most integrated setting according to the individual's current needs, based on generally accepted professional standards of care;
- ◆ The resource center has adequate facilities to serve the individual;
- ◆ The resource center has determined that it has the available services and supports the individual currently needs;
- ◆ The admission will not result in overcrowding;
- ◆ Funding responsibility has been clearly established or, when in dispute, the process for resolving disputes is being followed;
- ◆ The individual or the individual's guardian has given informed consent to treatment;
- ◆ A minor has given consent to the admission during the preadmission diagnostic evaluation, or, if consent was not given, the admission was approved by a juvenile court in accordance with [Iowa Code subsection 222.13A\(2\)](#); and
- ◆ For commitments:
  - An individual shall be admitted to full residence once the superintendent has recommended the admission and the court has issued an order.
  - The superintendent shall acknowledge to the court receipt of the individual, upon receipt of an individual's order of commitment from the court.

### **Temporary Admission Approval**

Resource center written policies and procedures shall assure that temporary admission approval is given only when:

- ◆ An application has been submitted using form 470-4402, *Application for Admission to a State Resource Center*.
- ◆ An application has been approved through a central point of coordination process, when required, and by a county board of supervisors.
- ◆ The applicant or the applicant's guardian consents to release of all information the resource center needs to determine the appropriateness of the admission, using form 470-4402, *Application for Admission to a State Resource Center*.
- ◆ When the individual has been determined or alleged to be a state case, the deputy director or the deputy director's designee shall also sign the application.
- ◆ The application provides information supporting a diagnosis or possible diagnosis of mental retardation.
- ◆ The individual or the individual's guardian has given informed consent for care, treatment, and training.

### **Outpatient Admission Approval**

Resource center written policies and procedures shall assure that:

- ◆ Voluntary outpatient admission approval is given only when:
  - An application has been submitted using form 470-4402, *Application for Admission to a State Resource Center*.
  - The application has been approved through a central point of coordination process, when required, and by a county board of supervisors.
  - The applicant or the applicant's guardian consents to release of all information the resource center needs to determine the appropriateness of the admission using form 470-4402, *Application for Admission to a State Resource Center*.

- The deputy director or the deputy director's designee has signed the application when the individual is or is alleged to be a state case,.
- The application provides information supporting a diagnosis or possible diagnosis of mental retardation.
- The individual or the individual's guardian has given informed consent for care, treatment, and training.
- ◆ Involuntary outpatient admission approval is given only when a district court has requested that a diagnostic evaluation of an individual be made.

### **Informed Consent**

Resource center written policies and procedures shall assure that:

- ◆ Informed consent for care, treatment, and training shall be given by:
  - The individual if the individual is competent to give informed consent, or
  - If the individual is not competent to give informed consent, by the individual's parent, guardian, or legal representative.
- ◆ A general informed consent for services shall be obtained using form 470-4403, *Resource Center Agreement and Consent for Services*.
- ◆ The general informed consent shall be renewed no less frequently than every 12 months.
- ◆ Specific informed consent shall be obtained for participation in treatment that includes:
  - Invasive or potentially harmful procedures,
  - Programmatic use of restraints,
  - Use of a behavior modifying medication,
  - Non-emergency transfer to another facility,
  - Programmatic use of aversive stimuli or response cost,
  - Programmatic use of time out,
  - Medical consents that are restrictive based on a medical condition, or
  - Participation in experimental research.

### **Application Denial**

Resource center written policies and procedures shall assure that voluntary applications shall be denied if:

- ◆ The application has not gone through the central point of coordination process and been signed by a board of supervisors;
- ◆ The individual for whom the application is made does not meet the definition of mental retardation;
- ◆ The application has not been approved by the residential technical assistance team;
- ◆ The resource center does not have adequate facilities or services to serve the individual or admission would result in overcrowding;
- ◆ Any other application requirement has not been complied with;
- ◆ There is clear evidence that the individual has an appropriate and more integrated setting available; or
- ◆ The individual for whom application is made is not competent to give informed consent for admission or treatment and does not have a parent, guardian, or legal representative with the legal authority to give consent.

### **Readmission**

Resource center written policies and procedures shall assure that:

- ◆ An application for readmission shall be made in the same manner as for a first admission except the resource center may waive the re-submittal of any information already in the resource center files and shall require only that information be updated.
- ◆ Readmission from alternative placement with a return agreement shall not require approval through the residential technical assistance team.

### **Performance Improvement**

Resource center written policies and procedures shall assure that quality assurance practices are in place to:

- ◆ Monitor the voluntary application and involuntary commitment process to identify actual or potential systemic issues, needing corrective action; and
- ◆ Monitor the implementation and completion of corrective action plans.

### **Data Collection and Review**

Resource center policies and procedures shall assure the collection of data on admissions:

- ◆ Data collected shall include, at a minimum, the following categories:
  - Name of each individual for whom application or court order was received
  - Date the application or court order was received
  - Residential Technical Assistance Team (RTAT) approval decision (yes, no, or not applicable)
  - Type of application:
    - Voluntary adult
    - Voluntary minor
    - Involuntary court order
    - Time limited
    - Outpatient
    - First admission
    - Readmission
  - County of admission
  - Resource center's admission decision
  - Reason application was denied, if applicable
  - Legal settlement resolved or disputed
  - County of legal settlement or approval as a state case
  - Barriers to community living that have led to the need for admission

- ◆ Data gathered from data analysis shall be used consistently for identifying and addressing individual or systemic issues to improve the application process.
- ◆ The resource center quality council shall review data from all admissions to assure that:
  - Problems are timely and adequately detected and appropriate corrective actions are implemented; and
  - When possible, root causes are identified that lead to corrective action.

### **Reporting Requirements**

The resource center written policies and procedures shall assure that:

- ◆ The monthly reporting process of admissions to the quality council shall be defined.
- ◆ The data collected shall be available for analysis by each data element collected.
- ◆ The deputy director's office shall be provided with:
  - A monthly summary of applications received, approved, and denied,
  - A quarterly summary of the quality council's analysis of identified systemic issues, and
  - A quarterly summary of how the data analysis was used to improve the application process.

### **Employee Training and Education on Admissions**

Resource center policies and procedures shall assure that competency-based employee training shall be provided on admission policies and procedures, which shall include but not be limited to:

- ◆ The philosophy and policies that:
  - Individuals will be admitted only when a professional determination has been made that the community does not have adequate services to meet the needs of the individual and the resource center has been determined to be the least restrictive setting, and
  - The goal of all admissions is to return the individual to a less restrictive community setting, and
  - Discharge planning starts with admission.
- ◆ State laws and rules that govern voluntary and involuntary admissions including but not limited to:
  - Voluntary application process,
  - Involuntary court process,
  - Differences between adult and minor admissions,
  - Application of catchment areas,
  - Availability of adequate space and services,
  - Role of RTAT in admissions,
  - Legal settlement, and
  - Required diagnosis and evaluation (D&E).
- ◆ The policies and procedures for processing and approving admissions including but not limited to:
  - The rights of the individual seeking or for whom admission is sought
  - The types of possible admission
  - Admission approval requirements
  - Informed consent
  - Data collection on admissions
  - Reporting requirements

### **Employees Trained on Admissions**

Resource center written policies and procedures shall assure that training is provided to all new employees who will be involved in the application, approval, and admission process, including:

- ◆ New employees and
- ◆ Transferred employees who have not been trained previously.

### **Continuing Education on Admissions**

Resource center written policies and procedures shall assure that at any time when there is a change in the laws, rules, policies, or procedures relating to admissions, employees who are involved in the application, approval, and admission process shall receive competency-based training specific to the change.

### **General Training Policies on Admissions**

Resource center written policies and procedures shall assure that:

- ◆ Employee training shall be regularly documented in the training record for each employee in a manner that permits the information to be available individually and in aggregate form.
- ◆ Training curriculum shall be updated regularly to reflect changes in laws, policies, and procedures.
- ◆ Training shall be implemented in a timely manner.

## **Policy on Human Rights**

It is the policy of the Department of Human Services that the constitutional and legal rights of every individual who resides at or receives services from a resource center shall be protected and asserted. Individuals residing at a resource center possess the rights to:

- ◆ Receive an explanation and written copy of the rules of the facility.
- ◆ Receive an explanation of the individual's medical condition, developmental status, and behavior status, and be informed as to treatment plans and the attendant risks of treatment.
- ◆ Receive appropriate treatment, services, and habilitation for their disabilities, including appropriate and sufficient medical and dental care.
- ◆ Have confidentiality of, and reasonable access to, their personal resource center records.
- ◆ Work, when available and desired, and be compensated for their work.
- ◆ Receive care in a manner maintaining their dignity and respecting their individuality.
- ◆ Have opportunities for privacy, including during the care of personal needs.
- ◆ Keep and use personal possessions, including wearing their own clothing.
- ◆ Share a room with a spouse when both live in the same facility.
- ◆ Be free from unnecessary drugs and restraints.
- ◆ Be free from physical, psychological, sexual, or verbal abuse, neglect and exploitation.
- ◆ Communicate and access people and services at the facility and in the community, including organizing and participating in resident groups while at the facility.
- ◆ Receive visits from parents, guardians, legal representatives, or family without prior notice given to the facility unless the visits have been determined inappropriate by the individual's treatment team.
- ◆ Communicate and meet privately with individuals of their choice without prior notice given to the facility.
- ◆ Send and receive unopened mail.
- ◆ Have private phone calls unless the calls have been determined inappropriate by the individual's treatment team.

- ◆ Have a dignified existence with self-determination, making choices about aspects of their lives significant to them.
- ◆ Give informed consent including the right to withdraw consent at any time.
- ◆ Refuse treatment (such as medication, behavioral interventions, etc.) and to be explained the consequences of those refusals unless the treatment is necessary to protect the health and safety of the individual or others.
- ◆ Refuse to perform services for the facility and not be coerced to perform services.
- ◆ Manage the individual's own financial affairs unless limited under law or is determined not appropriate by the individual's treatment team.
- ◆ Choose activities, schedules, and care consistent with their interests, needs, and care plans.
- ◆ Engage in social, religious, and community activities.
- ◆ Exercise their rights as an individual and as a citizen of the United States.
- ◆ File a grievance pursuant to rule 441-28.4(218) without any form of intimidation or reprisal resulting from the grievance.

An individual's rights shall not be limited or abridged without due process under the laws of the state of Iowa or a restrictive intervention program approved under this policy with written consent of the individual or the individual's parent, guardian, or legal representative.

### **Human Rights Principles**

Resource center written policies and procedures shall assure that:

- ◆ Individuals receiving services shall have the same legal and civil rights of all United States citizens, including the right to a dignified, self-directed existence in a safe and humane environment.
- ◆ Individuals shall be acknowledged as having full possession of these rights. Any restriction or encumbrance on an individual's rights shall be based on:
  - A court order (involuntary commitment, guardianship, etc.);
  - The written consent of the individual; or
  - A programmatic restrictive intervention process approved under this policy before such encumbrance occurs, except in the case of an emergency.

- ◆ An individual's rights shall be respected and protected against violation.
- ◆ Upon admission and at least annually thereafter, each individual, or the individual's parent, guardian, legal representative, or family, shall receive an explanation of the individual's rights and responsibilities in a manner and format the recipient understands.
- ◆ A standardized rights violation grievance process shall be established and maintained.
- ◆ All suspected rights violations, whether as an individual or a group, shall be investigated promptly and addressed through the identified grievance process.
- ◆ Individuals shall be educated on their rights and encouraged to exercise those rights in a manner that respects and does not violate the rights of others.
- ◆ Any allegation of rights violation that meets the definition of abuse under federal or state laws shall be reported and investigated in compliance with the Department's policies on abuse.

### **Rights Posting**

Resource center written rights violation process policies and procedures shall assure that the rights of individuals are conspicuously posted in each living area and day program site in a brief and easily understood statement. The posting shall include:

- ◆ Information on how an individual may assert the individual's rights including the process for reporting alleged rights violations or grievances.
- ◆ A statement that retaliation shall not occur for good faith reporting.

### **Restrictions or Constraints on Rights**

Resource center written policies and procedures shall assure that:

- ◆ The intentional violation of an individual's rights without due process, or the failure to report such violation is prohibited.
- ◆ All employees shall be responsible for protecting and promoting individual rights and support individuals in exercising their rights independently and, if necessary, with staff assistance.

- ◆ A process for approving restrictive interventions shall be implemented that requires:
  - Completion before an individual's rights are limited;
  - An interdisciplinary team review;
  - The informed consent of the individual or the individual's parent, guardian, or legal representative.
  - Documentation justifying the need for restriction including:
    - The purpose of the restriction.
    - The identified need and rationale for the restriction.
    - Less restrictive interventions tried without success.
    - Risk/benefit analysis supporting the need for the restrictive intervention.
    - The review and approval of the resource center's human rights committee.
- ◆ At or before admission, each individual or the individual's parent, guardian, or legal representative shall be provided with a copy of the rules of the facility and an explanation in a manner and format that the individual, parent, guardian, or legal representative understands.
- ◆ All court-ordered restrictions shall be incorporated into the individual support plan.

### **Emergency Rights Restrictions**

Resource center written policies and procedures shall assure that a process for approving emergency restrictions is implemented and requires that:

- ◆ The process shall be used only when intervention is necessary to immediately protect the health or safety of the individual or others.
- ◆ A supervisor shall approve the intervention.
- ◆ The individual's interdisciplinary team shall review the emergency restriction within three business days of the emergency rights restriction.
- ◆ The individual's interdisciplinary team shall review any instance of more than three emergency restrictions in any four-week period and the individual's individual support plan is revised as appropriate.
- ◆ Data shall be collected and reviewed monthly.

### **Human Rights Committee**

Resource center written policies and procedures shall assure that a human rights committee shall be maintained which is responsible to:

- ◆ Review recommended programmatic restrictive interventions;
- ◆ Approve or deny approval of recommended programmatic restrictive interventions;
- ◆ Monitor approved interventions to assure that programmatic restrictive interventions are implemented in accordance the Department's policy;
- ◆ Investigate grievances or allegations of rights violations;
- ◆ Make recommendations for program improvement; and
- ◆ Maintain a record of the decisions of the committee.

### **Reporting of Violations**

Resource center written policies and procedures shall assure that:

- ◆ All employees, volunteers, and contractors witnessing or having knowledge of a rights violation shall be required to report the rights violation.
- ◆ The employee shall immediately report all allegations of rights violation orally to the employee's direct line supervisor, unless the allegation involves the supervisor, in which case the report shall be made to the supervisor's supervisor. Volunteers and contractors shall report allegations to their designated facility employee contact.
- ◆ All information pertaining to the allegation and subsequent investigation shall be kept confidential, including the name and position of the person making the report.
- ◆ Retaliation shall not occur for good faith reporting.
- ◆ Failure to report allegations of rights violation shall not be tolerated, including the willful failure to report rights violation.

### **Response to Report**

Resource center written policies and procedures shall assure that:

- ◆ Notification of grievances filed shall be provided to the treatment program administrator, the Office of Quality Management, and the human rights committee.
- ◆ All allegations and rights violation allegations shall be immediately reported to the superintendent or the superintendent's designee.
- ◆ The superintendent or the superintendent's designee shall provide a monthly report of rights violations to the deputy director as outlined in the [Reporting Requirements on Rights Data](#) section of this policy.

### **Allegations of Abuse**

Resource center written policies and procedures shall assure that:

- ◆ All allegations of rights violation that meet the definition of abuse shall be investigated under the policies governing abuse investigations.
- ◆ If an allegation of rights violation does not meet the definition of abuse, but does meet the definition of mistreatment or neglect, it shall be investigated under the policies governing abuse.

### **Grievance Filing Process**

Resource center written rights violation process policies and procedures shall assure that:

- ◆ A grievance filing process is developed and implemented for use by an individual who believes one or more of the individual's rights have been violated or has any other complaint. The process shall:
  - Specify the right for an individual or the individual's parent, guardian, legal representative, or family to file a written or oral grievance;
  - Provide assistance in filling out the grievance if needed by the individual;
  - Specify whom the grievance may be filed with; and
  - Provide written notification to the individual's parent, guardian, legal representative, or family of the grievance and the investigation outcome.
- ◆ Retaliation shall not occur for good faith reporting.

### **Investigation Process**

Resource center written policies and procedures on the grievance and rights violation investigation process shall assure that:

- ◆ A copy of all grievances filed shall be sent to and reviewed by the human rights committee.
- ◆ The human rights committee shall investigate all grievances or allegations of rights violation, regardless of merit, unless resolved earlier in the process.
- ◆ All grievances or allegations filed shall be investigated by:
  - The first-line supervisor and treatment program manager. Within five business days after initiation of the grievance, the first-line supervisor and the treatment program manager shall investigate the grievance. The treatment program manager shall meet with the individual filing the grievance.

If the complaint isn't resolved at this level, the findings shall be submitted to the treatment program administrator.

- The treatment program administrator. Within five business days of receipt of the grievance, the treatment program administrator shall meet with the individual filing the grievance. If the grievance cannot be resolved at this level, the findings shall be submitted to the human rights committee.
- The human rights committee. Within ten business days the committee shall complete its investigation and then within five business days shall develop recommendations for resolution and make a written report.

- ◆ Investigative reports shall be made using form 470-4367, *Resource Center Individual Grievance*, and shall contain, at a minimum:
  - The name of the individual who filed the grievance or rights violation report.
  - The date, place, and time of the incident.
  - The date the incident was reported.
  - Each grievance or allegation of rights violation.
  - The names of all individuals involved.
  - The names of all employees and individuals who witnessed the grievance or alleged rights violation.
  - The names of all persons interviewed during the investigation.
  - For each interviewee, the questions asked and responses given, or if a tape of the interviews is available and maintained, a summary of the questions asked and responses given.
  - All documents reviewed during the investigation.
  - All sources of evidence considered, including previous investigations involving the individual or the employee.
  - The finding of the investigation and a clear statement as to the reasons for human rights committee conclusions.
  - Recommendations for any corrective action (other than personnel actions).
  - The outcome of the grievance or rights violation investigation.
- ◆ The findings and conclusions of all investigations resolved before reaching the human rights committee level shall be sent to the committee within two business days for review at the next meeting. The minutes of the human rights committee shall document the review.
- ◆ The individual's guardian, family, legal representative and the individual's parent, if the individual is a child, shall be notified of the resolution and findings and shall be provided with a statement specifying the right to appeal the decision to the superintendent.

### **Appeal Process**

Resource center written grievance and rights violation process policies and procedures shall assure that:

- ◆ The individual filing the grievance shall have the right to appeal the decision of the human rights committee to the superintendent. The appeal can be made orally or in writing and must be filed within 14 business days of the human rights committee issuing its written report.
- ◆ The superintendent shall provide a written decision on the appeal within 14 business days.
- ◆ If the individual filing the appeal to the superintendent isn't satisfied with the superintendent's decision, the individual shall be provided with information on the individual's right to have a further appeal to the district court.

### **Corrective Action**

Resource center written policies and procedures shall assure that:

- ◆ There is a process to assign the development and implementation of specific corrective action plans to address issues identified in all human rights committee findings with the purpose of correcting any specific violations and preventing future violations. This process shall assure that:
  - Written corrective action plans shall be developed within five business days of assignment.
  - Corrective action plans shall identify the tasks, timelines, outcomes to be accomplished, and the employees responsible for implementation.
  - Corrective action plans shall be implemented in a timely manner.
  - The results of corrective action plans shall be documented.
- ◆ The superintendent or the superintendent's designee shall approve all corrective action plans and any proposed modification to content or timeline.

There is a monitoring process to assure that all corrective actions shall be developed and implemented as written.

### **Personnel Practices**

Resource center written policies and procedures shall assure that:

- ◆ Any employee, volunteer, or contractor who has been found to have violated the rights of an individual shall be subject to sanctions up to, and including, dismissal or termination of contract.
- ◆ All decisions on type and severity of disciplinary actions taken against employees shall:
  - Be made timely; and
  - Be based on an evaluation of the type and severity of the incident based on the evidence in the incident report, prior personnel actions taken with the employee, and other components of just cause.

### **Rights Performance Improvement**

Resource center written policies and procedures shall assure that quality management practices are in place to monitor the reporting of and review of grievances and alleged rights violations; identify systemic issues, actual or potential, needing corrective action; and monitor the completion and implementation of corrective action plans.

### **Data Collection and Review**

Resource center policies and procedures shall assure the collection of data on grievances or alleged rights violations as described in this section.

Data collection shall include, at minimum, the following categories and shall be provided in the format defined by the deputy director:

- ◆ Name of individual for whom grievance or alleged rights violation is filed
- ◆ Case number
- ◆ Date of grievance or alleged rights violation
- ◆ Date the grievance or alleged rights violation was reported
- ◆ Time of the grievance or alleged rights violation
- ◆ Living unit
- ◆ Location where grievance or alleged rights violation occurred
- ◆ Type of grievance or alleged rights violation
- ◆ Immediate action taken with staff
- ◆ Immediate action taken with individual

- ◆ Names of individual and employee involved
- ◆ Names of all witnesses
- ◆ Names of other individuals directly or indirectly involved
- ◆ Reported causes of the grievance or rights violation
- ◆ Outcomes of the human rights committee investigation
- ◆ Date the human rights committee investigation began
- ◆ Date the human rights committee investigation completed
- ◆ Final personnel action taken and date
- ◆ Corrective actions assigned, including:
  - The person responsible for corrective action completion,
  - The date by which the corrective action plan is to be completed, and
  - The date documentation of corrective action completion was submitted.

Records of the results of every investigation of grievances or alleged rights violations shall be maintained in a manner that permits investigators and other appropriate staff to easily access each investigation involving a particular employee or individual.

Data gathered from data analysis shall be consistently used for identifying and addressing individual and systemic issues to improve the quality of life for individuals. The resource center's quality council shall review data from all rights violation investigations to assure that:

- ◆ Problems are timely and adequately detected;
- ◆ Timely and adequate protections are implemented;
- ◆ Timely and appropriate corrective actions are implemented; and
- ◆ Root causes are identified, when possible, that lead to corrective action.

### **Reporting Requirements on Rights Data**

Resource center written policies and procedures shall assure that:

- ◆ The monthly reporting process of grievances or rights violation allegations and related investigative findings to the facility quality council shall be defined.
- ◆ The data collected shall be available for analysis by each data element collected.

- ◆ The deputy director's office shall be provided with:
  - A monthly summary report of individual grievances or rights violations filed,
  - A quarterly summary of the analysis of the investigations of grievances or rights violations identifying systemic issues,
  - A quarterly summary of how the data analysis from investigations was used to identify systemic issues, and
  - A quarterly summary of how the data analysis was used to address systemic issues and improve the quality of life of individuals.

### **Employee Training and Education on Rights**

Resource center policies and procedures shall assure that competency-based employee training shall be provided on the implementation of human rights policies and procedures, which shall include but not be limited to:

- ◆ The principles of human rights,
- ◆ An individual's rights based on federal and state law,
- ◆ The use and approval process for any restriction or constraint on an individual's rights.
- ◆ The process for use of emergency restrictions of rights,
- ◆ The role, processes and responsibilities of the human rights committee,
- ◆ The responsibilities and processes for reporting grievances or allegations of rights violations,
- ◆ The grievance filing process,
- ◆ The grievance investigation and appeal process, and
- ◆ The consequences arising from violations of an individual's rights.

### **Employees Trained on Human Rights**

Resource center written policies and procedures shall assure that training on human rights is provided to:

- ◆ All new employees;
- ◆ Volunteers, who will work regularly with individuals; and
- ◆ Contractors.

### **Continuing Education on Human Rights**

Resource center written policies and procedures shall assure that annual competency-based refresher training, which may be an abbreviated version of the initial required training, shall be provided to:

- ◆ All employees;
- ◆ Volunteers, who work regularly with individuals; and
- ◆ Contractors.

### **General Training Policies on Human Rights**

Resource center written policies and procedures shall assure that:

- ◆ Employee training shall be regularly documented in the training record for each employee in a manner that permits the information to be available individually and in aggregate form.
- ◆ Training curriculum shall be updated regularly to reflect changes in laws, policies, and procedures.
- ◆ Training shall be implemented in a timely manner.

## **Policy on Clinical Care**

Each resource center shall provide the highest quality clinical care possible. Clinicians shall understand served individuals' needs, be knowledgeable of best practices to meet those needs, and collaborate with other professionals to design and implement services around the lifestyle of the person.

### **Clinical Care Principles**

Resource center written policies and procedures shall assure that all clinical care is:

- ◆ Consistent with current professional and clinical standards of practice.
- ◆ Both preventive and responsive in its diagnosis, treatment and intervention.
- ◆ Holistic, with full recognition of the bio-psycho-social aspects of individuals' lives and the multidimensional nature of "quality."

- ◆ Person-centered, including but not limited to, services being:
  - Designed by, or with full participation by, the individual and the guardian, parent or legal representative,
  - Individualized to the specific needs and values of the individual,
  - Functionally and clinically integrated within the lifestyle planning of the individual, and
  - Responsive to the individuals' changing needs and conditions.
- ◆ Designed and monitored by competently trained professionals licensed in good standing with their respective licensing body.
- ◆ Implemented by competently trained employees capable of adapting care to a variety of settings.
- ◆ Routinely monitored, modified and updated to ensure individuals receive timely care and services.
- ◆ Measured and analyzed at a variety of organizational levels.

### **Treatment Services**

Resource center written policies and procedures shall assure that an individual's clinical treatment services shall:

- ◆ Be designed around the bio-psycho-social needs of the individual as determined by the interdisciplinary team, led by the individual whenever possible, and by timely assessments completed in a routine and responsive fashion, as indicated by modifications due to:
  - A change in an individual's lifestyle plan;
  - Changes in an individual's bio-psycho-social status; or
  - Lack of progress under the current clinical care plan.
- ◆ Be individualized to the degree that relevant baseline data is easily obtainable to determine:
  - Parameters in which status change is deemed acceptable, and
  - Signs, symptoms, status changes, or thresholds for action, requiring notification of the appropriate clinical team members.

- ◆ Be provided in accordance with current professional standards of practice as documented by:
  - Evidence-based practices in the acceptable fields of study,
  - Current clinical and professional knowledge as supported by research and education, and
  - Clinical judgment based upon current professional knowledge and the individual's individualized needs as identified through integrated assessments and review.
- ◆ Be measurable, with clearly identified indicators by which treatment efficacy can be determined.
- ◆ Be responsive to the changes noted in the individual's health care status, including:
  - Implementing individualized risk support plans for present risk, and
  - Timely development and implementation of supports for newly identified risks in accordance with the policy on risk management.
- ◆ Be monitored, supervised, and managed through clinical supervision and leadership, internal and external peer review, and monthly program reviews that are documented in the individual's record and contain:
  - A summary of individual's status, including progression, regression, or lack of progress,
  - The status of the individual's ability to meet the objectives of the plan, and
  - Action to be taken or changes to be made based on the individual's status, change in priorities, or recommendations made by outside consultants in response to face-to-face consultations held with the individual.

### **Care Performance Improvement**

Resource center written policy shall assure that quality of clinical care is measured through clinical indicators and performance measures consistent with current professional standards and guidelines. Each resource center shall ensure that clinical care and allied health services are consistent with current professional knowledge, both in care planning and service delivery.

At minimum, the resource center policies and procedures shall assure that:

- ◆ Each specialty area shall be maintain easily retrievable information on currently accepted standards of practice and clinical indicators related to their discipline;
- ◆ Each specialty area shall develop and maintain internal quality improvement initiatives based on the principles of quality management and clinical care, including:
  - Regularly scheduled peer reviews or case studies in accordance with the deputy director's policy,
  - Regularly scheduled departmental team meetings to foster open communication, cohesiveness and cross-educational opportunities,
  - Ongoing review of clinical processes to determine efficiency, relevancy, and opportunities for streamlining or improvement, and
  - Ongoing research in the field, via journals, Internet, etc., to ensure programming is consistent with currently accepted standards of practice.
  - The resources necessary to implement the Department's policies shall be allocated, secured, and maintained to provide optimal clinical care.

#### **Data Collection on Clinical Care**

Resource center written policies and procedures shall assure that:

- ◆ Each profession required to do peer review shall develop appropriate quality indicators for quality improvement purposes in their area and these indicators shall be identified in the Quality Indicator Report.
- ◆ All quality indicators shall be reviewed no less than annually to ensure their applicability and relevancy to clinical care.
- ◆ Recommendations for change or expansion shall be made to the director of quality management.
- ◆ Data collected shall be reviewed and analyzed no less than monthly with the findings reported at the quality council meeting.
- ◆ The Office of Quality Management and Office of the deputy director shall work with resource center employees to assess required changes, updates, or removal of data sets.

### **Employee Training and Education on Clinical Care**

Resource center policies and procedures shall assure that competency-based employee training shall be provided on clinical care policies and procedures, which shall include but not be limited to:

- ◆ All new employees, or transferred employees who have not been trained previously, who will be providing direct services or supports to individuals, shall receive training, including:
  - The importance of person centered healthcare services,
  - The role of direct care employees in providing or supporting clinical services,
  - The bio-psycho-social treatment approach to clinical care, and
  - The importance of integrated clinical care.
- ◆ All professional clinical employees, including transferred employees who have not been trained previously, shall receive training to assure that clinical services are:
  - Based on and incorporate the bio-psycho-social treatment approach to serving individuals.
  - Integrated, through the use of:
    - Effective communication with direct support employees and other clinicians of ordered clinical services,
    - Ongoing collaboration with other clinical team members to assure that services provided to each individual are appropriate and coordinated.
  - Incorporated as part of the individualized treatment plan and revised based on an ongoing assessment of the individual's needs.
  - Consistent with current professional standards.
  - Person centered.
  - Implemented by licensed professional employees.
  - Routinely monitored and revised as necessary.

- Measureable using baseline data indicators of effectiveness of treatment.
- Regularly measured and analyzed to assess effectiveness.

#### **Continuing Education on Clinical Care**

Resource center written policies and procedures shall assure that all professional clinical employees shall:

- ◆ Receive annual competency-based refresher training on clinical care, which may be an abbreviated version of the initial required training;
- ◆ Have opportunities, resources, and allotted time for professional development and education required to perform duties as assigned; and
- ◆ In collaboration with the training department, identify specialty training courses and conferences addressing best practices.

#### **General Training Policies on Clinical Care**

Resource center written policies and procedures shall assure that:

- ◆ Employee training shall be regularly documented in the training record for each employee in a manner that permits the information to be available individually and in aggregate form.
- ◆ Training curriculum shall be updated regularly to reflect changes in laws, policies, and procedures.
- ◆ Training shall be implemented in a timely manner.

## **Policy on Individual Support Plans**

It is the policy of the Department of Human Services that each individual residing at a resource center shall have treatment, training, and education that are based, to the extent possible, on the strengths, needs, and desires of the individual.

The individual support plan is the fundamental document detailing the self-identified goals and aspirations of an individual and the various supports the individual needs to reach those goals. Resource center policies and procedures shall be written and implemented to ensure that individual support plans are person-centered, person-driven, and built upon the principles set forth below.

### **Support Plan Principles**

The resource center written policies and procedures shall assure that:

- ◆ Each individual has the right to lead and direct the individual's life to the best of the individual's ability.
- ◆ The facility has the responsibility to teach and train individuals to lead and direct their lives to the best of their abilities.
- ◆ True personal development occurs when individuals lead their lifestyle planning to the best of their abilities, tailoring their life activities around their strengths, interests, and personal goals.
- ◆ All individuals grow and develop best in a strength-based environment that:
  - Is driven by recognized strengths and abilities as opposed to recognized deficits;
  - Fully utilizes and builds upon those strengths and abilities to meet personal goals and needs;
  - Emphasizes and encourages learning and responsibility;
  - Recognizes, in an ongoing fashion, one's efforts as well as one's progress; and
  - Provides supports that meet the individual's preferences and learning style.
- ◆ An individual's well being is a bio-psycho-social condition and cannot be disjointed or compartmentalized.

### **Individual Support Plans Required**

The resource center written policies and procedures shall assure that each individual residing at a resource center shall have a current individual support plan. "Current" is defined as:

- ◆ Within 30 days of admission or readmission to the resource center, and
- ◆ Within each 365 consecutive days annually thereafter.

### **Comprehensive Functional Assessment**

The resource center written policies and procedures shall assure that:

- ◆ A comprehensive functional assessment shall be completed within 30 days before the development of the original individual support plan that accurately addresses:
  - The individual's strengths, preferences and positive attributes,
  - The individual's disabilities and diagnoses, and
  - The individual's functional abilities and needs.
- ◆ The assessment shall be updated with each subsequent annual plan update.

### **Individual Support Plan Development**

Resource center written policies and procedures shall assure that each individual support plan shall:

- ◆ Be person-centered, reflecting the individual's preferences, strengths and desires, and fully reflect the desired lifestyle of the individual.
- ◆ Be developed based on comprehensive assessments that are consistent with current, generally accepted professional standards.
- ◆ Be written and implemented to assist individuals in gaining and exercising self-determination and independence to the greatest degree possible.
- ◆ Be developed with full participation by the individual and the individual's parent, guardian or legal representative, as applicable, and all interdisciplinary team members.

### **Plan Coordination**

Resource center written policies and procedures shall assure that the development of an individual's individual support plan shall incorporate and coordinate all the other support plans developed for an individual including:

- ◆ The behavior support plan,
- ◆ The risk management plan,
- ◆ The individual education plan, and
- ◆ All clinical care plans.

### **Individual Training Program**

Resource center written policies and procedures shall assure that each individual support plan shall contain a comprehensive training program, which shall include:

- ◆ Opportunities for choice and self management.
- ◆ Formal training goals identified by priority, with specific and measurable objectives, based on the comprehensive functional assessment, barriers to community living, and the individual's wishes, that outline:
  - Single behavioral outcomes;
  - Methods and schedule for implementation;
  - Documentation requirements;
  - Type and frequency of data collection; and
  - Monitoring requirements, including persons responsible.
- ◆ Independent living skills development including, for individuals lacking them, training in personal skills, including:
  - Toileting;
  - Personal hygiene;
  - Dental hygiene;
  - Self-feeding;
  - Bathing;
  - Dressing;
  - Grooming; and
  - Communication of basic needs.

### **Program Review and Modification**

Resource center written policies and procedures shall assure that:

- ◆ Each program shall be reviewed at least monthly and more often as indicated by an individual's needs, by:
  - The treatment program manager or qualified mental retardation professional, and
  - The interdisciplinary team member assigned to review the individual's progress on the specific training program.
- ◆ Program reviews shall be documented in the individual's record and minimally include:
  - A review and analysis of the program data;
  - A summary of the individual's progress;
  - A statement reflecting the program's efficacy and what, if any, modifications are needed to better address the individual's goals and needs.
- ◆ When a lack of expected progress or a significant change in the individual's status has occurred, the interdisciplinary team shall meet to determine if the individual support plan needs to be modified, and shall modify the individual support plan as appropriate.

### **Plan Performance Improvement**

Resource center written policies and procedures shall assure that quality management practices are in place to monitor the quality of individual support plans, individually and collectively.

### **Individual Support Plans**

Resource center written policies and procedures shall assure that:

- ◆ Individual support plans shall be developed based on current professional standards of practice, as evidenced by:
  - Language or content that is written in a user-friendly format and easily understandable to those responsible for implementation,
  - Thorough and complete components for the comprehensive functional assessments, behavior support plans, risk management plans, individual education plans, clinical care plans, and
  - Present and complete implementation standards, i.e., identified training needs, documentation requirements, assessments, etc.
- ◆ Individual support plans shall be monitored based on current professional standards of practice, as evidenced by:
  - Data that is collected as prescribed,
  - Evidence of interdisciplinary team members completing observations and record reviews, and
  - Goals that are updated when criteria have been met or when a lack of progress or a consistent decrease is noted.

### **Data Collection and Review on Support Plans**

Resource center written policies and procedures shall assure that:

- ◆ Each individual's progress towards independence shall be assessed at least monthly.
- ◆ Progress shall be based on the individual's ability to meet the specific objectives outlined in the individual support plan.
- ◆ The resource center shall document significant events that:
  - Are related to the individual's program plan and assessments; and
  - Contribute to an overall understanding of the individual's ongoing level and quality of functioning.

### **Employee Training and Education on Support Plans**

Resource center written policies and procedures shall assure that competency-based employee training shall be provided on support plan policies and procedures.

- ◆ One employee who shall be designated and shall be responsible for:
  - Ensuring that appropriate training and technical assistance support plan development shall be provided to the treatment teams responsible for the development and implementation of individual support plans, and
  - Providing quality management oversight of the development of individual treatment plans.
- ◆ Employee training on the implementation of support plans shall include but not be limited to:
  - Support plan principles,
  - Philosophy and purpose of support plans,
  - Regulatory requirements,
  - Comprehensive functional assessments,
  - Development of a support plan,
  - Implementation of a support plan,
  - Coordination of a support plan,
  - Monitoring of a support plan,
  - Review of a support plan,
  - Modification of a support plan, and
  - Documentation of a support plan.

### **Employees Trained on Support Plans**

Resource center written policies and procedures shall assure that training shall be provided to professional and direct care employees regularly assigned to work with individuals who are newly hired or are transferred employees not previously trained.

### **Specific Support Plan Training**

Resource center written policies and procedures shall assure that all employees responsible for implementing a specific individual's support plan shall receive competency-based training on the implementation of the initial plan and all subsequent revisions.

### **Continuing Education on Support Plans**

Resource center written policies and procedures shall assure that all professional and direct care employees regularly assigned to work with individuals shall receive annual competency-based refresher training. This may be an abbreviated version of the initial required training.

### **General Training Policies on Support Plans**

Resource center written policies and procedures shall assure that:

- ◆ Employee training shall be regularly documented in the training record for each employee in a manner that permits the information to be available individually and in aggregate form.
- ◆ Training curriculum shall be updated regularly to reflect changes in laws, policies, and procedures.
- ◆ Training shall be implemented in a timely manner.

## **Policy on Risk Management**

Each resource center shall effectively assess and address each individual's risk factors. Policies and structured processes shall be maintained to assist employees in quickly identifying the individual's risk factors and promptly take action to address those risks. Clinical and professional specialties shall collaborate to providing optimal care and support.

Policies and procedures shall give attention to the broad, and often diverse, risk issues affecting an individual's quality of life and address the complex medical issues which can lead to an increased risk for physical or emotional harm.

### **Risk Management Principles**

Resource center written policies and procedures shall assure that:

- ◆ An understanding and commitment to integrated team planning shall be developed.
- ◆ A clear understanding of the multidimensional nature of risk and its impact on an individual's quality of life shall be developed.
- ◆ An environment of learning where each team member, including direct-line employees, are free and encouraged to participate, question and gain knowledge from one another shall be developed.
- ◆ A commitment to prevention, including educating individuals on their risk factors and how to manage their risks to the best of their abilities shall be developed.
- ◆ An understanding of the "dignity of risk" and its significance to an individual's self-determination shall be developed. See Definitions: "[dignity of risk](#)."

### **Risk Screening**

Resource center written policies and procedures shall assure that each individual shall be screened for the risk factors identified below before the development of the individual's initial individual support plan and no less than annually thereafter.

Resource center risk factors include:

- ◆ 2 or more falls in a calendar month
- ◆ 3 or more psychotropic medications
- ◆ A/C & psychotropic medications
- ◆ Aggressor
- ◆ Alternative communication
- ◆ Aspiration pneumonia
- ◆ Colostomy
- ◆ Decubiti
- ◆ Diabetes
- ◆ Dysphagia
- ◆ Enteral tube
- ◆ Fractures
- ◆ GERD
- ◆ Hearing impairment
- ◆ Increased seizure activity
- ◆ Nonambulatory
- ◆ Obesity
- ◆ Osteoporosis diagnosis
- ◆ Pica
- ◆ Seizure diagnosis
- ◆ Self-injurious behavior
- ◆ Sexual aggressor
- ◆ Tracheotomy
- ◆ Underweight
- ◆ Unplanned weight change
- ◆ Upper airway obstruction
- ◆ Ventilator dependency
- ◆ Victimization
- ◆ Visual impairment

The risk screening shall be:

- ◆ Person-centered, with presence and participation by the individual and the individual's parent, guardian, or legal representative when possible.
- ◆ Interdisciplinary, to ensure that:
  - Causal issues are appropriately identified,
  - The bio-psycho-social effects of the risks are identified, and
  - Co-morbidities are identified and considered during the screening.

### **Risk Assessment**

Resource center written policies and procedures shall assure that the following actions shall be completed within five business days of the screening process revealing a risk factor or within five business days of an individual having a change of status (new risk identified or change in current risk status):

- ◆ A comprehensive assessment by qualified team members to examine:
  - Causal issues and the pervasive nature of the risk, including co-morbidities caused or affected by the risk factor;
  - The impact each risk factor has on the daily living of the individual;
  - The goals or desired outcomes of treatment and support; and
  - The supports required to actualize those goals or desired outcomes.
- ◆ An integrated team dialogue between all applicable disciplines (absence by exception only). Participation of a direct support employee familiar with the individual and the individual's daily lifestyle shall be required. This dialogue shall include:
  - A review of the assessment and the impact the risk factor has on the individual's quality of life;
  - The goals or desired outcomes of treatment and support;
  - The supports required to actualize those goals and desired outcomes;
  - Ways to provide the supports, with special emphasis given to:
    - The individual's strengths, preferences and lifestyle; and
    - The most integrated and naturalized fashion to provide supports, including opportunities to integrate the provision of supports with the individual's goals or objectives.

- ◆ Documentation of the team's discussion, outcomes, and planned course of action placed in the individual's resource center record.

### **Risk Management Plan**

Resource center written policies and procedures shall assure that if supports are identified as necessary to address the risks shall be incorporated into the individual support plan within 30 days of the interdisciplinary assessment, or sooner when indicated by risk status.

At minimum, the individual support plan shall include:

- ◆ The dates of the assessment, team meeting and plan.
- ◆ The authors of the plan.
- ◆ A brief summary of each identified risk and its impact the individual's health, safety, self-determination and lifestyle.
- ◆ The risk of harm if the support is not properly implemented.
- ◆ The goals and desired outcomes of each support.
- ◆ Specific and measurable objectives easily understood by all employees.
- ◆ Preventative actions or steps to be taken by employees responsible for implementation.
- ◆ Specific triggers, symptoms or identified precursors to alert employees that the individual may be at immediate risk.
- ◆ Notification guidelines including what changes in the individual's condition shall require that a nurse, doctor, or other team be notified.
- ◆ Implementation guidelines including employees responsible and documentation requirements.
- ◆ Monitoring schedule, including the person's responsible, frequency, and documentation standards.
- ◆ Training requirements including persons to be trained, persons responsible for conducting training sessions and documentation requirements.

### **Risk Review**

Resource center written policies and procedures shall assure that the individual support plans of individuals identified with a risk factor shall be reviewed at least monthly and more often if indicated by the individual's risk severity or status change. The review shall include the following:

- ◆ Observations of employees implementation of the plan, where appropriate, to ensure appropriateness and assess the plan's efficacy;
- ◆ Discussions with the individual and employees routinely implementing the plan, to determine if any changes or modifications to the plan are recommended;
- ◆ Review of progress notes for the previous 30 days to determine if any unreported changes or symptomatology occurred, following up with employees as indicated;
- ◆ Review of the documentation and data collection specified by the plan to determine progress, changes, trends, etc.; and
- ◆ Documented summary, based on the review components identified above, of:
  - The individual's progress during the previous 30 days, present risk status, and current needs;
  - Changes to the individual support plan supports, if any, and rationale for the changes; and
  - Planned course of action for next 30 days and projected date for next review.

### **Organizational Risk**

Resource center written policies and procedures shall assure that:

- ◆ Actual or potential risks, failure, or points of vulnerability that affect the health or safety of individuals, employees, and visitors or the operation of the resource center are regularly identified.
- ◆ Identified organizational risks shall be assessed and a plan of action developed which prioritizes the areas for improvement based on the actual or potential impact on individual care or loss to the resource center.

### **Reporting Unexpected Events**

Resource center written policies and procedures shall assure that:

- ◆ Unexpected events that occur that create a risk that could influence or be disruptive to the provisions of services to or safety of individuals shall be reported. Such events includes but are not limited to the following:
  - Fire;
  - Employee theft, assault, illegal drug activity, criminal activity;
  - Damage to physical plant or operations resulting from natural disasters; or
  - Major disruption in facility operational systems such as phone, electrical communications, heating or air conditioning, utilities;
  - Work-related death or serious injury to an employee; or
  - Any other event that is or may become disruptive to the normal operation of the resource center and may affect the public outside the resource center.
- ◆ Any event significant enough to immediately and significantly disrupt the operation of the resource center or which is of interest to the public shall be reported within two hours of the event by direct phone contact with the deputy director during business days, evenings, weekends, and holidays.
- ◆ A written report of the event shall be submitted by E-mail to the deputy director no later than 12 p.m. the next business day.
- ◆ All other situations shall be reported to the deputy director by E-mail no later than 12 p.m. the next business day.

### **Risk Performance Improvement**

Resource center written policies and procedures shall assure that quality management and performance improvement efforts shall include specific focus on the goal to limit the impact the risk has on the individual's health and safety.

In concert with this policy's annual review, established criteria shall be reviewed to ensure their adherence to current professional standards. Resource centers shall work collaboratively with the Office of Quality Management in the Division of Field Operations to determine if any changes, modifications, or additions need to be made.

### **Risk Data Collection and Review**

Resource center written policies and procedures shall assure that:

- ◆ Supervisors shall routinely review and monitor documentation by employees implementing risk support plans to ensure:
  - Timely completion of documentation requirements, and
  - Notification requirements for changes of status are followed when indicated.
- ◆ Individual and aggregate risk management data shall be maintained and furnished to designated persons, departments, etc.
- ◆ Data shall be reviewed, both individually and aggregately, to identify trends, patterns, or other issues related to risk issues.
- ◆ The facility's risk data profile shall be maintained with current monthly data and reviewed by the interdisciplinary teams and the quality council.

### **Risk Criterion Review**

Resource center written policies and procedures shall assure that the risk factors identified under [Risk Screening](#) are reviewed annually along with the established criteria, to:

- ◆ Ensure their adherence to current professional standards; and to
- ◆ Determine what, if any, modifications or additions need to be made.

The review shall be done in collaboration with the Office of Quality Management and the deputy director.

### **Employee Training and Education on Risk Management**

Resource center written policies and procedures shall assure that competency-based training shall be provided on risk management policies and procedures, which shall include but not be limited to:

- ◆ The principles of risk management,
- ◆ The risk screening process,
- ◆ The factors screened for,
- ◆ The risk assessment process,
- ◆ The development, modification, and documentation of the risk management plan, and
- ◆ Required risk plan review.

### **Employees Trained on Risk Management**

Resource center written policies and procedures shall assure that training on risk management shall be provided to all newly hired, or transferred employees not previously trained, professional and direct care employees regularly assigned to work with individuals.

### **Continuing Education on Risk Management**

Resource center written policies and procedures shall assure that all professionals and direct care employees responsible for the development and implementation of support plans shall receive annual competency-based refresher training on risk management . This may be an abbreviated version of the initial required training.

### **General Training Policies on Risk Management**

Resource center written policies and procedures shall assure that:

- ◆ Employee training shall be regularly documented in the training record for each employee in a manner that permits the information to be available individually and in aggregate form.
- ◆ Training curriculum shall be updated regularly to reflect changes in laws, policies, and procedures.

## **Policy on Incident Management**

It is the policy of the Department that individuals served by the resource centers shall be provided opportunities to develop independent skills in a safe humane environment, free from abuse or harm.

Incidents directly involving the care, treatment, or habilitation of an individual shall be identified and tracked for the purpose of scrutiny and investigation, prevention of future harm and to assure the maximum safety and protection of the individuals served.

Federal and state laws have been enacted to recognize and protect the civil rights of individuals with developmental disabilities, prohibiting the abuse of these individuals. These rights are specified in the [Policy on Human Rights](#).

### **Incident Management Principles**

- ◆ Abuse shall not be tolerated.
- ◆ There are consequences for persons who commit abuse.
- ◆ A safe environment provides the basis to accomplish the resource center mission of providing quality treatment and habilitation services to enable individuals to fully achieve their maximum potential.
- ◆ All staff, contractors, and volunteers have a responsibility to assure individual safety and protection from harm and therefore shall report all incidents immediately.
- ◆ In order to carry out these responsibilities effectively, staff, contractors, and volunteers must be adequately trained to recognize abuse and other incidents and what to do to protect the individuals served.

### **Personnel Practices**

Resource center written policies and procedures shall assure that:

- ◆ Before beginning employment, volunteering, or contracting, all applicants for employment, reinstatement to employment, regular volunteering, or ongoing personal service contracts shall be screened for:

- 
- Employment history,
  - Criminal history,
  - Child abuse history,
  - Dependent adult abuse history,
  - Inclusion on the federal list of excluded individuals and entities, and
  - Inclusion on the Sex Offender Registry.
- ◆ Any person seeking employment or reinstatement to employment who has a record of founded child or dependent adult abuse or denial of critical care or has any conviction based on those offenses shall be denied employment unless:
    - The person submits form 470-2310, *Record Check Evaluation*, for screening by the Department, and
    - The Department determines that the person is employable.
  - ◆ Any person seeking a personal services contract or seeking to volunteer regularly who has a record of a founded child, dependent adult abuse, or denial of critical care or has any conviction based on these offenses shall be denied the contract or the opportunity to volunteer.
  - ◆ All personnel actions resulting from investigations shall follow state personnel policy and procedures.
  - ◆ Any employee, volunteer, or contractor shall report within 24 hours or on the next scheduled business day any allegation or founding of abuse or being arrested for, charged with, or convicted of any felony or misdemeanor against the person arising from the person's actions outside the work place.

Employees shall make the report to the employee's direct-line supervisor.  
Volunteers or contractors shall report to their facility contact person.
  - ◆ When such a report is made, the employee, volunteer, or contractor shall complete form 470-2310, *Record Check Evaluation*, and the resource center shall submit the form for screening by the Department under [Iowa Code section 218.13](#) to determine if the person continues to be employable.
  - ◆ The resource center shall follow up on any information it receives that indicates that an employee, volunteer, or contractor has not reported any allegation or founding of abuse or arrest, charge, or conviction for any felony or misdemeanor.

- ◆ Any employee, contractor, or volunteer who fails to report any allegation of abuse or arrest, charge, or conviction for any felony or misdemeanor against the person arising from the person's actions outside the work place within 24 hours or on the next scheduled business day shall be subject to sanctions, up to and including dismissal or termination of contract.
- ◆ Any employee, volunteer, or contractor who has been found to have contributed to adult or child abuse, to have committed adult or child abuse, to have been convicted of child or adult abuse, denial of critical care, or to have committed mistreatment shall be subject to sanctions, up to and including dismissal or termination of contract.
- ◆ All decisions on type and severity of disciplinary actions taken against employees shall be done timely and shall be based on an evaluation of the type and severity of the incident based on the evidence in the incident report, prior personnel actions taken with the employee, and other components of just cause.

### **General Incident Management**

Resource center written policies and procedures shall assure that:

- ◆ No employee, contractor, or volunteer shall behave in an abusive or neglectful manner toward individuals. No employee, contractor or volunteer shall violate the Iowa Code provisions related to:
  - Child abuse. (See [Iowa Code section 232.68\(2\)](#) and [441 IAC 175.21\(232, 235A\)](#).)
  - Abuse or neglect of dependent adults. (See [Iowa Code section 235B.2\(5\)](#) and [441 IAC 176.1\(235B\)](#).)
  - Sexual abuse. (See [Iowa Code Chapter 709](#).)

NOTE: The Department's policy defines abuse more broadly than does the Iowa Code. Employee, contractor, or volunteer actions that meet the Department's definition of abuse in this chapter will be in violation of this policy and are strictly prohibited.

- ◆ All employees, contractors, and volunteers who have regular contact with individuals shall be trained to:
  - Identify and report abuse and other incidents; and
  - Respond to incidents threatening the health and safety of individuals as defined by this policy.

- ◆ Employees, contractors, or volunteers who fail to report incidents as required; who give false, misleading, or incomplete information; or who otherwise do not participate in the investigation or review process as outlined shall be in violation of this policy and shall be subject to:
  - Discipline or termination of services, whichever is applicable; and
  - Where appropriate, criminal prosecution.
- ◆ Employees who retaliate against any individual, employee, contractor, or volunteer for that person's involvement in the reporting and investigation process as a reporter or witness or in any other capacity shall be in violation of this policy and shall be subject to discipline, and where appropriate, criminal prosecution.
- ◆ Individuals shall be encouraged and educated to assert the legal and civil rights they share with all United States citizens, including the right to a dignified, self-directed existence in a safe and humane environment, free from abuse or harm.
- ◆ All incidents involving the care, treatment or habilitation of an individual that occur at the resource centers shall be identified and tracked for the purpose of scrutiny and investigation, in the interest of preventing future harm, and ultimately to assure maximum safety and protection of the individuals served.
- ◆ An electronic system that is uniform across both resource centers shall be developed and implemented to track reported incidents with the data listed in the performance improvement section of this policy.
- ◆ Incidents shall be monitored and evaluated to determine if any policy, procedure, training, or operational changes are needed to minimize the future risk to individuals.

### **Individual Safety**

Resource center written policies and procedures shall assure that:

- ◆ The health and safety needs of an individual involved in an incident are an immediate priority.
- ◆ All employees, volunteers, and contractors shall take immediate steps to assure that an individual involved in an incident receives needed appropriate treatment and protection from further harm. Such actions include but are not limited to:
  - Providing first aid,
  - Calling for emergency medical services,
  - Removing the individual from an environment that threatens further harm,
  - Removing an aggressor from further contact with the individual,
  - Removing a caretaker from contact with the individual when the caretaker has allegedly abused the individual, or
  - Any other appropriate action.
- ◆ The supervisor responding to the incident shall document the health and safety needs that the individual had because of the incident and the actions take in response to those identified needs.

### **Elopement**

Resource center written policies and procedures shall assure that:

- ◆ When an employee responsible for the supervision of an individual determines that the individual's location is unknown, either on campus or off campus, the employee shall immediately notify the supervisor and initiate a search for the individual.
- ◆ If the individual is not found within 15 minutes the supervisor shall immediately notify the administrative officer of the day, the doctor on call, and the superintendent or the superintendent's designee.
- ◆ The superintendent or the superintendent's designee shall implement an organized, extended search.

- ◆ Law enforcement shall be contacted for assistance in accordance with locally established agreements when the individual:
  - Is involuntarily committed and is known to be or may be off campus, or
  - Is on campus or off campus and presents a danger to self or others, or
  - Has not been located within 45 minutes of the initiation of the extended search.
- ◆ The superintendent or the superintendent's designee shall determine when to end the organized, extended search.

### **Elopement Reporting**

Resource center policy and procedures shall assure that:

- ◆ When an extended search has been initiated upon an elopement, the superintendent or the superintendent's designee shall report to the deputy director by direct phone contact within two hours of the initial report of the elopement.
- ◆ The superintendent or the superintendent's designee shall report to the deputy director by direct phone contact within two hours of receipt of a report that during the elopement, the individual:
  - Has sustained a serious injury,
  - Has seriously threatened to harm or harmed anyone,
  - Is alleged to have committed a crime, or
  - Has engaged in high-risk behavior.
- ◆ Reports shall be made during business days, evenings, weekends, and holidays.
- ◆ The superintendent or the superintendent's designee shall submit to the deputy director a written report of the event no later than 12 p.m. of the next business day.

### **Incident Reporting and Tracking**

Resource center written policies and procedures shall assure that:

- ◆ A system shall be developed that individuals, employees, contractors, or volunteers use to report incidents.
- ◆ A uniform electronic system shall be developed and implemented to track reported incidents with the data list in performance improvement section of this policy.
- ◆ Incidents shall be monitored and evaluated to determine if any policy, procedure, training, or operational changes are needed to minimize the future risk to individuals.
- ◆ The following incidents involving an individual shall be reported and tracked:
  - Accidents on or off campus resulting in injury
  - Adverse drug reaction
  - Alleged abuse
  - Aspiration pneumonia
  - Assault to employees by individuals
  - Assault to peers by individuals
  - Bowel obstruction
  - Choking
  - Death (natural cause, other)
  - Elopement
  - Falls
  - Injuries of unknown origin
  - Injuries resulting from restraint
  - Medical emergency
  - Medication variances
  - New onset seizure
  - Pica
  - Self injuries
  - Significant weight change
  - Site infection (G-tube, tracheotomy, etc.)
  - Skin breakdown
  - Status epilepticus
  - Suicide attempt or gestures
  - Suspension or termination at work, school, etc.

### **Employee Reporting Requirements**

Resource center written policies and procedures shall assure that:

- ◆ An employee shall immediately report all incidents verbally to the employee's direct line supervisor. This includes incidents that may be reported to the employee by a contractor or volunteer. If the incident is an allegation of abuse and involves the supervisor, the report shall be made to the supervisor's supervisor.
- ◆ When an employee suspects, has knowledge of, or receives a report of abuse that may have been caused by a person other than a resource center employee, contractor, or volunteer, the employee shall also verbally report this information immediately to the supervisor.
- ◆ All mandatory reporters shall report alleged abuse to the Department of Inspection and Appeals within 24 hours of knowledge of the incident using the Department of Inspections and Appeal's reporting system.
- ◆ All employees shall immediately report to their direct-line supervisor or covering supervisor all calls to law enforcement pertaining to incidents or other activities occurring at the resource center, whether the call was made by an individual or made by the employee personally.

### **Reporting Requirements for Volunteers and Contractors**

Resource Center written policies and procedures shall assure that:

- ◆ Volunteers and contractors shall immediately report all incidents verbally to the employee who is their designated facility contact.
- ◆ All contractors or volunteers who receive a report of or have knowledge of abuse or suspected abuse that may have been caused by a person other than an employee, contractor, or volunteer shall immediately report the allegation to their designated facility contact.
- ◆ All information pertaining to any allegation or report and subsequent investigation of an incident shall be kept confidential, including the name and position of the person making the report.
- ◆ All volunteers and contractors shall immediately report to their designated facility contact all calls to law enforcement, made by individuals or made personally, pertaining to incidents or other activities occurring at the resource center.

### **Supervisor Reporting Requirements**

Resource center written policies and procedures shall assure that all supervisors receiving an incident report from an employee shall immediately report to the superintendent or the superintendent's designee:

- ◆ All allegations of abuse,
- ◆ All deaths,
- ◆ All serious injuries,
- ◆ All medical emergencies,
- ◆ All sexual assaults by individuals on peers or caretakers,
- ◆ All elopements,
- ◆ All attempted suicides,
- ◆ All injuries of unknown origin, and
- ◆ All calls made to law enforcement by individuals or caretakers.

### **Superintendent or Designee Reporting Requirements**

Resource center written policies and procedures shall assure that the superintendent or the superintendent's designee shall report incidents to the deputy director or the deputy director's designee as follows:

- ◆ The following incidents shall be reported by direct phone contact with the deputy director within two hours of receipt of initial incident report during the business days, evenings, holidays, or weekends:
  - All allegations of abuse resulting in serious injury.
  - All allegations of sexual abuse.
  - All allegations of neglect involving elopement that results in a call to DIA or law enforcement or lack of supervision that results in sexual contact between individuals or peer-to-peer assault with serious injury.
  - All deaths caused by abuse or which are suspicious or unexplained.
  - All serious injuries of unknown origin.
  - All medical emergencies resulting in hospitalization.
  - All attempted suicides.
  - All calls made to law enforcement.
- ◆ All other serious injuries or allegations of abuse shall be reported to the deputy director by E-mail no later than 12 p.m. on the next business day.

### **Reports to Law Enforcement**

Resource center written policies and procedures shall assure that the following shall be reported to law enforcement authorities:

- ◆ All allegations of sexual abuse shall be reported within two hours of receiving notification.
- ◆ All abuse investigatory findings that lead to the suspicion of a criminal act having been committed shall be reported as soon as identified.
- ◆ Any other reports or information identified in jointly developed agreements with local law enforcement authorities shall be reported.

### **Reports to Guardians and Families**

Resource center written policies and procedures shall assure that the following shall be reported to guardians, legal representatives, parents, and families:

- ◆ Incidents requiring a Type 1 investigation shall be reported within 24 hours.
- ◆ All other incidents shall be reported in a timely manner.

### **Incident Investigation**

Resource center written policies and procedures shall assure that:

- ◆ All incidents shall be investigated or reviewed.
- ◆ Incidents shall be categorized into types for purposes of distinguishing the specifics of the investigatory review process.
- ◆ All persons who perform investigations or reviews shall be trained and competent in carrying out these duties.
- ◆ All employees, volunteers, or contractors involved in the investigative process shall cooperate with the investigators and shall be apprised of the following:
  - Any incidents of "witness tampering," such as threats, intimidation, or coercion of employees, volunteers, contractors, or individuals involved in the investigation, shall be examined and, if confirmed, shall be regarded and addressed as violence in the work place.

- All verbal and written statements shall be presented with truthfulness and made without discussion or collaboration with other persons.
- Employees shall maintain confidentiality at all times during the investigation, including not discussing or disclosing any information pertaining to the investigation except as requested by the investigator.

### **Type 1 Incident Investigations**

Resource center written policies and procedures shall assure that:

- ◆ Type 1 investigations shall be done for:
  - All allegations of abuse.
  - All serious injuries.
  - All suspicious or unexpected deaths, and all deaths allegedly caused by abuse.
  - All allegations of sexual abuse.
  - All suspicious injuries.
  - All injuries resulting from restraint.
  - All suicide attempts.
  - All individual sexual assaults of another individual.
  - All physical assaults resulting in serious injury.
  - Any physical assault when in the professional judgment of the treatment program manager, treatment program administrator or other authority, a type 1 review is deemed appropriate based on:
    - The nature of the incident,
    - The potential of harm from the incident, or
    - The prior incident frequency or history of the individuals involved.
  - Other incidents as assigned by the superintendent or deputy director.
  - All other incidents in which an initial type 2 incident review or clinical or interdisciplinary team review indicates a potential allegation of abuse

- ◆ All type 1 investigations shall be conducted by a qualified investigator who:
  - Holds the position or classification of investigator II, investigator III, director of quality management, investigations coordinator, assistant superintendent, or superintendent;
  - Is supervised by a person that is independent of program operations;
  - Has successfully completed competency-based training on current professional standards for conducting investigations; and
  - Is able to work collaboratively with law enforcement officials when needed.
- ◆ All type 1 investigations shall commence within four hours of the report of the incident unless otherwise assigned by the director of quality management or designee, but no later than 24 hours after the report of the incident. Waiver of four-hour initiation shall not apply to allegations of:
  - Physical abuse with injury,
  - Sexual abuse,
  - Incidents of serious injury,
  - Unexpected or suspicious deaths,
  - Attempted suicides,
  - Cases where law enforcement is involved, or
  - Neglect that involves elopement requiring DIA notification, sexual contact between individuals, or serious injury due to peer-to-peer aggression.

When four-hour initiation is waived, the director of quality management or designee must document the reasons, including the steps taken to ensure safety of all individuals and the integrity of the investigation.

- ◆ Type 1 investigations shall be completed within five business days of the reporting of the incident.
- ◆ Investigation written reports shall be made using form 470-4366, *Incident Investigation Report*.

- ◆ The investigator's supervisor shall review all investigation reports for thoroughness, accuracy, completeness, coherence, and objectivity. Any subsequent corrections or revisions deemed necessary shall be submitted on a timely basis as an addendum.
- ◆ When the investigation report is completed, it shall be sent to the superintendent or the superintendent's designee for review and approval.

### **Type 2 Incident Reviews**

Resource center written policies and procedures shall assure that:

- ◆ A process shall be in place to review all incidents that will not have a type 1 investigation, in order to evaluate:
  - The cause of the incident,
  - The impact on the individual, and
  - The need for corrective action.
- ◆ Supervisory or administrative staff shall conduct type 2 incident reviews.
- ◆ The findings of the review shall be documented in the individual's record.
- ◆ Type 2 incident reviews shall:
  - Commence within four hours of the report of the incident; and
  - Be completed within five business days of the incident.
- ◆ Written reports shall be made on form 470-4345, *Type 2 Incident Review Report*.
- ◆ The treatment program manager shall review the completed report for:
  - Completeness of the report.
  - Whether appropriate corrective action was identified.
  - Whether the corrective action complied with corrective actions policies.
  - Whether a required clinical or interdisciplinary team review was completed.

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### **Clinical or Interdisciplinary Team Review of Incidents**

Resource center written policies and procedures shall assure that:

- ◆ The interdisciplinary team shall conduct an immediate clinical review of the following incidents:
  - Adverse drug reaction,
  - New onset seizure,
  - Aspiration pneumonia,
  - Choking,
  - Significant weight change,
  - Skin breakdown,
  - Site infection,
  - Bowel obstruction,
  - Suicide attempts, and
  - Medical emergency.
- ◆ The individual's interdisciplinary team shall review the following incidents within five business days of the incident:
  - Two or more injuries of any type within 10 calendar days,
  - Suicide threats,
  - Two or more falls within 30 calendar days,
  - Suspension or termination of school, work, etc.),
  - Two or more elopements, as defined in this chapter, within 10 calendar days,
  - Increase in target behavior of 20% or more in past 30 days.
- ◆ The findings of all immediate clinical reviews and interdisciplinary team reviews shall be documented in the individual's chart.
- ◆ The individual's individual support plan shall be revised as appropriate based on the review.

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### **Treatment Program Manager Review of Incidents**

Resource center written policies and procedures shall assure that:

- ◆ No less frequently than weekly, each qualified mental retardation professional shall review all incidents from the previous week against the previous six months incident data for each person and collectively to identify any trends related to:
  - Incident type,
  - Incident cause,
  - Incident location,
  - Employees assigned,
  - Program area,
  - Resident treatment supervisor response,
  - Corrective actions taken, or
  - Notifications.
- ◆ All qualified mental retardation specialists shall conduct the review by on the same day of the week, as selected by the superintendent.
- ◆ A summary of the weekly review shall be submitted to the treatment program administrator. The summary shall highlight areas of concern and corrective actions to be taken.
- ◆ No less than monthly, each treatment program administrator shall review the summaries submitted by the treatment program managers and provide a summary of the findings and recommendations to the quality council.

### **Corrective Actions**

Resource center written policies and procedures shall assure that:

- ◆ There shall be a process to assign the development and implementation of specific corrective actions plans to prevent future incidents and protect individuals' safety. The corrective action plans shall address issues identified in all:
  - Type 1 incident investigations,
  - Type 2 incident reviews, and
  - Clinical or interdisciplinary team reviews.

- ◆ This process shall assure that:
  - Written corrective action plans shall be developed with five business days of assignment.
  - Corrective actions plans shall identify the tasks, timelines, outcomes to be accomplished, and the employees responsible for implementation.
  - Corrective action plans shall be implemented in a timely manner.
  - The results of corrective action plans shall be documented.
- ◆ The superintendent or the superintendent's designee shall:
  - Approve all corrective action plans created as the result of an investigation before implementation and
  - Approve any proposed modification to content or timeline before implementation.
- ◆ There shall be a monitoring and tracking process to assure that all corrective actions are developed within specified time limits and are completed as approved.

### **Incident Performance Improvement**

Resource center written policies and procedures shall assure that quality management practices are in place to:

- ◆ Monitor the reporting and investigation of incidents;
- ◆ Identify systemic issues, actual or potential, needing corrective action; and
- ◆ Monitor the completion and implementation of corrective action plans.

### **Incident Data Collection and Review**

Resource center policies and procedures shall assure that:

- ◆ Data collection on incidents shall include, at a minimum, the following categories:
  - Name of individual
  - Case number
  - Names of all witnesses
  - Names of employees and clients present
  - Names of employees assigned

- Date, day of week, and time of incident
- Individual's living unit
- Abuse or incident type
- Incident cause
- Injury type
- Body part where injury occurred
- Injury class (serious or other)
- Name of alleged perpetrator, if appropriate
- Location where incident occurred
- Activity where incident occurred
- Treatment required
- Time incident was discovered
- Time and date report was completed
- Person completing the report
- Incident details
- Resident treatment supervisor response
- Resident treatment supervisor action
- Immediate actions with employee
- Immediate actions with the individual
- Additional corrective actions (yes/no)
- Corrective actions
- Person responsible for corrective action
- Date plan is to be completed
- Date documentation received indicating corrective action completed
- Corrective action type
- Date facility investigation began
- Date facility investigation completed
- Outcomes of the investigation
  - Abuse substantiated or unsubstantiated
  - Cause of injury of unknown origin remains unknown
- Notifications
  - Guardian, legal representative, parents and family
  - Superintendent
  - Deputy director
  - Department of Inspections and Appeals (DIA)
  - Law enforcement, if appropriate
- Final personnel action taken

- Date DIA declined to investigate, if applicable
  - Date DIA started investigation, if applicable
  - DIA finding, if any
  - Review by treatment program manager
  - Review by treatment program administrator
- ◆ The information shall be tracked and provided in the format defined by the deputy director.

### **Data Review**

Resource center policies and procedures shall assure that:

- ◆ Data gathered from the data analysis shall be:
  - Reviewed by the incident review committee; and
  - Consistently used for identifying and addressing individual and systemic issues to improve the quality of life for individuals.
- ◆ The resource center's incident review committee shall review data from all investigations to assure that:
  - Problems are timely and adequately detected;
  - Timely and adequate protections are implemented;
  - Timely and appropriate corrective actions are implemented; and
  - Root causes are identified, when possible, that lead to corrective action.
- ◆ Resource center records of the results of every investigation and review of incidents or serious injuries shall be maintained in a manner that permits investigators and other appropriate staff to easily access each investigation involving a particular employee or individual.

### **Reporting Requirements for Incident Data**

Resource center written policies and procedures shall assure that:

- ◆ The monthly reporting process of incidents and investigative findings to the resource center's quality council shall be defined.
- ◆ The data collected shall be available for analysis by each data element collected.

- ◆ The resource center shall provide to the deputy director:
  - A monthly summary report on the incident reports;
  - A quarterly summary of the analysis identifying systemic issues; and
  - A quarterly summary of how the data analysis was used to address systemic issues and improve the quality of life of individuals.

### **Employee Incident Training and Education**

Resource center written policies and procedures shall assure that competency-based employee training shall be provided on incident policies and procedures, including but not limited to the:

- ◆ Principles of incident management,
- ◆ Definition of child and dependent adult abuse,
- ◆ Department's zero tolerance of abuse or neglect,
- ◆ Mandatory abuse reporting requirements and processes,
- ◆ Identification and reporting of alleged abuse and other incidents,
- ◆ Policies and processes for responding to elopements
- ◆ Consequences for failure to report abuse or incidents,
- ◆ Policies and processes for protecting individuals when abused is alleged,
- ◆ Processes for investigating allegations of abuse and other incidents, and
- ◆ Responsibility of employees to cooperate in investigations.

### **Employees Trained on Incidents**

Resource center written policies and procedures shall assure that training is provided to:

- ◆ All new employees;
- ◆ Volunteers who will work regularly with individuals; and
- ◆ Contractors.

### **Continuing Education on Incidents**

Resource center written policies and procedures shall assure that annual competency-based refresher training, which may be an abbreviated version of the initial required training, shall be provided to:

- ◆ All employees;
- ◆ Volunteers, who work regularly with individuals; and
- ◆ Contractors.

### **General Training Policies on Incidents**

Resource center written policies and procedures shall assure that:

- ◆ Employee training shall be regularly documented in the training record for each employee in a manner that permits the information to be available individually and in aggregate form.
- ◆ Training curriculum shall be updated regularly to reflect changes in laws, policies, and procedures.
- ◆ Training shall be implemented in a timely manner.

### **Policy on Transition and Discharge**

Each resource center shall encourage and assist individuals admitted to and residing at a Resource center to move to the most integrated setting consistent with the individual's professionally identified needs and individual choice.

All discharges of individuals from a resource center shall be based on a discharge plan developed by the individual's interdisciplinary team as part of the individual support plan. The discharge plan shall:

- ◆ Be developed with the individual and the individual's parent, guardian, legal representative, or family, and
- ◆ Identify the barriers to discharge and the strategies that shall be implemented to enable the person to move to the most integrated setting.

Each resource center shall actively encourage individuals and their parents, guardians, family, or legal representatives to consider community options and work toward moving to the community when the move can reasonably be accommodated, taking into consideration the statutory authority of the state, the resources available to the state, and the needs of others with mental disabilities.

### **Transition Principles**

Resource center written policies and procedures shall assure that:

- ◆ Discharge planning shall begin with admission and is a part each individual's ongoing individual support plan.
- ◆ The assigned county case manager shall be encouraged to participate as a member of the individual's interdisciplinary team.

- ◆ The individual support plan shall identify the supports and protections that need to be provided to assure safety and adequate habilitation in the most appropriate integrated setting.
- ◆ The individual and the individual's parent, guardian, or legal representative shall be meaningfully involved in the planning leading to discharge and any concerns are addressed.
- ◆ The individual's living preferences shall be given preference with attention to supports necessary for health and safety.
- ◆ The individual's barriers to successful discharge shall be clearly identified.
- ◆ The individual support plan shall identify the strategies to be implemented to address the barriers.
- ◆ The individual's plan shall be updated as appropriate but no less than annually.
- ◆ As identified barriers change, appropriate strategies shall change.
- ◆ When a specific placement is identified:
  - A transition plan shall be developed and implemented.
  - The provider of any new service shall be included in the planning.
  - The entities responsible for funding the individual's services and supports shall be given notice and asked to assist in implementing the transition.
  - Other essential local staff, i.e. case managers, shall be involved in planning.
  - Appropriate consents shall be in place.
- ◆ A transition plan shall be developed and implemented to assure that the essential supports called for in the individual's latest comprehensive assessment are put into place.
- ◆ A crisis plan shall be developed in case an emergency arises with the discharge.
- ◆ An individual voluntarily placed at a resource center shall be able to exercise the right to move without a plan, with written consent of the individual or the individual's guardian.

### **Notice of Discharge Planning**

Resource center written policies and procedures shall assure that at the time of admission, the individual and the individual's parent, guardian, or legal representative shall be notified:

- ◆ Of the individual's rights for discharge.
- ◆ That discharge and transition plans will be developed with the goal of placing the individual in the most integrated setting appropriate to the individual's needs.
- ◆ Of the right to participate in the planning and to approve or disapprove any discharge or transition plan.

### **Discharge Planning**

Resource center written policies and procedures shall assure that:

- ◆ Discharge planning shall be a part of the initial individual support plan for each individual and is updated on a regular basis at the time of each individual's annual individual support plan review or more frequently as needs change.
- ◆ The discharge plan shall identify:
  - The barriers that exist for the individual that would make it difficult for the individual to move to the most integrated setting; and
  - The strategies to be implemented to overcome the barriers.
- ◆ The individual's local case manager, when assigned, shall be invited and encouraged to participate in the individual's discharge planning.
- ◆ Any concerns the individual or the individual's parent, guardian, or legal representative has regarding discharge or transition shall be identified and, if possible, resolved on a timely basis.

### **Transition Plan**

Resource center written policies and procedures shall assure that, when an individual is accepted for and agrees to service in a new setting:

- ◆ The individual's comprehensive assessment and proposed supports shall be reviewed with the individual and the individual's parent, guardian, or legal representative to facilitate their decision.
- ◆ A transition plan shall be developed for the individual that includes:
  - Identification of the individual's essential supports that the new provider shall have in place before the discharge can occur; and
  - Identification of the individual's non-essential supports the new provider shall have in place within 60 days of the discharge.
- ◆ Informed consent for the transition from the individual and the individual's parent, guardian, or legal representative shall be in place.
- ◆ In the case of a committed individual, notice of the proposed transition shall be sent to the appropriate court.
- ◆ Notice of the proposed transition shall be given to the entities responsible for funding the individual's care.
- ◆ Notice shall be given to all local county or Department employees who have some responsibility for services to the individual.
- ◆ The individual's comprehensive assessment and individual support plan shall be updated within 30 days before the individual leaves the facility.
- ◆ An agreement shall be signed between the resource center and the agency to whom transition is being made, that:
  - Identifies the essential supports the agency shall have in place before the discharge is made,
  - Identifies the non-essential supports the agency shall have in place within 60 days of discharge and the time frame for their implementation,
  - Requires the agency, when not all non-essential supports are in place within 60 days of placement, to develop a plan to have all non-essential supports in place within 90 days of placement,

- Identifies the follow-up services the resource center shall provide during the post-placement oversight period, and
- Identifies the resource center employee who shall be the contact person in case of an emergency with the placement.
- ◆ The transition plan shall identify:
  - The actions needed to notify the appropriate funding agencies, and other appropriate local staff, of the discharge, and to request approval and assistance in implementing the discharge.
  - The employees who shall be responsible to complete the specific actions necessary to implement the discharge and specify the time limits for completion.

### **Discharge**

Resource center written policies and procedures shall assure that an individual who has been placed at the resource center on voluntary basis shall be discharged upon the request of the individual or the individual's parent, guardian, or legal representative when the request is made pursuant to [Iowa Code section 222.15](#).

The individual shall be discharged from the rolls of the resource center 60 days after an individual is placed with another provider. EXCEPTIONS: Resource center written policies and procedures shall assure that:

- ◆ The supports in the transition plan shall be modified when requested in writing by the individual or the individual's parent, guardian, or legal representative.
- ◆ Discharges may be extended past 60 days only with the prior approval of the deputy director.
- ◆ Transition plans may be extended beyond 90 days only with the prior approval of the deputy director.

### **Post-Transition Oversight**

Resource center written policies and procedures shall assure that:

- ◆ The individual's placement shall be safe and appropriate.
- ◆ The employees responsible for monitoring the placement, the actions they shall take to monitor, and the period for monitoring are identified.

- ◆ The essential supports shall continue in place.
- ◆ Nonessential supports shall be put in place according to the most current comprehensive assessment.
- ◆ Problems occurring with the discharge shall be identified and needed corrective actions implemented.
- ◆ Oversight shall be terminated after 60 days unless all the non-essential supports are not in place, in which case a plan shall be developed to fully implement the supports within 30 days.
- ◆ All oversight activities by the resource center shall be terminated after 90 days.

### **Discharge Performance Improvement**

Resource center written policies and procedures shall assure that quality management practices are in place to monitor the implementation of the discharge and transition procedures to identify systemic issues, actual or potential, needing corrective action, and monitor the completion and implementation of corrective action plans.

### **Discharge Data Collection and Review**

Resource center policies and procedures shall assure that:

- ◆ Data collection shall include, at minimum, the following categories:
  - Name of individual,
  - Identifying information (age, sex, functioning level, etc.),
  - Discharged with/without transition plan,
  - Category of type of placement at discharge (home, ICF/MR, waiver),
  - Date of discharge,
  - Date of admission,
  - Length of time to complete transition plan:
    - Number of plans completed in 60 days,
    - Number of plans completed in over 60 days,
  - Reasons for failure of the transition plan, and
  - Essential supports required.

- ◆ Documentation of transition plans shall be maintained, including:
  - Individual actions required to implement plan, and
  - Length of time required to accomplish individual actions.
- ◆ Data gathered from data analysis shall be consistently used for identifying and addressing individual and systemic issues to improve the discharge process.
- ◆ The data on discharges and transitions shall be provided to the Quality Assurance Council for their review to assure that:
  - Problems are timely and adequately detected;
  - Timely and appropriate corrective actions are implemented; and
  - Root causes are identified that lead to corrective action.
- ◆ Information shall be collected, aggregated, and analyzed on the existing barriers to movement of individual's to the community.

#### **Reporting Requirements for Discharge Data**

Resource center written policies and procedures shall assure that the deputy director's office is provided:

- ◆ A monthly summary report on individuals placed during the month;
- ◆ A monthly summary report on the individuals in transition oversight; and
- ◆ An annual comprehensive report and assessment of the barriers that exist to discharging individuals into more integrated settings.

#### **Employee Training and Education on Discharge**

Resource center written policies and procedures shall assure that competency-based employee training shall be provided on discharge policies and procedures, including but not limited to:

- ◆ Transition principles,
- ◆ Discharge notification,
- ◆ Discharge planning as part of the individual's support plan,
- ◆ The content of the discharge plan,
- ◆ The development and content of a transition plan,
- ◆ Discharge policy, and
- ◆ Post-transition oversight.

### **Employees Trained on Transition and Discharge Plans**

Resource center written policies and procedures shall assure that training shall be provided to all newly hired, or transferred employees not previously trained, professional and direct care employees regularly assigned to work with individuals.

### **Continuing Education on Transition and Discharge Plans**

Resource center written policies and procedures shall assure that all professional and direct care employees regularly assigned to work with individuals shall receive annual competency-based refresher training. This may be an abbreviated version of the initial required training.

### **General Training Policies on Transition and Discharge Plans**

Resource center written policies and procedures shall assure that:

- ◆ Employee training shall be regularly documented in the training record for each employee in a manner that permits the information to be available individually and in aggregate form.
- ◆ Training curriculum shall be updated regularly to reflect changes in laws, policies, and procedures.
- ◆ Training shall be implemented in a timely manner.

## **Policy on End of Life**

It is the policy of the Department of Human Services that the death of any individual in our care is considered a significant event. Individuals who are at the end of life are provided care and supports in a dignified manner and in compliance with the individual's stated desires.

Families play an important role and in accordance with state and federal laws are included in the end-of-life decisions and necessary decisions subsequent to the individual's death.

All deaths are reviewed internally and externally to try to understand the cause of death. This includes a review of the services provided preceding the death. Unexpected deaths receive additional review including review by an independent physician.

The recommendations from reviews are used in the resource center's quality performance improvement process to continuously improve the services provided.

### **End-of-Life Policy Principles**

Resource center written policies and procedures shall assure that:

- ◆ The safety of each individual served shall be basic to the mission of each facility.
- ◆ Individuals being served who are at an end-of-life stage shall be provided appropriate medical services and comfort in an atmosphere of dignity and respect.
- ◆ Any advance directives in effect shall be complied with.
- ◆ All deaths shall be seen as a serious event to be responded to promptly with respect for the deceased individual and the individual's next of kin.
- ◆ Every death shall receive a comprehensive review as part of a continuous quality improvement process to:
  - Determine the cause of death and to
  - Better understand any impact facility services may have had on the death and when indicated, to improve policy and procedures.
- ◆ At the point of death, all decisions regarding the decedent devolve to the decedent's next of kin. All court-appointed guardianships end at the point of death.
- ◆ All state and federal laws pertaining to death shall be complied with.

### **Near Death**

Resource center written policies and procedures shall assure that when an individual is near death, the facility shall:

- ◆ Continue care and treatment using all resources as appropriate.
- ◆ Give relief from any pain as indicated.
- ◆ Respect the wishes of the individual as expressed in an advance directive.
- ◆ Inform the individual's family contact, guardian, or other legal representative of the situation and assist in any appropriate planning.

### **Hospice Care**

For individuals with terminal illnesses with a life expectancy of six months or less, resource center policy and procedures shall assure that:

- ◆ The individual and the individual's family contact, guardian, or other legal representative is made aware of the availability of hospice services.
- ◆ At the request of and with the written consent of the individual or the individual's family, guardian, or other legal representative, assistance shall be given in making a referral to a licensed hospice agency.
- ◆ When the hospice referral is for placement with another agency:
  - Appropriate referral information is provided,
  - It is understood that the individual will be discharged upon placement, and
  - A community physician is identified who can assume the responsibility for continuing medical services.
- ◆ When the hospice referral is for services to be provided within the facility:
  - Appropriate referral information is provided;
  - There is a written agreement as to which services will be provided by employees of the hospice agency and which will be provided by employees of the resource center;
  - The written agreement assures that the resource center's physician shall continue as the primary physician with the final authority on all medical decisions; and
  - The hospice services shall be provided on a unit that can provide the medical services specified in the plan to meet the medical needs of the individual.

### **Deaths Covered**

Resource center written policies and procedures shall assure that the following deaths are covered under this policy:

- ◆ All deaths of individuals that occur on the campus of the resource center.
- ◆ All deaths of individuals who are off campus but who are:
  - On home visit from the resource center,
  - Placed on leave from the resource center,
  - Under the care or supervision of a facility employee, including waiver homes,
  - On temporary placement or transfer for medical treatment, or
  - Discharged from one of the statuses listed above within five days before the date of death.

### **Confidentiality**

Resource center written policies and procedures shall assure that confidentiality concerning the individual is maintained after an individual's death. Information concerning the individual shall be released only to:

- ◆ The next of kin, or
- ◆ An individual, agency, law enforcement, or licensing or accrediting body that:
  - Is governed by the same confidentiality requirements as the Department, and
  - Is legally required to be notified as defined in this policy.

### **Internal Reporting Procedures**

Resource center written policies and procedures shall assure that:

- ◆ Procedures for providing timely notice of all reported deaths to all the employees responsible for implementation of this policy, including but not limited to the medical director, director of nursing, directors of treatment programs, and social work services shall be developed and implemented.
- ◆ The responsibilities of each employee shall be clearly specified, including duties or responsibilities and expected time frames.

### **Physician Responsibilities**

Resource center written policies and procedures, when a death occurs, shall assure that:

- ◆ For all deaths occurring in the resource center, a physician shall:
  - Pronounce death.
  - Provide immediate notice to the superintendent or administrator or the superintendent or administrator's designee.
  - Identify the body.
  - Care for the body and secure the death scene including any possible evidence related to the death pending instructions from the medical examiner.
  - Assure that the details and circumstances surrounding the death and the actions employees took in response to the death are documented, including but not limited to the facts used to establish death, the time of death, and apparent cause of death (in the physician's best professional judgment).
  - Certify cause of death and complete the death certificate as required in Iowa Code section 144.28 within 72 hours of receipt of the death certificate from the undertaker or other person responsible for filing the death certificate.

- ◆ For all deaths occurring outside the resource center, a physician shall contact the hospital where the death occurred or the physician attending the decedent at the time of death to:
  - Confirm date, time, and place of death.
  - Determine the apparent cause and circumstances of the death,
  - Determine if the death meets any of the reporting requirements in this policy,
  - Determine if the county medical examiner was notified of the death, and
  - Document the findings in the individual's facility record.

### **Nursing Responsibilities**

Resource center written policies and procedures shall assure that:

- ◆ The director of nursing is immediately notified.
- ◆ The nurse present at or called to the death scene shall:
  - Assist the physician in documenting the facts surrounding the death and securing the death scene or,
  - In the absence of a physician, document the facts surrounding the death and secure the death scene pending further instructions from the medical examiner.

### **Reporting Deaths**

Resource center written policies and procedures shall assure that all deaths are reported to the individual's next of kin, the division, and otherwise as required by accreditation standards, policy, or by law. The superintendent or administrator or the superintendent's or administrator's designee, as specified in the facility's policy, shall be responsible for making the following reports:

### **County Medical Examiner**

Resource center written policies and procedures shall assure that:

- ◆ The report shall be made immediately upon knowledge of the death to the medical examiner of the county in which the death occurred. The employee may call the county medical examiner directly or may call the local sheriff and have the dispatcher page the responding medical examiner.
- ◆ For a death occurring outside the facility, the facility shall report the death to the medical examiner even if there is information that someone else has reported the death to ensure independent compliance with the law.

Covered deaths occurring outside the state shall be reported to the medical examiner for the county in which the resource center is located to assure compliance with the law. The notice shall be documented and include the name of the employee who gave the notice and date and time notice was given.

- ◆ For a death occurring in the facility, the body, clothing, and any articles upon or near the body shall not be disturbed or removed from the position in which they are found. Physical or biological evidence shall not be obtained or collected from the body without authorization of the county or state medical examiner. Exceptions may be made:
  - For the purpose of preserving the body from loss or destruction, or
  - To permit the passage of traffic on a highway, railroad, or airport, or
  - If failure to immediately remove the body might endanger life, safety, or health.

### **Medical Examiner Preliminary Investigation**

Resource center policies and procedures shall assure that:

- ◆ The information requested by the medical examiner is provided promptly,
- ◆ All employees work cooperatively with the medical examiner,
- ◆ The information provided the medical examiner is documented, and
- ◆ Payment shall be promptly made to the medical examiner upon receipt of a signed itemized bill.

### **Individual's Next of Kin**

Resource center written policies and procedures shall specify which employees are responsible to assure that the individual's next of kin shall be notified of a death as follows:

- ◆ By telephone within one hour of knowledge of the death, to:
  - Ask which funeral home is to be used,
  - Respond to questions,
  - Determine the next of kin's wishes as to any property the resource center has that belonged to the deceased,
  - Notify the next of kin of the right to request an autopsy, at the next of kin's expense, if the medical examiner does not order an autopsy, and
  - Determine whether further follow-up with next of kin will be needed.
- ◆ By written notice sent by mail to the decedent's next of kin within three days of the date of death.

### **Department of Inspection and Appeals**

Resource center written policies and procedures shall assure that notice of any death is provided to the Department of Inspection and Appeals:

- ◆ By phone within 24 hours of the death, and
- ◆ In writing within 48 hours of the death.

### **Deputy Director**

Resource center written policies and procedures shall assure that reports of all deaths are made to the deputy director or the deputy director's designee as follows:

- ◆ All deaths caused by abuse or suicide or which are suspicious or unexplained shall be reported by direct phone contact with the deputy director within two hours of receipt of notice of the death during the business days, evenings, holidays, or weekends.
- ◆ All other deaths shall be reported by E-mail to the deputy director no later than 12 p.m. on the next business day.

### **Involuntary Commitments**

Resource center written policies and procedures shall assure that notice of the death, including time, place, and alleged cause, is sent within three business days of the death to:

- ◆ The county board of supervisors of the county of commitment,
- ◆ The judge of the court that had jurisdiction over the commitment, and
- ◆ The central point of coordination of the county of admission.

### **Voluntary Admissions**

Resource center written policies and procedures shall assure that for a death of an adult individual voluntarily admitted, notice shall be sent within three business days to:

- ◆ The central point of coordination of the county of admission, and
- ◆ The central point of coordination of the county of legal settlement, if different.

### **Protection and Advocacy Services**

Resource center written policies and procedures shall assure that:

- ◆ Written notification shall be provided to Protection and Advocacy Services for all Conner class members within five business days of the death. The notice shall include the treatment team's summary of the death.
- ◆ A copy of the notice to the Protection and Advocacy Services shall be provided to the Division's compliance officer.
- ◆ Documentation of the notice shall be placed in the individual's facility record and shall include at a minimum the date and time the death was reported to the Protection and Advocacy Services.

### **Iowa Foundation for Medical Care**

Resource center written policies and procedures shall assure that a request for a death review is submitted to the Iowa Foundation for Medical Care as soon as the individual's file contains the information needed for the review.

## **Autopsy**

Resource center policies and procedures shall assure that when the next of kin requests an autopsy, the next of kin is:

- ◆ Provided information as to how to request an autopsy,
- ◆ Provided with needed support in the process, and
- ◆ Informed that the autopsy will be at the next of kin's expense.

### **Request by Resource Center**

When an autopsy is not ordered by the medical examiner and the next of kin has not obtained an autopsy, resource center policies and procedures shall:

- ◆ Provide for seeking an autopsy when:
  - There is no clear cause of death,
  - The circumstances of death suggest that autopsy findings may be useful, or
  - It is believed that the autopsy findings can be used in the facility's performance improvement activities.
- ◆ Provide that if the resource center wants to request an autopsy, the superintendent shall take the following steps:
  - Request that the medical examiner order an autopsy.
  - If the medical examiner does not order the autopsy, request that the next of kin authorize an autopsy.
  - If both refuse to authorize an autopsy, consult with the deputy director or the deputy director's designee as to whether additional steps shall be taken to seek an autopsy.

NOTE: If the individual's body has been donated to medical school by will or at the direction of the spouse, parents, or adult children in accordance with Iowa Code section 331.802(8) and this is known to the facility, the facility shall not seek an autopsy.

- ◆ Include the procedure for arranging for autopsy to be performed when authorized by the next of kin that includes at a minimum:
  - Identifying the pathologist to be used,
  - Making arrangements for the pathologist to examine the body, and
  - Getting the consent for the autopsy to the pathologist.

### **Seeking Next of Kin Authorization**

Resource center written policies and procedures shall assure that in seeking next-of-kin authorization for an autopsy:

- ◆ When the death is expected, the process shall start before the death and shall be done in person with the next of kin. The process shall include:
  - Providing the facility's rationale as to why an autopsy is requested.
  - Exploring the next of kin's feeling about an autopsy.
  - Informing the next of kin that the autopsy will be at no cost to the next of kin and that the next of kin will be provided with a copy of the autopsy report.
  - Ensuring that the next of kin clearly understands that the decision about the autopsy is up to the next of kin.
- ◆ The facility shall document the consent, including clear identification of:
  - The relationship of the next of kin member giving the authorization.
  - The next of kin's order in the list of persons authorized to give consent.
- ◆ When the next of kin is not available to meet in person, the request shall be done by phone, covering the same information, and the facility shall:
  - Have at least two employees witness the phone call.
  - Have all employees who witness the call sign the documentation.
    - For documentation made by voice recording, signature shall be made by each witness stating name, job title, date, and time.
    - For documentation made using an electronic medical records system, signature shall be made by the witness entering /S/ followed by typed name, job title, date and time.
  - Follow up the phone consent by sending a written consent for the next of kin to sign and return.

### **Autopsy Reports**

Resource center written policies and procedures shall assure that when an autopsy report is received:

- ◆ A copy of the report is made available to the next of kin,
- ◆ A copy of the report is provided to the deputy director, and
- ◆ A copy is placed in the deceased individual's facility record.

### **Property of Deceased Individual**

Resource center written policies and procedures shall assure that at the time of death of an individual:

- ◆ The superintendent or the superintendent's designee shall immediately take possession of all property of the deceased individual left at the resource center.
- ◆ When there is a duly appointed and qualified representative for the deceased individual, property in the possession of the resource center shall be delivered to the representative.

### **Property of Small Value**

Resource center written policies and procedures shall assure that the property left by the decedent shall be delivered to a surviving spouse or heirs of the decedent if:

- ◆ If within one year of the death of the decedent administration of the estate has not been granted,
- ◆ The estate of the deceased is so small to make the granting of administration inadvisable, and
- ◆ There is no claim for Medicaid estate recovery,

### **No Administrator or Heirs**

Resource center written policies and procedures shall assure that, if an estate administrator is not appointed, a surviving spouse or heir is unknown, and there is no claim for Medicaid estate recovery:

- ◆ The superintendent shall convert the decedent's property to cash. Upon doing so, the superintendent has the powers possessed by a general administrator of an estate.
- ◆ As soon as practicable after one year, the funds shall be transmitted to the treasurer of the state.
- ◆ The superintendent shall keep a permanent record of all funds transmitted to the treasurer that includes:
  - By whom and with whom the funds were left,
  - The amount of the funds,
  - The date of death of the owner,
  - The owner's reputed place of residence before admission,
  - The date the funds were transmitted to the state treasurer, and
  - Any other facts that would identify the intestate and explain the case.
- ◆ A copy of the record shall be transmitted to the state treasurer.

### **Mortality Administrative Reviews**

Resource center written policies and procedures, as part of the facility's performance improvement actions, shall assure that, at a minimum, each death receives the following reviews:

#### **Type 1 Incident Investigation**

Resource center written policies and procedures shall assure that:

- ◆ A Type 1 investigation shall be conducted of each death.
- ◆ The investigation shall review the events leading up to and surrounding the death.
- ◆ A report of the investigation shall be made using form 470-4366, *Type 1 Incident Investigation Report*. (See [3-B-Appendix](#) for a sample and instructions.)

- ◆ A preliminary investigation and report shall be completed within five business days after the death and submitted to the superintendent and quality management director.
- ◆ A full investigation shall be completed within 15 business days after death incorporating the physician mortality review and the nursing peer review information, which are due within ten business days after the death.
- ◆ The full report shall be submitted to the superintendent and quality management director.
- ◆ If the investigation determines that abuse or neglect may have been involved, the policies and procedures for investigating and reporting abuse and neglect shall be followed.

### **Physician's Death Review**

Resource center written policies and procedures shall assure that a physician's death review is conducted on each death.

- ◆ The review shall be conducted by the physician responsible for the medical treatment of the individual and shall include:
  - A review of the background information on the individual,
  - A review of the circumstances surrounding the individual's death including but not limited to:
    - Where the death occurred,
    - Who determined death had occurred,
    - Time of death,
    - Factors used to make the determination,
    - Notifications made by the attending physician, and
    - The attending physician's opinion as to probable cause of death.
  - A review of the individual's medical record for the past 12 months covering changes in the individual's physical status and services received or omitted, including but not limited to:
    - Current diagnosis and diagnosis history.
    - Current medication and medication history.
    - Health history including identified risk factors.
    - Treatment history.
    - Significant medical events, including outside consultations.
    - Whether the individual was in restraint or seclusion within the 24 hours before death.

- A review of the autopsy findings (if done and available), and
- Other documented information appropriate to the review.
- ◆ A report shall be prepared and submitted to the superintendent and quality management director within ten business days of the death. The report shall include:
  - A summary of the information reviewed.
  - A summary of medical care provided in the 12 months before death,
  - An assessment of the medical care provided and identification of any concerns related to the care provided.
  - An assessment of compliance with physician policy and procedures.
  - Recommendations for opportunities for improvement of policy or procedures for medical services.
- ◆ A copy of the report shall be provided to the investigator conducting the Type 1 investigation to identify any inconsistencies between the two reports as to the facts of the case.

#### **Nursing Peer Death Review**

Resource center written policy and procedures shall assure that the director of nursing services for the resource center shall complete a nursing peer death review.

- ◆ The review shall include:
  - A review of the background information on the individual,
  - A review of the individual's health history and nursing interventions over the past 12 months.
  - A review of the circumstances surrounding the individual's death, including but not limited to:
    - Direct care employees' observations of any changes in the individual's health or behavior status,
    - History of direct care employees reporting health or behavior changes to nursing employees,
    - History of nursing employees' response to reported changes,

- Nursing assessments of the individual,
  - Timeliness of nursing employees in reporting medical issues to medical staff,
  - Timeliness and appropriateness of medical staff responding to reported issues.
- ◆ A report of the review shall be completed within ten business days of the death and shall be submitted to the superintendent and director of quality management. The report shall include:
- A summary of the information reviewed,
  - An summary of the nursing services provided in the 12 months before death,
  - An assessment of the nursing services provided and identification of any concerns related to the services provided,
  - An assessment of compliance with nursing policies and procedures, and
  - Recommendations for opportunities for improvement of policies or procedures for nursing services.
- ◆ A copy of the report shall be provided to the investigator conducting the Type 1 investigation to identify any inconsistencies between the two reports as to the facts of the case.

### **Mortality Review Committee**

Resource center written policies and procedures shall assure that for every death:

- ◆ The superintendent shall appoint, within five business days of the death, a morality review committee. The purpose of the committee shall be, as part of the resource centers quality improvement process, to:
- Conduct a thorough review all of documentation and the circumstances of the death,
  - Assess the quality and appropriateness of the services provided to the individual,

- Identify any concerns about the quality of services provided, and
- Recommend opportunities for improvement of the policies, procedures, or service delivery system of the resource center with the goal of improved service delivery.
- ◆ The membership of the committee shall be composed of:
  - The superintendent,
  - The physician who completed the physician's mortality review,
  - The director of nursing,
  - The medical director,
  - Program treatment and nursing staff responsible for directing the individual's treatment services,
  - A direct care employee who was involved in providing services to the individual,
  - A social service employee providing services to the individual,
  - A professional support services (OT, PT, dietary) representative responsible for providing services to the individual as part of a treatment plan,
  - The investigator completing the Type 1 investigation,
  - The quality management director, and
  - Any other employee determined by the superintendent as appropriate to the review.
- ◆ The superintendent or quality management director shall be the chair of the committee.
- ◆ The superintendent, the quality management director, and the medical director shall be responsible for determining whether the death is expected or unexpected. This decision shall be made the same day the committee is appointed. The basis for the decision shall be documented.
- ◆ When the death is determined to be unexpected, the chair of the committee shall immediately initiate additional reviews of the death through an internal peer review process and an external independent physician review process.

- ◆ The committee shall have available all documentation relating to the death include but not limited to:
  - The complete resource center record of the individual,
  - All physician and nursing reports,
  - Incident and other staff documentation reports related to the death,
  - The autopsy report (if done and available),
  - Medical reports from another facility if the death occurred there,
  - The Type 1 investigation report,
  - The physician's death review,
  - The nursing peer death review, and
  - Any other information deemed necessary by the committee.
- ◆ The committee shall meet within seven business days of the receipt of the full Type 1 investigation report, the physician's death review report, and the nursing peer death review report.
- ◆ When the reports of the profession peer review or the independent physician peer review are not available at the time of the committee's meeting, the chair shall prepare a preliminary report to the superintendent.
  - Within two business days of receipt of the reports, the superintendent, and the quality management director shall meet and determine whether the information is sufficient to call another meeting of the mortality review committee.
  - If the decision is that another meeting is not required, the rationale for that decision shall be documented and filed with the report of the committee along with the peer review report and the independent physician report.
  - If another meeting of the committee is held subsequent to the filing of the 15 business day report, the chair shall prepare an addendum to the final report which shall be filed within five business days of the meeting.
- ◆ If the autopsy report is not available at the time of the mortality review committee's meeting, this shall not delay the committee's meeting, review, and report.

- ◆ When the autopsy report is received, the superintendent shall review the autopsy with the medical director and the independent peer review physician, when such is required, to determine whether the findings require another meeting of the full committee.
- ◆ The information provided to the committee and the proceedings of the committee shall be confidential. Members of the committee shall not disclose any written or verbal information provided to the committee or from the committee's discussions to another party other than a member of the committee without authorization from the superintendent.
- ◆ The chair of the committee shall prepare a confidential written report of the meeting within 15 business days of the committee's meeting. The content of the report shall be limited to the following:
  - The names of members of the review committee,
  - A statement of documents reviewed,
  - The opportunities for improvement identified by the committee, and
  - Any recommended plans for corrective action.
- ◆ The written report shall be drafted by the chair and circulated to the other members of the committee for review and comment.
- ◆ The final report shall be submitted to the superintendent.
- ◆ All copies of written information and reports provided to the committee during the review are not for distribution and shall be returned to the chair of the committee upon completion of the review.
- ◆ The information used by the committee and the written report of the committee shall be considered a confidential administrative record and shall be maintained in a secure file separate from the individual's record.
- ◆ One copy of the written information used by the committee and the report shall be maintained as part of the confidential administrative record. All duplicate copies shall be destroyed.
- ◆ The report and related documents may be released to another employee of the resource center for administrative purposes with consent of the superintendent.
- ◆ A copy of the report shall be provided to:
  - The resource center's quality management department,
  - The deputy director, and
  - The department's attorney general representative.

- ◆ Any other release of the confidential administrative record shall require the approval of the deputy director.
- ◆ The report shall not be used for any personnel actions.
- ◆ The quality management director shall be responsible for implementing and tracking implementation of all the recommendations made by the committee.

### **Professional Peer Review of Unexpected Death**

Resource center written policies and procedures shall assure that for all unexpected deaths:

- ◆ A professional peer review shall be conducted by a professional selected by the committee who:
  - Is licensed in the profession whose area of professional expertise is most closely related to the primary cause of the individual's death, and
  - Has not been involved in the provision of services to the individual.
- ◆ When an appropriate peer is not employed by the resource center, a peer from another Department facility shall be used to conduct the peer review.
- ◆ The reviewer shall have available the complete facility record of the individual, the report of the investigator, the physician's review, the nursing peer review, and any report of the mortality review committee.
- ◆ The professional peer review report shall include:
  - Background information on the individual,
  - A review of the care provided by the reviewer's area of professional expertise,
  - A review of the events leading up to the death,
  - Any concerns, questions, inconsistencies found by the reviewer between the information in previous reports and the findings of the peer reviewer,
  - A summary of any discussions with staff to clarify any inconsistencies, and
  - The opportunities for improvement identified in services provided.

- ◆ The professional peer review report shall be submitted to the superintendent and the quality management director within seven business days of the mortality review committee's assignment.
- ◆ The superintendent shall be responsible for presenting the report to the mortality review committee for their review and consideration.
- ◆ This report shall not be used for any personnel actions.

### **Independent Physician Peer Review**

Resource center written policies and procedures shall assure that for all unexpected deaths:

- ◆ A licensed physician who is not employed by the resource center shall conduct an independent physician peer review.
- ◆ The reviewer shall have available:
  - The complete institutional record of the individual,
  - The report of the investigator,
  - The physician's review,
  - The nursing review,
  - Any report of the mortality review committee, and
  - Any other documents or information the reviewer believes is relevant.
- ◆ The purpose of the review shall be to:
  - Evaluate the medical care provided to the individual by the resource center's physicians and other appropriate clinical disciplines based on current standards of care for the profession being reviewed.
  - Provide recommendations to the resource center for opportunities for improvement of the clinical services provided to individuals.
- ◆ The reviewer shall prepare a report based on the evaluation and identify any recommendations for opportunities for improvement in the quality of care being provided.
- ◆ The report shall be submitted to the superintendent and the chair of the mortality review committee within 25 business days of the determination that the death was unexpected.

- ◆ If all external information is not available (i.e. the autopsy report), the report shall be submitted on a preliminary basis and the report finalized with five business days of the reviewer's receipt of the missing information.
- ◆ The superintendent shall be responsible for presenting the report to the mortality review committee for their review and consideration.

### **Employee Training and Education on End of Life**

Resource center written policies and procedures shall assure that competency-based employee training shall be provided on end of life policies and procedures, including but not limited to:

- ◆ End of life principles,
- ◆ Near death care,
- ◆ Hospice care,
- ◆ Reporting procedures, and
- ◆ Autopsy requests.

### **Employees Trained on End of Life**

Resource center written policies and procedures shall assure that training is provided to new employees and transferred employees not trained previously who are responsible for implementation of end-of-life policies and procedures.

### **Continuing Education on End of Life**

Resource center written policies and procedures shall assure that all employees who are responsible for implementation of end-of-life policies and procedures receive annual competency-based refresher training and procedures. This may be an abbreviated version of the initial required training.

### **General Training Policies on End of Life**

Resource center written policies and procedures shall assure that:

- ◆ Employee training shall be regularly documented in the training record for each employee in a manner that permits the information to be available individually and in aggregate form.
- ◆ Training curriculum shall be updated regularly to reflect changes in laws, policies, and procedures.
- ◆ Training shall be implemented in a timely manner.

### **Policy on Peer Review**

Each resource center shall continuously seek to improve the quality of services to the individual's served. The quality management principles listed below using current standards of practice in the healthcare community shall be used to implement peer reviews and integrated care reviews with the goal of improving the quality of care given at the resource center.

To ensure quality care is maintained and continuously improved, professional accountability and clinical judgment shall be evaluated against practice standards established by each professional specialty.

### **Peer Review Principles**

Resource center written policies and procedures shall assure that peer review processes shall be guided by the following principles:

- ◆ Responsible healthcare requires an integrated approach to quality, which is transparently measured against currently accepted standards of practices.
- ◆ Peer review is a quality improvement initiative driven by the desire to improve services and outcomes for individuals who live at the resource centers.
- ◆ Peer review is most successful when implemented in a culture of learning, free from blame.

- ◆ Chapter B: State Resource Centers Policy on Peer Review
- ◆ Revised November 27, 2009 Peer Review Principles
- ◆ Professional development occurs most readily in a strength-based environment that:
  - Is driven by recognized strengths and abilities of the individuals served as opposed to recognized deficits,
  - Fully utilizes and builds upon those strengths and abilities to meet personal and organizational goals, and
  - Emphasizes and encourages learning and responsibility.
- ◆ Properly implemented, peer review processes will result in integration and multidisciplinary learning through team building.

### **Peer Review Required**

Resource center written policies and procedures shall assure that:

- ◆ The following professional specialties shall conduct specialty peer reviews:
  - Dentistry
  - Dietary
  - Medicine
  - Neurology
  - Neuropsychiatry
  - Nursing
  - Occupational therapy
  - Physical therapy
  - Psychiatry
  - Psychology
  - Speech and language pathology
- ◆ The deputy director shall approve all peer review schedules.

### **Peer Review Performance Improvement**

Resource center written policies and procedures shall assure that quality management practices are in place to:

- ◆ Monitor the implementation of peer review;
- ◆ Identify systemic issues, actual or potential, needed corrective action; and
- ◆ Monitor the completion and implementation of corrective action plans.

### **Data Collection and Review**

Resource center written policies and procedures shall assure that:

- ◆ Reviews shall be documented in a standardized format.
- ◆ Review data shall be tracked and reviewed by the quality council.
- ◆ Review data shall be electronically maintained by:
  - Specialty area
  - Date and type of review (internal or external)
  - Participants' names and titles
  - Review content, including:
    - Focus of meeting, e.g., individual cases, system, process, etc.
    - Standards of practice applied
    - Findings and outcomes
    - Issues identified
    - Type of issue identified (individual, systemic, procedural, etc.)
    - Corrective action plans developed when indicated, including responsible persons and the date by which such actions shall be completed
- ◆ Each specialty required to do peer review shall provide a brief presentation to the quality council at least annually, describing:
  - What changes have occurred in assessment and treatment,
  - Quality or performance improvement initiatives implemented,
  - Changes in outcome and performance measure data,
  - Lessons learned, and
  - Actions planned (including corrective actions and improvement plans).

### **Staff Training and Education on Peer Review**

Resource center written policies and procedures shall assure that competency-based employee training shall be provided on peer review policies and procedures, which shall include but not be limited to:

- ◆ For new employees, or transferred employees who have not been trained previously:
  - The principles of peer review, and
  - The benefits of peer review to the individuals served.
- ◆ For new professional employees subject to peer review, or transferred professional employees who have not been trained previously:
  - The principles of peer review,
  - The benefits of peer review to the individuals served,
  - The procedural guidelines for conducting internal and external peer reviews, and
  - The current approaches and advancements in peer review practices.

### **Continuing Education on Peer Review**

Resource center written policies and procedures shall assure that all professional employees subject to peer review receive annual competency-based refresher training. This may be an abbreviated version of the initial required training.

### **General Training Policies on Peer Review**

Resource center written policies and procedures shall assure that:

- ◆ Employee training shall be regularly documented in the training record for each employee in a manner that permits the information to be available individually and in aggregate form.
- ◆ Training curriculum shall be updated regularly to reflect changes in laws, policies, and procedures.
- ◆ Training shall be implemented in a timely manner.

## **Policy on Quality Management**

Each resource center shall continuously improve the quality of services it provides. Continuous improvement is best achieved when leadership is committed to excellence, there are established performance expectations, and there is a formal quality management system.

“Quality management” is a planned, systematic, organization-wide approach to the monitoring, analysis, and improvement of organization performance, thereby continuously improving the quality of patient care and services provided and the likelihood of desired patient outcomes. (Source: JB Quality Solutions, Inc., The Healthcare Quality Handbook 2005)

A quality management system is focused on improving all services, systems, and processes within an organization. This approach to health care involves each person in the organization, recognizing that the “whole” is dependent upon its “parts.” Quality management is based upon the question of “How can we do better?” (not “What did we do wrong?”). Quality assurance is not to be used in a punitive manner.

In its simplest form, quality management is the pervasive and continual pursuit of excellence. An effective quality management system requires that there be strong, proactive leadership, sound structures and processes, and an environment conducive to continuous quality improvement.

### **Quality Management Principles**

Resource center written policies and procedures shall assure that:

- ◆ A culture of quality management philosophy shall be created and integrated into the general operations of the facility and shall reflect the following principles of quality:
  - An individual’s well-being is a bio-psycho-social condition and cannot be conclusively measured compartmentally.
  - Effective decision-making involves those managing services, those providing services and, most importantly, those receiving services.
  - Effective results for an individual are achieved by integrated service delivery that is based upon currently accepted standards of practices.

- The pursuit of “quality” has no final destination as it is fluid, changing with an ever-growing knowledge base.
- Employees operate through processes developed within a system. Therefore, to ensure positive change, systems and their processes must be thoroughly assessed and taken into account before employee performance is evaluated.
- ◆ All employees shall be committed to continuous improvement of care for each individual and are directly responsible for the quality of services provided to individuals served by the resource center.
- ◆ Leadership shall be committed to and foster multi-disciplinary teamwork including all employees working with individuals.
- ◆ Leadership shall understand and recognize the interdependence of allied health services and the skill base each brings to quality health care.
- ◆ Leadership shall utilize and build upon the strengths and abilities of each employee to meet personal and organizational goals.
- ◆ Leadership shall create a culture of continuous improvement and shall emphasize and encourage learning and responsibility.

### **Facility Leadership Responsibilities**

Resource center written policies and procedures shall assure that:

- ◆ Facility leadership is knowledgeable of current best practice standards.
- ◆ Facility leadership is responsible for ensuring that facility practices are consistent with current standards of care for individuals with developmental disabilities.
- ◆ Facility leadership is committed to the institution of quality and shall foster this throughout the organization with all employees.

### **Structures and Process**

Resource center written policies and procedures shall assure that:

- ◆ Structures and processes shall be established to implement quality improvement initiatives effectively.
- ◆ A quality council shall be established to oversee the quality assurance and performance improvement practices facility wide. The council shall meet no less than monthly.

- ◆ The council shall be composed of leaders in the areas of administration, clinical review and direct service management including but not limited to:
  - The superintendent or designee, who shall chair the council;
  - The director of quality management;
  - Assistant superintendents;
  - The directors of psychology, nursing, and habilitation;
  - Directors or lead persons in dietary, occupational therapy, physical therapy, speech/language therapy, and psychiatry;
  - A qualified mental retardation professional;
  - Treatment program administrators; and
  - Other key persons.
- ◆ The quality council shall:
  - Review clinical and performance outcome reports that focus on individual safety and wellness, client growth, and independence and facility practices. The reports shall include quality indicators as determined by the deputy director.
  - Review and refine systems and processes to better integrate and streamline services.
  - Assist interdisciplinary teams as appropriate.
- ◆ The quality council shall keep minutes of its actions in the format specified by the deputy director. At a minimum, the minutes shall, include the following information:
  - The meeting date, chairperson, members present, members absent, and the recorder.
  - The topics discussed at the meeting, a list of the handouts used, and a summary of the discussion.
  - The corrective actions identified, the person responsible for implementation, and the due date.

- ◆ Each specialty area, or discipline, resource center department director or responsible supervisor, shall assure that:
  - Employees shall be knowledgeable about and apply current professional knowledge in the field;
  - Current professional standards of practice and measurable outcomes shall be identified and monitored;
  - Professional practice is evidence-based, whenever possible, and minimum standards of quality care shall be identified and monitored; and
  - Employees closest to the individual and responsible for implementing programs shall be actively recruited for their assistance in identifying opportunities for integration of programming.
- ◆ Supervisors and managers shall maintain close contact with their employees to foster the pursuit of quality and assess its progress. Meetings shall occur regularly with all employees to assure their understanding and involvement in quality improvement processes, which shall include:
  - Defining, measuring and improving quality,
  - Implementing quality initiatives in their respective area.
- ◆ Supervisors and managers shall maintain effective communication processes to ensure employees remain involved and knowledgeable of quality issues, including individual and facility outcomes, and improvement initiatives.
- ◆ Supervisors and managers shall assure the integration of the concept and expectation of quality care into position descriptions and performance evaluations.

### **Environment**

Resource center written policies and procedures shall assure that:

- ◆ There shall be a continuous assessment of the culture of the facility, with specific focus on any attitudinal barriers affecting the implementation of self-determination and person-centeredness. Identified issues shall be addressed.

- ◆ There shall be ongoing processes to assure that employees are up to date regarding current disability-rights issues and to ensure that the facility's practices are congruent with contemporary thought and practices in the community. Identified issues shall be addressed.

### **Quality Performance Improvement**

Resource center written policies and procedures shall address quality assurance and quality improvement efforts directed towards improvement of services and shall assure that:

- ◆ Key performance data shall be routinely collected and analyzed.
- ◆ Quality performance indicators and reporting formats shall be identified by July 1 of each year.
- ◆ Corrective or improvement activities shall be based upon relevant data.
- ◆ Data collection activities shall assure data integrity and reliability.

### **Quality Reporting Requirements**

Resource center written policies and procedures shall assure that:

- ◆ Systems and methods shall be in place to assure the collection of key performance and performance data on a monthly basis. Other data items will be collected as defined by the quality councilor the deputy director.
- ◆ At a minimum, the outcome and quality indicators shall include the data items determined by the deputy director.
- ◆ Quality council minutes shall be provided to the deputy director on a monthly basis in a format determined by the deputy director.
- ◆ Written policies and procedures shall assure that performance and quality management data is provided on a monthly basis to the quality council.
- ◆ Policies and procedures shall assure that monthly data is reported to the deputy director in the required format.

### **Employee Training and Education on Quality Management**

Resource center written policies and procedures shall assure that competency-based employee training shall be provided quality management policies and procedures, which shall include but not limited to:

- ◆ Terms and processes related to "quality."
- ◆ The principles upon which quality management philosophy is built.
- ◆ The Department's and resource center's commitment to quality.
- ◆ How quality is defined, measured, and reported.
- ◆ The integration of quality measures across service areas or domains.
- ◆ The purpose and importance of data collection including:
  - Documentation requirements,
  - Data authenticity and reliability, and
  - Data integrity.
- ◆ The role of internal quality management systems.
- ◆ Specific quality indicators relevant to the employee's job assignment.
- ◆ Tools, reports, and other mechanisms used by the resource center in the provision of quality healthcare.

### **Employees Trained on Quality Management**

Resource center written policies and procedures shall assure that training is provided to new employees, or transferred employees who have not been trained previously.

### **Continuing Education on Quality Management**

Resource center written policies and procedures shall assure that all employees receive annual competency-based refresher training. This may be an abbreviated version of the initial required training.

**General Training Policies on Quality Management**

Resource center written policies and procedures shall assure that:

- ◆ Employee training shall be regularly documented in the training record for each employee in a manner that permits the information to be available individually and in aggregate form.
- ◆ Training curriculum shall be updated regularly to reflect changes in laws, policies, and procedures.
- ◆ Training shall be implemented in a timely manner.