DEPARTMENT OF DEVELOPMENTAL SERVICES

LICENSURE AND CERTIFICATION

PROVIDER FOLLOW-UP REPORT

Provider: SEVEN HILLS FOUNDATION

Provider Address: 81 HOPE AVE , WORCESTER

Name of Person Completing Form: Tammy Peterson

Date(s) of Review: 02-AUG-23 to 02-AUG-23

Follow-up Scope and results :

Service Grouping	Licensure level and duration	# Indicators std. met/ std. rated
Residential and Individual Home Supports	2 Year License	4/7
Employment and Day Supports	2 Year License	2/4

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

Indicator #	L63
Indicator	Med. treatment plan form

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Area Need Improvement	In sixteen out of thirty-nine medications treatment plans reviewed, one or more required elements of medication treatment plans were not fully addressed. When medications are administered to control or modify behaviors, the agency needs to ensure that medication treatment plans contain all required components. This includes clearly defined and measurable target behaviors identified for treatment by each medication as well as measurable criteria set by the prescriber for medication adjustment or discontinuance. Additionally, for individuals who need pre-sedation prior to medical appointments, the agency needs to develop strategies to assist the individual in learning to cope with medical treatment and reducing or eliminating need for sedative medication over time.
Process Utilized to correct and review indicator	SHF is working on improvements to our MTP form to ensure required components are addressed as we implement a new EHR. The form will be submitted to OQE for review and a consultation has been requested. Once we complete this process we will train staff in the new form and monitor compliance.
Status at follow-up	We are in process of developing a form that will prompt the required components are addressed.
Rating	Not Met

Indicator #	L87
Indicator	Support strategies
Area Need Improvement	For fourteen out of forty-five individuals, provider support strategies were not submitted to DDS within the required timeline. The agency needs to ensure that provider support strategies are submitted fifteen days prior to the ISP meeting.

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Process Utilized to correct and review indicator	Each Residential Service changed processes to better comply with ISP deadlines. All staff responsible for support strategies were retrained in June. Designated staff use strategies such as reports, calendar reminders and spreadsheets. These are reviewed in supervisions. Additional required training is given to staff to understand ISP timelines navigating and reports in HCSIS.
Status at follow-up	Reports from HCSIS for the month of July 2023 were reviewed for Support Strategy submission timeline compliance. In Residential/IHS/Placement 30/32 (93%) and Employment/Day 10/10 (100%) were completed within required timelines.
Rating	Met

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

Indicator #	L69
Indicator	Expenditure tracking
Issue Identified	Overall at residential service programs, this indicator was rated met at sampled programs 34 out of 41 times and were found to meet the standard. Four SHCS and SHNC homes did not meet the standard. However, audits completed in the past year showed issues identified with tracking expenditures. Seven Hills has already worked to improve in this area. The sample rating meeting the standard shows progress. Auditors found the new systems in place at all but 4 sampled locations.
Actions Planned/Occurred	This area of concern was identified prior to the self-assessment, and Seven Hills plans to conduct a full process review and improvement and retraining. The plan will include optimizing the use of technology to automate the process and dedicating specific resources for monitoring, auditing, and analysis.

Process Utilized to correct and review indicator	Seven Hills is conducting a process review and retraining to continue to improve in this area. Area Directors have been retrained in financial audits. New financial forms are in place and staff have been trained. Sr Leadership, Quality Office and the Business Offices created a workgroup and met to review additional safeguards for client funds. We are exploring alternate rep-payee cash disbursement methods to limit staff access to client funds while maintaining and improving individual access. The business office has increased audits. In all recent audits the business office has found that expenditure tracking is in place. The business office completed follow-up audits to ensure all recommendations are followed and the results have been very good.
Status at follow-up	In the months of June and July 2023, the business office completed 6 audits. The results were that expenditure tracking was in place, there were no material issues or fraud. At the follow-up audits to ensure recommendations were in place, it was determined that they were addressed.
Rating	Met

Indicator #	L89
Indicator	Complaint and resolution process
Issue Identified	Two ABI homes did not have evidence of consistent implementation of the grievance procedure in place that was consistently followed. One home had a binder in place but it was not in use.
Actions Planned/Occurred	All staff are trained in the agency grievance procedure at orientation. ABI staff will be retrained in the grievance and complaint procedures.
Process Utilized to correct and review indicator	All ABI staff were retrained in the grievance and complaint procedure.

Status at follow-up	The AVP overseeing ABI programs verified as of July 2023 that grievance procedures and binders are in place. ABI staff have been retrained. All staff continue to be trained at agency orientation.
Rating	Met

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

Indicator #	L91
Indicator	Incident management
Issue Identified	The agency's internal incident report tracking spreadsheet showed that overall compliance was 84.9% of incidents submitted within timelines. However among those, 7 out of 26 CBDS incident reports were submitted late.
Actions Planned/Occurred	Three late reports were due to an email that was sent to one person in DAQE and was missed. In 2022, the agency put in place an incident reports email which is monitored by several members of the quality team and has streamlined reporting. Timeline compliance reports have been developed and will be sent to leadership to help improve incident submission timeline compliance.
Process Utilized to correct and review indicator	The dedicated mailbox has improved the workflow. Incident report procedures and timelines have been reviewed with managers. We have created timeline compliance reports that will be sent quarterly to management for all service types.
Status at follow-up	On July 25, 2023, an audit was completed for Employment/Day incident reports submissions and finalization. In the past 13 months, 25 reports were submitted and finalized. 22 were submitted on time for 88% compliance. In the months of June and July 5 out of 5 were submitted on time for 100% compliance. For the same 13-month sample 23/24 (96%) were finalized on time and in June and July 100% were finalized on time.
Rating	Met

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

Indicator #	L48
Indicator	HRC
Area Need Improvement	Seven Hills has five human rights committees. A review of human rights committee meeting minutes for the past two years showed that two committees did not have a member with legal expertise. For one committee, the legal representative did not attend the majority of meetings. For two committees, the medical representative did not attend the majority of meetings, and one committee did not meet quarterly as required. The agency needs to ensure that each human rights committee is comprised of the requisite expertise among its membership and that members with required expertise, i.e., legal, medical, and clinical representatives, are present at scheduled meetings. Additionally, the agency must support its human rights committees to meet at least quarterly.
Process Utilized to correct and review indicator	The agency continues to recruit and has added committee members. We have conducted a review of our committee structure with the Office of Human Rights (OHR). The OHR affirmed that we have a comprehensive Human Rights Committee system. We plan to meet in the coming weeks to further improve our human rights committee system and enhance communication.
Status at follow-up	We continue to seek legal representation for two of the committees. The committees have met quarterly since the missed meeting in 2022.
Rating	Not Met

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

Indicator #	L65

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Indicator	Restraint report submit
Issue Identified	Out of 38 restraint reports, 14 were not submitted or finalized within timelines.
Actions Planned/Occurred	The agency will retrain staff in timelines for submission and finalizing restraint reports and review the current workflow to facilitate faster turnaround. Timeline compliance reports will be sent to Area Directors and Program Directors to review with their staff.
Process Utilized to correct and review indicator	Restraint timelines were reviewed with staff. Clinical staff and Quality Staff are collaborating to identify the common errors in reports that cause delay in reporting. Training modules will be created for training and future training.
Status at follow-up	In July the Director of DAQE reviewed the previous 13 months of restraint reports. From June 2022 to June 30, 2023, there were 30 restraint reports. Of those, 27 were both submitted and finalized on time (27/30) for 90% compliance.
Rating	Met

Indicator #	L76
Indicator	Track trainings
Issue Identified	Seven Hills transitioned to a new learning management software in 2022. Training compliance was not easily reported to managers at first. There was a delay due to implementation issues with assigning content to users.
Actions Planned/Occurred	Currently, the training department sends completion reports twice a week to Vice Presidents and managers. Compliance improved greatly in the past two months. All staff are assigned the required trainings that are completed or tracked through the learning management software.

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Process Utilized to correct and review indicator	The Director of DAQE and the Chief Learning Officer reviewed training records in our learning software. There continues to be significant progress in training tracking and compliance. Staff usage of the system has increased. Managers have been trained in how to run reports. We continue to invest in improving our training reporting system so that our new hires, transfers and terminated staff are automatically updated in the system by program and the course and user data from the system is migrated to our data lake for enhanced reporting capacity. This project will be completed in the fall. With our current twice weekly training reports, we were able to successfully monitor and target a specific training to achieve full compliance in that training.

Status at follow-up	In the month of June, frequent compliance reports were sent to managers for specific training. SH leadership was able to successfully monitor that training compliance percentage by program, identify gaps and respond. This effort resulted in full compliance for that training. An audit was completed on July 30 of 23 training records. There was a marked improvement in tracking and compliance since the last review. The Director of DAQE also completed a spot check of onsite fire safety training records for the sampled staff. These records are tracked in our online system but are entered manually. So, the records that were on-site were reviewed. Some challenges remain in tracking historical trainings/ one-time trainings from our previous LMS. These are being addressed by the data lake (the project referenced above). Currently the data is accessible for review in the data lake and on site. The result of the audit of the 23 sampled staff training records was that of the L76 trainings (First Aid, CPR, Basic Fire Safety, Basic Human Rights, PBS and universal supports, Incident Reporting, Universal Precautions, and Transmission Prevention for Specific Diseases (Covid 19)), there was over 80% completion compliance for all trainings except COVID-19 Transmission Prevention. All programs continue to have an FSO and HRO. Rated by staff compliance, we were able to verify that 12/23 had completed the full set of L76 trainings. This may be due to the challenges in the tracking software that will be addressed in the coming months.
Rating	Not Met