DEPARTMENT OF DEVELOPMENTAL SERVICES

LICENSURE AND CERTIFICATION

PROVIDER FOLLOW-UP REPORT

Provider: ARC OF BRISTOL COUNTY

Provider Address: 141 Park St. , Attleboro

Name of Person Completing Form: Katie Baril

Date(s) of Review: 20-JUN-23 to 22-JUN-23

Follow-up Scope and results :		
Service Grouping	Licensure level and duration	# Indicators std. met/ std. rated
Residential and Individual Home Supports		
Employment and Day Supports	2 Year License	

Residential and Individual Home Supports Areas Needing Improvement on Standard not met - Identified by DDS

Indicator #	L27
Indicator	Pools, hot tubs, etc.

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Area Need Improvement	At one of two locations with a pool present, the provider had not taken a water safety course. The agency needs to ensure that providers that have a pool receive water safety training.
Process Utilized to correct and review indicator	During ISP, when annual consents are completed, providers and individuals will be presented the Water Safety Policy & Procedure for signatures, as well as completed required online training if a pool is present. The annual consent checklist has been updated to reflect, as well as the Provider Home Binder table of consent to include water safety section. Updated Water Safety Policy & Procedure wording: "The Arc of Bristol County recognizes that having a pool at one's home can be a positive addition to the household members' quality of life. If used safely, it can increase a person's physical fitness and overall sense of wellbeing as well as facilitate a positive social experience for household members. The following training link (http://onlinewatersafetycourse.com/) and the document entitled "Pool Safety Guidelines" are informational resources for Adult Family Care, Shared Living and General Family Support programs. This group of individuals is also, as appropriate or warranted, able to access other trainings and assessments as deemed useful that may be offered in other programs."
Status at follow-up	The Shared Living provider at location 43 E Plain St Berkley MA has completed the online water safety training and home binder has been updated with Pool Safety Guidelines.
Rating	Met

Indicator #	L43
Indicator	Health Care Record

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Area Need Improvement	Of the eight individuals, three had missing or inaccurate information on their HCR including vaccination dates, preventative screening dates, and annual exam dates. The agency needs to ensure that HCRs reflect current and accurate information.
Process Utilized to correct and review indicator	As part of an updated Quality Improvement initiative, quarterly peer record reviews will be completed across adult service models. Internal Record Review Tool has been updated with an addition of "Golden Thread Checklist" portion. This tool requires the peer auditor to review the Annual Physical Exam to identify: 1) Diagnosis 2) vaccination dates and 3) preventative screening dates and will require check that information is communicated across assessments, such as EFS, ISP, HCR etc
Status at follow-up	Status at follow-up On 5/8/2023, two Health Care Records (PN/DM) were updated with current and accurate information. On 5/4/2023 (RG) Health Care Record was updated.
Rating	Met

Indicator #	L56
Indicator	Restrictive practices
Area Need Improvement	One location with a restrictive practice impacting all of the individuals living there lacked all of the required components, including a plan to eliminate or fade the restriction, and no mitigation plan to limit its impact on those not requiring the restriction. The agency needs to ensure that all restrictive practices include a written rationale for the restriction, a plan to eliminate/fade the restriction and if the restriction impacts others, a plan to mitigate its impact.

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Process Utilized to correct and review indicator	As part of action plan, the agency Protocol form has been updated to include 1) Action Steps 2) Mitigation & 3) Criteria for fading and/or removal, which includes data collection of targeted behavior which can be communicated to Human Rights Committee and involved parties as needed. In addition, a location for the Director of Clinical services to review document and sign prior to implementation has been added
Status at follow-up	On 4/21/2023, the Human Rights Committee signed an updated Chime Protocol for Sharps Lot individual with outlines Mitigation and Criteria for fading and/or removal. All updated documents have been communicated with individuals/Guardians impacted, as well as individual's DDS service coordinator via email.
Rating	Met

Indicator #	L61
Indicator	Health protection in ISP
Area Need Improvement	For one individual, the use of two health-related supports lacked all required components, including their authorization of use, parameters of appropriate use, and an outline for their continued need. The agency needs to ensure that all supports and health-related protections are included in ISP assessments and contain all required components including an outline for their continued need.

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Process Utilized to correct and review indicator	Support and Protective Device format has been updated to include location for agency staff to identify if and when information has been communicated with treatment team via ISP meeting, HCR, etc. In addition, as part of an updated Quality Improvement initiative, quarterly peer record reviews will be completed across adult service models. Internal Record Review Tool has been updated with an addition of "Golden Thread Checklist" portion, which includes checking protocols as part of auditing tool. Within ABI Residential Setting, nursing staff will be responsible for reviewing document to ensure all components are addressed, as well as sign as "Person Supervising Device." Nurse Manager and Quality Assurance Coordinator will complete "how to training" with Nursing staff.
Status at follow-up	As of 4/21/2023, updated Support and Protective Device have been completed for gait belt and walker. All documents have been signed by required parties, including Individual/Guardian, Practitioner, Human Rights Committee and Person Supervising Device, and location for agency staff to identify if data has been communicated with DDS/treatment team
Rating	Met

Indicator #	L80
Indicator	Symptoms of illness
Area Need Improvement	At five of six locations, staff/providers had not received training in Health Observation Guidelines and Just Not Right. The agency needs to ensure that staff are trained in the correct curriculum for signs and symptoms of illness.

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Process Utilized to correct and review indicator	The Training Coordinator has developed a "DDS Required Training" folder within the shared drive for all departments to access. The Training Coordinator will be responsible for ensuring all material is the most updated complete versions. Employees have been informed on how to access materials and the agency's online training platform Relias has been updated. All employees are released and required to complete Health Observation Guidelines and Just Not Right training material as part of an annual training plan each March.
Status at follow-up	All providers have been trained on the most updated Health Observation Guidelines and Just Not Right material as of 6/1/2023. All home binders have the most updated training material present.
Rating	Met

Indicator #	L94 (05/22)
Indicator	Assistive technology
Area Need Improvement	Two out of eight individuals did not have any assistive technology explored, or in place, to maximize independence. The agency needs to ensure that individuals are given the opportunity to have assistive technology options to maximize their independence.

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Process Utilized to correct and review indicator	Process Utilized to correct and review indicator As part of an updated Quality Improvement initiative, quarterly peer record reviews will be completed across adult service models. Internal Record Review Tool includes verification that Assistive Technology (AT) Assessments are completed as part of annual ISP assessments or more often if needed. For individuals who express interest or desire to further independence through access of AT, a formal referral will be submitted to individual's DDS Service Coordinator. In addition, the agency will be developing an Assisted Technology Policy & Procedure as part of Remote Monitoring and Supports initiative, which will outline DDS providers' role in AT services.
Status at follow-up	Status at follow-up Assisted Technology Assessments have been completed and or revised to reflect individual needs and requests as of 5/13/2023.
Rating	Met

Indicator #	L99 (05/22)
Indicator	Medical monitoring devices
Area Need Improvement	One individual's medical monitoring device lacked authorization and did not include all required components including the parameters of use and care of the device. The agency needs to ensure that all medical monitoring devices are authorized with completion of components for use and are implemented as directed.

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Process Utilized to correct and review indicator	As part of an updated Quality Improvement initiative, quarterly peer record reviews will be completed across adult service models. Internal Record Review Tool has been updated with an addition of "Golden Thread Checklist" portion, which includes checking protocols as part of auditing tool. In addition, within ABI Residential Setting, nursing staff will be responsible for reviewing document to ensure all components are addressed, as well as sign as "Person Supervising Device." Nurse Manager and Quality Assurance Coordinator will complete "how to training" with Nursing staff
Status at follow-up	As of 4/21/2023, updated Support and Protective Device have been completed identifying parameters and care of device (hearing aid).
Rating	Met

Employment and Day Supports Areas Needing Improvement on Standard not met - Identified by Provider

Indicator #	L49
Indicator	Informed of human rights
Issue Identified	Grievance/How to file a complaint was not returned signed by guardian for 2023.
Actions Planned/Occurred	Re-sent Grievance training and consent, as well as followed up with phone call. Will work on updating consent "packets" checklists to ensure that all required documentation is sent and returned with signatures.

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Process Utilized to correct and review indicator	As part of an updated Quality Improvement initiative, quarterly peer record reviews will be completed across adult service models. Internal Record Review Tool includes in Section 5: Human Rights/Incident Reports verification of Human Rights Family/Guardian Mailing. In addition, Quality Assurance Coordinator/Human Rights Coordinator will begin holding at least twice annual Human Rights Advocate Cadre Meeting in which roles and responsibilities will be communicated and reviewed to ensure understanding and compliance.
Status at follow-up	5/1/2023 "how to file a grievance" was signed by Guardian
Rating	Met

Indicator #	L88
Indicator	Strategies implemented
Issue Identified	Progress Summary was not completed until 1/19/23 (45 days late), which is after the due date of 12/5/2022.
Actions Planned/Occurred	Progress summary was due on 12/5/2022; Initial request was sent by DDS Service Coordinator on 7/19/22. Was approved by DDS on 2/15/23. Email was sent to DDS Service Coordinator on 2/9/2023. As part of record audit tool, progress summaries are identified and reviewed for compliance. In addition, twice a month HCSIS alerts are provided outlining current, past due, and active actions. Provide additional training to Program Manager related to checking HCSIS for pending or approaching tasks for this individual.
Process Utilized to correct and review indicator	Program Manager has been retrained on HCSIS timeline and completion. In addition, at least twice month HCSIS alerts are run and sent to all departments by Quality Assurance to ensure timely completion

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Status at follow-up	Identified individual had HCSIS assessments due by 5/23/23. On 5/5/23 DDS Service Coordinator requested documents, on 5/9/2023 documents where started and submitted by provider staff and approved by DDS Service Coordinator on 6/7/2023.
Rating	Met

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Administrative Areas Needing Improvement on Standard not met - Identified by DDS

Indicator #	L48
Indicator	HRC
Area Need Improvement	The agency's Human Rights Committee had not reviewed reported allegations of abuse or neglect, including DPPC case findings, investigation outcomes and follow-up action plans. The agency needs to ensure that their HRC has been provided with all necessary documentation/ information needed to properly review all allegations of abuse or neglect.
Process Utilized to correct and review indicator	Agency internal Incident Report Flow Sheet has been updated to ensure proper tracking and documented communication of all reported allegations of abuse or neglect including DPPC case findings. The Flow Sheet, which is completed by Quality Assurance during monthly Incident Review Committee and following HRC meetings, identifies initial date of report, date reported to HRC, as well as outcome findings. There is also a location to identify the date and HRC meeting minutes that conclusion/findings has been communicated with HRC committee. An Incident Report Flow sheet will not be "closed" by Quality Assurance until action steps completed and communicated with HRC.
Status at follow-up	During HRC meeting dated 4/27/2023, all investigation outcomes/findings were reviewed with the committee and documented within meeting minutes
Rating	Met