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| |  |  |  | | --- | --- | --- | | **Follow-up Scope and results :** |  |  | | Service Grouping | Licensure level and duration | # Indicators std. met/ std. rated | | Residential and Individual Home Supports | 2 Year License with Mid-Cycle Review | 2/9 | |  |  |  | | Employment and Day Supports | 2 Year License | 1/2 | |  |  |  | | |  |

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| |  | | --- | | **Summary of Ratings** | |  |
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| |  |  | | --- | --- | |  |  | | |  |  | | --- | --- | | **Administrative Areas Needing Improvement on Standard not met - Identified by DDS** | | | **Indicator #** | L48 | | **Indicator** | HRC | | **Area Need Improvement** | The agency has two Human Rights Committees. There were issues identified such as not reviewing all investigations, and meetings lacking quorum, mandated composition and attendance. The agency needs to ensure that its Human Rights Committee(s) serve as an effective safeguard for all individuals. | | **Process Utilized to correct and review indicator** | The agency has taken the following corrective measures in order to ensure compliance with all HRC indicators:  Investigations: the committee, starting with the November Meeting, is now reviewing all investigations from beginning stages and not just finalized cases. In addition, the committee also has begun reviewing items screened for Administrative Review and CRT. This occurred in the full November meeting for Foxboro and in the subcommittee comprised of the members with legal and medical expertise for the November Brockton meeting.  The HRC coordinator reviewed with HRC members at both meetings licensing findings and strategized around issues related to meeting quorum and reviewing all materials in a timely fashion. The agency will continue to explore how to use technology to share materials and/or hold remote meetings. Until such time, all materials will be reviewed in person at the meetings.   Membership: the agency has collaborated with other area agencies in order to share resources for members with medical and clinical expertise. Currently each committee now has active members representing each required area of expertise. DDS requirements around attendance were reviewed with members at the November meeting. Several members thought they may be able to recruit additional volunteers to have more members with the required expertise.   BAMSI's Q&I Department will develop a review tool that will measure HRC required standards/indicators and conduct an official review annually of the HRC to ensure ongoing compliance and/or identify areas requiring attention. | | **Status at follow-up** | All investigations were reviewed at each November meeting  Although the agency now has the required membership, the nurse was not present at the November Foxboro meeting, therefore that committee was unable to review medical documents such as Supportive and Protective Devices. | | **Rating** | Not Met | | **Indicator #** | L66 | | **Indicator** | HRC restraint review | | **Area Need Improvement** | Seven out of twenty-three restraints were not reviewed by the Human Rights Committees within required timelines. The agency needs to ensure that restraints are reviewed by the Human Rights Committees within 120 days. | | **Process Utilized to correct and review indicator** | As indicated above, corrective measures to address attendance and membership issues have been implemented. With that, timely review of restraints with required quorum and members with required expertise will occur. | | **Status at follow-up** | As of the November meeting, all restraints for both committees were reviewed with required quorum and members with required area of expertise. | | **Rating** | Met | | **Residential and Individual Home Supports Areas Needing Improvement on Standard not met - Identified by DDS** | | | **Indicator #** | L56 | | **Indicator** | Restrictive practices | | **Area Need Improvement** | For nine out of fifteen individuals with restrictive practices, all required components such as a plan to fade and provisions to mitigate the restriction on others were not in place. The agency needs to ensure that all required components are in place when restrictive practices are being implemented. | | **Process Utilized to correct and review indicator** | The agency has taken the following corrective measures to ensure compliance with issues related to Restrictive Practices:  HRC Coordinators conducted a review of restrictive practices with committee members, including required elements.  HRC Coordinators will conduct a training on required elements/restrictive practices at the next Adult Services Management Conference.  The Residential Quality and Improvement Program Review Tool will be enhanced to include required elements of restrictive practices, not currently identified on the tool, in order to measure ongoing compliance and identify areas of need.  The agency has designated clinical staff as the responsible party for developing restrictive practices with behavioral components.  Data sheets to track plans to mitigate the effect on others (when door alarms are turned off for example) will be developed and utilized wherever restrictive practices are in effect.   The current program review process was utilized in order to measure a sampling from Oct 8-Dec 6 for compliance. | | **Status at follow-up** | Out of 23 restrictive practices reviewed, 17 met all of the required elements. | | **Rating** | Not Met | | **Indicator #** | L60 | | **Indicator** | Data maintenance | | **Area Need Improvement** | For two out of six individuals with behavior plans, data was not being consistently maintained and used to determine the efficacy of behavioral interventions. The agency needs to ensure that data is being consistently maintained and used to determine the efficacy of behavioral interventions. | | **Process Utilized to correct and review indicator** | The following corrective measures have been identified in regard to Behavior Plan tracking:  Review of behavior plan tracking will be added to the Monthly Program Manager and Assistant Director Management Reports so that closer oversight and follow up will occur.  Program Managers and Assistant Directors will complete data collection periodically to reinforce and model data collection.   The current program review process was utilized in order to measure a sampling from Oct 8-Dec 6 for compliance with behavior plans and tracking. | | **Status at follow-up** | Of 26 Behavior plans reviewed, 25 had consistent data tracking | | **Rating** | Met | | **Indicator #** | L62 | | **Indicator** | Health protection review | | **Area Need Improvement** | Supportive and health related protections for six individuals were not reviewed by the human rights committee. The agency needs to ensure that supportive and health related protections are reviewed by required groups. | | **Process Utilized to correct and review indicator** | The following corrective measures have been taken to ensure compliance with regard to HRC review of supportive and heath related protections:  HRC Coordinators reviewed required elements for supportive and health related Protections with committee members.   BAMSI's forms workgroup will review the Supportive and Protective template / form to determine whether improvements can be made to make the form more user friendly to avoid errors/forms getting rejected for HRC review.   Human Rights Coordinators will review required elements will occur at the next Adult Services Management Conference.  Additional reminder calendars noting S&P submission deadlines for HRC review will be published to the field.  When members with required expertise are not present or adequate quorum is not met, S and P's will be reviewed either in subcommittee or at following meeting.  The current program review process was utilized in order to measure a sampling from Oct 8-Dec 6 for compliance with S and P's in the field | | **Status at follow-up** | Of 54 S and P's evaluated, only 42 had the required HRC review. In addition, the Foxboro Committee HRC member with healthcare related expertise was not present at the November meeting so it was not possible to review S and P's submitted. | | **Rating** | Not Met | | **Indicator #** | L64 | | **Indicator** | Med. treatment plan rev. | | **Area Need Improvement** | Five out of twenty-one medication treatment plans were not reviewed by the ISP team. The agency needs to ensure that medication treatment plans are reviewed by the ISP team. | | **Process Utilized to correct and review indicator** | In order to ensure compliance the agency will:  Review expectations related to Med Treatment Plans during the next Assistant Director meeting to ensure full understanding around submission of MTP's for the ISP.  Managers will use technology such as Outlook calendars for reminders around ISP submissions.  The Q and I Program Review Tool will be enhanced to include assurance that MTP's are included in the ISP.  The current program review process was utilized in order to measure a sampling from Oct 8-Dec 6 for compliance. | | **Status at follow-up** | The majority of programs/plans reviewed have had ISP's in place since prior to licensing and therefore are still out of compliance. Moving forward ALL ISPs will include uploaded MTPs prior to finalization of ISP. | | **Rating** | Not Met | | **Indicator #** | L86 | | **Indicator** | Required assessments | | **Area Need Improvement** | Assessments were not submitted within required timeframes for eight individuals. The agency needs to ensure that assessments are submitted to the DDS Area Office at least 15 days prior to the ISP. | | **Process Utilized to correct and review indicator** | The following measures will be implemented to ensure improved compliance:  Managers will use technology such as Outlook calendars for reminders around ISP submissions.  Directors will run the HCSIS report to identify programs with missed deadlines to identify areas of noncompliance and prioritize training/supervisory follow up.   In order to assess current compliance a HCSIS report of ISPs completed since October 1 was run. | | **Status at follow-up** | HCSIS report review of ISP's since licensing demonstrates that this area remains out of compliance and requires supervisory oversight. | | **Rating** | Not Met | | **Indicator #** | L87 | | **Indicator** | Support strategies | | **Area Need Improvement** | Support strategies were not submitted within required timeframes for seven individuals. The agency needs to ensure that support strategies are submitted to the DDS Area Office at least 15 days prior to the scheduled ISP meeting. | | **Process Utilized to correct and review indicator** | The following measures will be implemented to ensure improved compliance:  Managers will use technology such as Outlook calendars for reminders around ISP submissions.  Directors will run the HCSIS report to identify programs with missed deadlines to identify areas of noncompliance and prioritize training/supervisory follow up.   In order to assess current compliance a HCSIS report of ISPs completed since October 1 was run. | | **Status at follow-up** | HCSIS report review of ISP's since licensing demonstrates that this area remains out of compliance and requires supervisory oversight. | | **Rating** | Not Met | | **Indicator #** | L91 | | **Indicator** | Incident management | | **Area Need Improvement** | In thirteen of the twenty-two locations where reportable incidents had occurred, there were instances in which reports had not been submitted and/or finalized within required timelines. The agency needs to ensure that incidents are reported within required timelines. | | **Process Utilized to correct and review indicator** | In order to improve compliance in this area, the agency's IT department will provide the Incident Management/Aging Incident Summary report to operations leaders weekly to assure open items are approved and closed within required timeframes and identify those programs where additional training is necessary. A report was run on Dec 6 to assess current compliance. | | **Status at follow-up** | Although there is some improvement, there remains gaps in compliance. | | **Rating** | Not Met | |  | | |