Dec-22

Quality Assurance Committee Manual

Sedgwick County... working for you

Community Developmental Disability Organization

SCDDO

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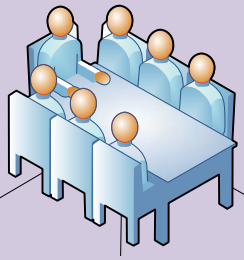
Quality Assurance Committee



Quality Assurance Committee (QAC)

Is made up of SCDDO QA, TCM Agency Representatives, and On-Site Monitoring Teams

SCDDO Quality Assurance

SCDDO Quality Assurance Coordinator or designated Quality Assurance staff

Targeted Case Management (TCM) Agency Representatives

The person who maintains oversight of quality assurance or targeted case management department at the agency.

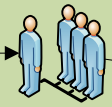
On-Site Monitoring Teams

Team established By the TCM Representative.

The team may include any of the following:

- Individuals receiving services
- Family members
- Guardians
- Interested citizens

Generates a random sample of individuals to review quarterly.



Established on-site monitoring team

Performs service reviews such as:

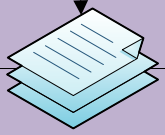
- Day Service
- Residential Service
- TCM Service
- Supportive Home Care Service

Evaluates submitted reviews, sends feedback to agencies, and provides follow-up on concerns.

Collects and assesses reviews and submits to SCDDO QA.

Community Council

Reviews quarterly trend data and provides additional feedback. SCDDO QA staff performs follow-up on feedback provided.



QAC Meets quarterly to review trend data

Intellectual and Developmental Disability Advisory Board

Reviews quarterly trend data and provides additional feedback. SCDDO QA staff performs follow-up on feedback provided.

SEDGWICK COUNTY
DEVELOPMENTAL DISABILITY ORGANIZATION
Quality Assurance Committee

Introduction: What is Quality Assurance Committee (QAC)

Developmental Disabilities Reform Act (KSA 39-1802)

In 1995, the Kansas Legislature enacted the Developmental Disabilities Reform Act. The purpose of this act was to assist individuals who have a developmental disability to have:

a. services and supports which allow individuals the opportunities of choice to increase their independence and productivity and integration and inclusion into the community;
b. access to a range of services and supports appropriate to such individuals; and
c. the same dignity and respect as individuals who do not have a developmental disability.

This Act gave the Kansas Department for Aging and Disability Services (KDADS) certain powers and duties including the authority to establish the policies and procedures by which the Developmental Disabilities Reform Act would be implemented. Those policies and procedures include the regulations for licensing providers of community services and operation of Community Developmental Disabilities Organizations (CDDOs).

Kansas Administrative Regulations Article 64

The regulations for quality assurance require a local committee made up of individuals served, their families, guardians, interested citizens, and providers to determine the following:

- Services that are paid for are delivered;
- Services that are delivered are paid for in accordance with the terms of any agreement or contract in force, including any payment requirement that the individual being served or a third party acting on behalf of the individual being served has the responsibility to meet;
- Services are being provided in a manner, which meets the requirements provided for in Article 63;
- The provider is affording the individual being served all of the individual's legally protected rights; and
- The provider is reporting any suspicions of abuse, neglect, or exploitation and taking corrective action when needed.

Determining Quality of Services

The QAC process evaluates services based on the support plan documentation, individual support needs and satisfaction. Compliance with this requirement is determined by interviewing the

individual and their support network to determine if they are receiving the services needed to work towards the individual's preferred lifestyle and that those services are meeting their expectations.

- Services should be person oriented. Community Service Providers (CSPs) should assure there are processes in place that are individually focused to meet the individual's needs.
- The guiding principles and values of QAC are followed to ensure appropriate services are being delivered.

Overview

1. The committee will be comprised of SCDDO Quality Assurance (QA) Coordinator, Targeted Case Management (TCM) representatives, on-site monitoring teams and Community Council members representing the following categories: individual receiving services, their family members and/or guardians and interested citizens.
2. The committee will review a sample of individuals who receive TCM plus one additional service; individuals will be randomly selected by SCDDO QA team.
3. Each CSP which provides licensed TCM will be assigned at least one individual each quarter for review by the agency's monitoring team.
4. Each CSP serving ten or more individuals will receive a review by a QAC monitoring team at least annually.
5. The QAC review will consist of the following:
    a. Review of the selected individual's documents pertaining to his/her individual services. At minimum, the support plan must be reviewed, as well as the Behavior Support Plan and Psychotropic Medication Plan when applicable.
    b. Completion of an on-site review of each service received. This will include Personal Care Services (PCS), Day and Residential services. The review must be conducted in the home for Residential services or where the individual receives services in the case of PCS. In the case of Supported Employment, the individual receiving that service may choose where the interview will occur. Individuals who receive Day services from more than one CSP shall be reviewed at the site where the majority of their time is spent.
6. For individuals who receive self-directed PCS, the QAC Representative will utilize the Self-directed Notification Letter to inform the family/individual that they have been selected for a review. This letter not only provides notice prior to scheduling of the visit it also includes a copy of the on-site services tool as the caregiver prepares for the review. (August 2022)
7. On-site reviews will be conducted both with the individual AND his/her paid staff, if applicable. This includes paid family members. Exceptions can be made if review team can demonstrate to SCDDO that sufficient attempts have been made to conduct the review with staff present. It is the decision of the individual whether his/her interview is conducted confidentially or with staff present.
8. The monitoring team will use the review tools which correspond with the services documented and reviewed. See Using the Review Tools.
9. If any concerns are noted from the document review or on-site monitoring, the monitoring team is responsible for completing the review forms and adding any additional comments,

questions or concerns. The monitoring team shall pass on agency concerns or praises regarding the reviews with the agency where the site visit was completed. This should be completed timely to allow the CSP to take action when necessary.

10. All original review tools and copies of reviewed documents will be submitted to SCDDO QA team along with the QAC packet by the due date assigned.
11. CSP's may request copies of the review tools for their records from either the TCM service provider performing the review or SCDDO QA Coordinator.
12. SCDDO QA Coordinator will provide feedback with any trends and positive items noted from the reviews on a quarterly basis to each CSP. See Service Modifications and Agency Intervention Plans.

How Individuals Are Selected

Selection for a QAC review is completed by SCDDO QA staff in December of each year. SCDDO will identify all qualifying individuals and sort by TCM provider. This sort will complete the first step in randomizing individuals for selection. The second step will determine each TCM provider's selection size which is 10% the providers TCM service population. Once the 10% is determined, it is divided by 4 to determine the number of reviews which will be assigned each quarter for the following year's review. To select the individuals per agency, every 10th individual on the list is chosen until the correct sample size is selected. If the selected individual has received a QAC review within the last five years, the following individual on the list is selected.

Date

Name
Address
Address

Dear {insert name}
This letter is to inform you that {Name} has been selected to have a review completed on {his/her} services. These reviews are completed by your case management agency by interviewing the support worker and visiting the service location.

Someone from {Agency} will be contacting you within the next few months to schedule this review. Enclosed you will find a copy of the questions that will be discussed with the support worker, please use it to prepare for the review. If you have questions, please contact your targeted case manager.

Thank you,

QAC Rep
Info

Enclosure

For more information regarding service reviews, please see the Quality Assurance Committee information located on Sedgwick County CDDO's website at
https://www.sedgwickcounty.org/developmental-disabilities/forms/

SEDGWICK COUNTY
DEVELOPMENTAL DISABILITY ORGANIZATION
Quality Assurance Committee

Guiding Principles and Values

Minimum Health and Safety

1. Individuals are free from abuse, neglect, and exploitation.
2. Individuals have their basic needs met including optimal health, safety, privacy, security, and personal well-being.

Equality and Full Citizenship

1. Individuals with developmental disabilities are people first.
2. All individuals are entitled to the same privileges and responsibilities.
3. Individuals are encouraged and assisted to exercise their rights.
4. Individual rights are not limited without due process.
5. Individuals are recognized for their abilities.
6. Individuals are full members of their communities.

Opportunities for Choice

1. Individuals have the opportunity to develop a broad base of experience and knowledge to use when making decisions.
2. Individuals participate in and contribute to their communities in unique and personalized ways they determine.
3. Individuals choose where they live, work and recreate.

Self-Determination

1. Individuals and their support network choose what services will be provided, who will provide the services and how those services will be delivered in accordance with the individual's preferred lifestyle.

People will influence the Quality and Responsiveness of Services

1. Individuals are given the opportunity to evaluate how effective and appropriate the services they receive are through the QAC process.
2. The opinion of the individual receiving services is given the most important consideration in evaluating service providers. In situations where the individual receiving services is a minor (under the age of 18), the opinion of the parent/guardian is given the most important consideration, however, the child should be included as deemed appropriate.

SEDGWICK COUNTY
DEVELOPMENTAL DISABILITY ORGANIZATION
Quality Assurance Committee

Expectations

Community Service Provider (CSP) Expectations

It is the expectation that each CSP which delivers Targeted Case Management (TCM) services will establish a Quality Assurance Committee (QAC) monitoring team and designate an agency representative to complete internal oversight of the QAC process. Refer to SCDDO policy G-01 Quality Assurance Committee.

The Monitoring Team

Each agency will establish one or more monitoring teams comprised of a representative from the TCM agency and at least one other member: an individual receiving service, a family member, a guardian or an interested citizen. The agency representative, or designee and at least one other member, not paid by the agency, must both be involved in the entire review process for the individual assigned to that team. To avoid any conflict of interest, case managers should not participate in the review of any individual for whom they are currently monitoring services. This limitation is applicable even in instances where the case manager did not write the current support plan for that individual. If it is requested by the family, a reviewee's case manager may assist the non-paid team member in conducting a visit to a family home for an individual with personal care services; however the case manager would function as a support to the family rather than a reviewer. The monitoring team will review all support plan documents prior to observing the individual within each service they receive.

Quality Assurance Representative

The agency's representative is the person who oversees TCM and/or QA department at the agency. This individual is the main contact between the agency and SCDDO during the review process and will communicate any difficulties during the review process. The quarterly assignments are sent directly to the agency representative to organize the team to complete the review. Once the document review, on-site visit and staff interviews are completed; the agency representative will review all documentation to ensure that the review is complete and there is no missing information. The agency representative will ensure that all concerns are addressed and submitted within the due dates established by SCDDO. The representative will also be expected to participate in the quarterly QAC meeting where County data and trends are discussed.

Agency representatives are required to complete on-line QAC Manual training via Relias as well as on-boarding with SCDDO QA Coordinator. The on-boarding may include an in-person review of the QAC manual, explanation of role and purpose, as well as, shadowing of individual/ staff interviews.

SEDGWICK COUNTY
DEVELOPMENTAL DISABILITY ORGANIZATION
Quality Assurance Committee

HIPAA and Identification

HIPAA

Every member of the Sedgwick County Quality Assurance Committee (QAC) is required to review and acknowledge the County's HIPAA Basic Training. This training will provide information regarding Sedgwick County expectations related to Health Insurance and Portability & Accountability Act (HIPAA) and Privacy Laws, which covers all information that is collected during a QAC review. Members will also review and sign the Sedgwick County Confidentiality Agreement for Non-Employees. The two forms will be collected and returned to SCDDO prior to any member participating with a monitoring team. Please indicate on the HIPAA acknowledgement form the role which the member holds: persons served, family of person served, guardian, interested citizen or service provider.

Identification

Each member of the QAC monitoring team, upon receipt of the HIPAA and Confidentiality Acknowledgment form, will be issued an annual QAC membership badge to wear while completing the QAC review. Annually, the QA Coordinator will verify the list of members with each designated agency representative to confirm on-going participation. If an agency receives a new monitoring team member at any time during the year, the agency is expected to go through this process prior to having the member take part in the review. If an individual is no longer participating in the committee, the agency representative will collect the badge and notify SCDDO QA department to remove the member from the listing.

HIPAA in BASIC TRAINING

For SCDDO On-Site Monitoring Teams

What will you Learn about HIPAA in BASIC TRAINING?

The BASIC Principles of Privacy.
Who has to Follow the Privacy Regulations.
Where Protected Health Information (PHI) is Found.
What the Privacy Law means for Sedgwick County Clients.
What the Privacy Law means for Sedgwick County Employees.

What is Privacy?

Privacy is about who has the right to access personally identifiable health information. The HIPAA Privacy Law covers all protected health information in the hands of covered entities, including Sedgwick County. This means it protects health information that is transmitted electronically as well as on paper.

What is HIPAA?

HIPAA, or the Health Insurance Portability & Accountability Act of 1996 Public Law 104-191, was enacted as part of a broad congressional attempt at incremental health care reform. There are two tenets with HIPAA: Portability and Accountability.
What do the Privacy Standards do?
Portability refers to the transfer of health insurance from one organization to another.
What are the Five Basic Principles of Privacy?
Accountability contains provisions to regulate and standardize information exchanges and to establish standards for the privacy and security of protected health information or PHI.
Who has to Follow the HIPAA Privacy Regulations?
Compliance with the Accountability or PRIVACY component of HIPAA will be required on April 14, 2003 for Sedgwick County.

What do the Privacy Standards do?

· Limit the non-consensual use and release of private health information.
· Give clients new rights to access their medical records and know who else has accessed them.
· Restrict disclosure of health information to the "minimum necessary" for the intended purpose.
· Establish criminal and civil sanctions for improper use or disclosure.
· Establish new requirements for access to records by researchers and others.

What are the Five Basic Principles of Privacy?
The HIPAA Privacy Regulation reflects the five basic principles:

· Consumer Control: Consumers have the right to control the release of their medical information.

· Boundaries: With few exceptions, an individual's health care information should be used for health purposes only, including treatment and payment.

· Accountability: Federal penalties will result if a client's right to privacy is violated.

· Public Responsibility: We need to balance privacy protections with the public responsibility to support such national priorities as protecting public health, conducting medical research, improving the quality of care, and fighting health care fraud and abuse.

· Security: We must protect health information against deliberate or inadvertent misuse or disclosure.

Who has to Follow the HIPAA Privacy Regulations?

All health care providers who transmit health information electronically, including Sedgwick County.
· All health plans (insurance companies).
· All health care clearinghouses.

Sedgwick County may disclose health information to persons or organizations hired to perform functions on its behalf. These business partners are not permitted, and have agreed to not use or disclose protected health information in ways that would not be permitted for Sedgwick County.

What is Protected Health Information or PHI?

Protected Health Information (PHI) relates to the physical or mental health of a client of Sedgwick County. This protected information includes the care provided to the client as well as payment for services. HIPAA protects all individually identifiable information transmitted or maintained electronically by a healthcare provider. This includes social security number, name, address, birth date or other information that could be used to identify a person if linked backed to protected health information.

Where is Protected Health Information (PHI) Found?

Sedgwick County Health Department
· COMCARE
· Community Developmental Disability Organization (CDDO)
· Department on Aging
· Emergency Medical Services (EMS)
· Division of Human Resources
· Any other departments that collect, maintain, and transmit PHI in its daily provision of care to the public.

What are the Rules Concerning Use and Disclosure of Protected Health Information?

The Privacy Law requires Sedgwick County to provide clients with notice of the client's privacy right and the privacy practices of the Covered Entity. Direct treatment providers are required to make a good faith effort to obtain a client's written acknowledgement of the Notice of Privacy Right and Practices.

What does the Privacy Law mean for Sedgwick County Clients?

· Provides clients greater control over their health information and limits the release of protected health information without proper authorization.

· Provides clients' access to their health records and grants the right to request amendments or make corrections to their protected health information.

· Informs clients how their health information is being used.

· Limits the amount of disclosed information to the "minimum necessary."

· Limits the use and disclosure of health records to safeguard security and identifies responsibility for inappropriate use and disclosure of information.

· Creates a balance between public responsibility with privacy protections.

What does the Privacy Law mean for Sedgwick County Employees?

Provides greater awareness of the rights of our clients to access, amend, and restrict their protected health information.

· Increases internal security measures for protecting and safeguarding client records.

· Ensures that our business partners adhere to the same duty to protect the integrity and confidentiality of health information already mandated under federal and state law.

· Encourages County employees to treat all individual medical records as confidential in accordance with professional ethics, accreditation standards, and legal requirements.

· Establishes a standard not to disclose financial or other client information except the minimum necessary for billing or other authorized purposes.

Makes us all more conscientious stewards of public health and the public trust.

Sedgwick County
Health Insurance Portability and Accountability Act
BASIC Training Acknowledgement Form

All Sedgwick County employees will be trained in the Privacy Regulations in accordance with the **Health Insurance Portability and Accountability Act (HIPAA)** 45 CFR Section 164.530 (b). The employee's role and access to Protected Health Information within Sedgwick County will be related to the level of training required.

I, the undersigned, hereby acknowledge that I have read and understand the above written Sedgwick County Basic Training and agree to abide by the HIPAA policies demonstrated through the training.

I understand this Acknowledgement does not in any way constitute an employment contract, and Sedgwick County reserves the right to amend this training and dependent HIPAA policies at any time, without prior notice to me.

_____ _____

Employee Name-Printed Date

_____

Employee Signature

_____

Sedgwick County Department

SEDGWICK COUNTY DEVELOPMENTAL DISABILITY ORGANIZATION
CONFIDENTIALITY AGREEMENT FOR NON-EMPLOYEES

I, the undersigned, acknowledge that during the course of my voluntary participation or performance of duties with the Sedgwick County Developmental Disability Organization (hereinafter "SCDDO") that I may receive access to confidential information of SCDDO that is prohibited from disclosure to others.

"Confidential Information" means information provided by SCDDO that is not commonly available to the general public, or is required by law or regulation to be protected from disclosure to third parties not considered part of the facility's "workforce" as that term is defined by federal and state health information privacy regulations including, but not limited to the Health Information Portability and Accountability Act. Confidential Information includes information contained in patient medical records and any other health information which identifies a patient; quality assurance, research or peer review information; and information concerning the facility's employees, services or business operations. Such information can be acquired by any means and in any form, written, spoken or electronic.

In exchange for the opportunity to voluntarily participate or perform duties for the Sedgwick County Developmental Disability Organization, I agree not to share, disclose or discuss Confidential Information with anyone who does not have a legitimate interest in such information. I will abide by Sedgwick County's policies and procedures concerning the use or disclosure of Confidential Information and I will contact a SCDDO representative if I have any questions regarding these policies and procedures.

I will maintain and protect the privacy of SCDDO's employees, medical staff and patients in my use and disclosure of Confidential Information and I will not misuse or be careless with such information. I understand that any violation of this Agreement or SCDDO's policies related to access, use or disclosure of Confidential Information may result in significant legal ramifications for which I will be held solely responsible with respect to this Agreement.

I acknowledge that I have reviewed all of the information above. I understand that compliance with the principles, policies and procedures expressed above is a condition of my participation and continued presence at SCDDO.

_____ _____

Name (please print) Date

_____

Signature

CONFIDENTIALITY AGREEMENT USES INCLUDE:

Quality Assurance Committee (QAC): As a member of the QAC on-site monitoring team, information will be provided which describes an individual's person-centered supports. Members will observe the individual and the services they receive as well as conduct interviews of the direct care staff. The Targeted Case Management agency establishes their review teams and will ensure that the Sedgwick County HIPPA Basic Training and Confidentially Agreement is completed prior to of review of services. Please contact SCDDO QA Coordinator for questions or concerns related to this role; SCDDO Main number 316-660-7630.

Community Council Speakers Bureau: As a Community Council Speakers Bureau participant, individuals or family members may disclose personal information related to an individual's health or disability and this information must be considered confidential. All relevant policies and procedures concerning the use or disclosure of confidential information are covered during orientation, but if you have any questions or require additional copies please contact Jeannette Livingston at the SCDDO 316-660-7630.

SEDGWICK COUNTY
DEVELOPMENTAL DISABILITY ORGANIZATION
Quality Assurance Committee

Using the Review Tools

Documentation

The tools used during the Quality Assurance Committee (QAC) review were developed using Developmental Disabilities Licensing Providers of Community Services K.A.R. 30-63-21 and the Guiding Principles and Values document. In addition, interview questions were added based on the SCDDO Affiliate Service Agreement and common practice.

The **Cover Sheet** is to be used for all reviews; this document identifies the service(s) which the individual receives as well basic information regarding the completed visit(s). The **QAC Review Checklist** will assist to ensure all documentation is submitted to SCDDO upon completion of the QAC review.

When an individual receives self-directed PCS the family/caregiver is provided an opportunity to review the services tool prior to the on-site review. Self-direction is a service model that allows an individual/guardian or designee to have decision making authority to manage, promote personal choice and control delivery of the service. This notification was originally created through an experiment to address low scores and has proven to be beneficial in not only reducing confusion and questions, it use has improved service outcomes. The QAC representative is responsible for delivery of the Self-directed Notification Letter prior to the scheduled visit. (August 2022)

Service/Site Visit Reviews

Each monitoring team will utilize the support plan review checklists and on-site review tools to collect, assess and document the QAC review. To evaluate whether the required information can be found in the individuals written documents the following tools were developed, please use when applicable: **Support Plan Review**, **Behavior Support Plan/Documentation Review and Psychotropic Medication Plan/Documentation Review**. There is also an **Employment Questionnaire** to complete when reviewing individuals between the ages of 18 to 65.

There are 5 on-site service tools created, they are as follows:
Residential Services- is to be used for adults who receive Residential services either in a group home setting or services in their own home.
Life Enrichment- is to be used for individuals who participate in a non-work day program.
Work Services- is to be used for individuals who participate in a work day program.
Personal Care Services-Adult- is for adults who receive in-home supports.

Personal Care Services-Child- is used for individuals under the age of 18 who receive in-home supports.

All members of the monitoring team shall become familiar with the questions asked on the review tool. The questions do not have to be asked in the order they are documented, but it is important for all the questions to be asked. All information which is gathered and documented assists in providing final feedback to the service provider reviewed.

There may be times when it is difficult to know how to rate a particular question, when this occurs document the response and observation. Discuss with the other member(s) of the monitoring team and agency representative.

Some review tool questions cannot be rated at particular locations, for these situations mark not applicable (N/A) within the document.

Comments/ Observations

Each review tool includes a general observation section which each review team will complete. This section provides feedback regarding the individual's interactions with others in services as well as agency staff. In addition, the service site property is reviewed for cleanliness, space and accessibility. Use this section to record any observations which the reviewer feels should be noted for additional follow-up, these observations may include positive observations, concerns or important information to be passed on to the agency representative, service provider or the SCDDO.

SEDGWICK COUNTY
DEVELOPMENTAL DISABILITY ORGANIZATION
Quality Assurance Committee

Conducting the On-Site Visit

Visit Arrangements

Coordinate the specifics of any visit with the other member(s) of the monitoring team and the agency representative. It should be decided what location will be visited, the time of the visit, and make sure all reviewers have directions to the location. Transportation arrangements for the reviewers should be worked out to ensure timely arrival at the designated service location and time. It may also be helpful to have contact information for the agency representative in case any questions or concerns arise while completing the visit.

Upon Arrival

If the review is at a residence, knock at the door, present the current QAC Member identification badge and introduce yourself. If the review is at a Day program location, check in at the agency's front desk and go through their visitor process. Additional identification, such as driver's license may be requested by staff. Explain to the individual and their support staff the reason for the visit and determine if there is anything which could be done to minimize disruption of others at the home or day program. If you are refused entry at the location, leave and contact your agency representative at the first opportunity.

Examples of times when a visit may not be completed:

1. If medications are being administered, staff may not be able to answer specific questions until the task is completed.
2. If a particular individual is having a bad day or they are getting ready to leave for an appointment, it may be preferable to interview the individual at a later visit.

During the Visit

Gathering Information: The best way to prepare for a visit and gather information is to spend time reviewing the Support Plan prior to the visit. This will provide the opportunity to learn about the individual and their preferred lifestyle, support needs and goals prior to the visit. This knowledge will also allow a better understanding when interviewing support staff during the visit. Please become familiar with the specific areas covered by the review tool which may assist with avoiding implications of an inspection and help put the individual and support staff at ease.

Respect Privacy: Residential visits, whether it is at a privately owned or provider owned location, shall be completed with respect and privacy. Ask for permission before opening doors or going into

rooms. Never enter an individual's bedroom or personal space without their permission. Do not intrude in situations that demand privacy.

Stick to the Review Tool: Ask adequate questions to understand and clarify the individual and/or support staff's responses to each question on the review tool. Do not request personal information unrelated to the services which are being reviewed.

Ask Staff for Assistance: When unsure about a particular response from the individual ask for assistance. Staff may be able to provide additional information or clarify the situation in a way which the review question is more accurately completed.

Discontinue the Visit if Necessary: If, at any time during the visit, the reviewer feels uncomfortable or unsafe, terminate the review process and leave the location. Notify the agency representative at the first available opportunity.

Health and Safety Concerns: If, during the visit, the reviewer has concerns regarding the health, safety, or well-being of the individual receiving services the following may occur: discuss concerns with staff, continue the review or terminate the visit and leave the location. Record the concerns in the comments section of the review form and report the findings to the agency representative at the first available opportunity. If there is any concern of abuse, neglect or exploitation happening in the location, a call to Adult Protective Services or Child Protective Services shall be completed immediately.

Leaving: When the review is completed, thank everyone for their assistance and time, and leave the location. If there is a need to discuss observations with other team members, find a private place away from the location. If individuals or support staff inquire about the review outcomes, explain that it will not be completed until final review by SCDDO. Assure them that they may access the final report through their agency.

Personal Care Services (PCS) Visits: These visits will be conducted in the family home and observations will be made of the persons providing the direct care with the individual which he/she provides support for. Prior to the site visit the agency representative or designee will contact the family to schedule the visit during a time when staff is present and when it would be least intrusive for the family. In lieu of the agency representative or designee, the TCM may assist the non-paid monitoring team member during the site visit at the request of the family.

After the Visit

Complete all review forms along with any additional comments, questions or concerns identified during any portion of the QAC review. Return the written review to the agency representative.

Results of the Visit

The agency representative will submit each QAC packet to SCDDO Quality Assurance staff. SCDDO will review all of the documents submitted and conduct additional reviews or use other methods to ensure the following:

- reviews are being completed as necessary
- CSP's are responding to areas of concern
- CSP is taking appropriate action as needed
- policies and procedures are being followed

After SCDDO QA staff have completed the final review, reports are generated and distributed back to the CSPs which had a service review completed during the quarter.

SCDDO QAC Review Checklist (submission of check list is not required)

Name of individual: **Click here to enter name.** Due Date: **Click here to enter a date.**

Submitted to SCDDO **Click here to enter a date.**:

Required Documents (Please submit in the order below.)

- QA Review Cover Sheet
- CDDO Employment Questionnaire
- Day Site Visit Review (if applicable)
- Residential Site Visit Review (if applicable)
- Personal Care Services Review (if applicable)
- Support Plan Review
- Behavior Support Plan / Psychotropic Medication Plan Review (if applicable)
- Support Plan
- Behavior Support Plan (if applicable)
- Psychotropic Medication Plan (if applicable)
- Psychotropic Consents (if applicable)
- Behavior Management Committee Reviews (if applicable)

Actions to be Taken Once Completed

- Submit full packet to SCDDO
- Day Program Review
    - If the program is provided by another agency, send a copy to the assigned QA member at the agency
- Residential Review
    - If the program is provided by another agency, send a copy to the assigned QA member at the agency
- PCS Agency Directed Review
    - If the program is provided by another agency, send a copy to the assigned QA member at the agency

SEDGWICK COUNTY DEVELOPMENTAL DISABILITY ORGANIZATION

Quality Assurance Review Cover Sheet

Name of Individual Reviewed: Click here to enter text.	**Date of Birth:** Click here to enter a date.
Review Team Agency: Click here to enter text.	**Name of Agency Representative/Designee** Click here to enter name. **Name of 2nd team member** Click here to enter name.
Date Support Plan(s) were Review by QAC team: Click here to select date.	
Agency and Address of Day Site: Click here to enter agency name.	**Date and Time of visit:** Click here to enter a date.
Click here to enter address.	Click here to enter Time
Agency and Address of Residential Site: Click here to enter agency name.	**Date and Time of visit:** Click here to enter a date.
Click here to enter address.	Click here to enter Time
Agency and Location of PCS Site: Click here to enter agency name.	**Date and Time of visit:** Click here to enter a date.
Click here to enter address.	Click here to enter Time
Please select: ☐ **Agency Directed** ☐ **Self-Directed**	

Complete on-site reviews ***after*** documentation reviews have been completed.

If completing this review with an individual who does not communicate verbally or has communication difficulties, the reviewer may also ask these questions to a staff person, guardian and/or family member. If completing the review in this manner, please indicate this in the appropriate box, which is located at the top of the review for all forms.

Reviews are to take place at both the residential and day sites, if both types of services are received.

If an adult attends two day programs, only the most attended program needs to be reviewed.

Additional information can be obtained within the QAC Manual. Copies are retained by Agency Representative and SG County CDDO website.

Please complete all tools with as much detail as possible.

SEDGWICK COUNTY DEVELOPMENTAL DISABILITY ORGANIZATION

Employment Questionnaire

To be completed for individuals age 18 through 65.

Name of Individual: **Click here to enter name.**

1. Is the person currently (at this snapshot in time) in competitive employment?

Competitive Employment means work in the competitive labor market that is performed on a full-time or part-time basis in an integrated setting; and for which the person is compensated at or above minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same of similar work performed by persons who are not disabled.

☐ Yes (If Yes, do not complete the remainder of this questionnaire)

☐ No (If No, proceed to question #2)

2. If no to question #1, does the person centered support plan describe barriers and plans to overcome barriers to achieve competitive employment?

☐ Yes (If Yes, proceed to question #3)

☐ No (If No, do not complete the remainder of this questionnaire)

3. If yes to question #2, choose **one** primary barrier from the list below:

☐ Person is currently in school

☐ Person is near retirement age

☐ Loss of government benefits

☐ Lack of support from guardian, family member, or staff

☐ Dislikes work

☐ Enjoys current work/day environment more than competitive employment

☐ Ongoing health concerns, fragile condition

☐ Ongoing behavioral challenges

☐ Transportation is not available

☐ Appropriate jobs are not available

☐ Workplace modifications/supports are not available or cannot be funded

☐ Person chooses work crew type setting that is paid through the DD provider

☐ Other

SEDGWICK COUNTY
DEVELOPMENTAL DISABILITY ORGANIZATION

Support Plan Review

Name of Individual Reviewed: _____ Effective Date of Plan: _____

Areas to Review	***Yes***	***No***	***N/A***	***Comments***
Lead Coordinator of Plan and Lead Medical Coordinator are identified				
What I Have Now: includes current lifestyle- residential setting, individuals they live with, work or valued activity, who they socialize with, and social/leisure/religious activities				
What I Want in the Future: includes dreams for the future, changes in current circumstances, or inclusion in things they do not currently participate in				
Opportunities for Choice and Control: it is clear how the individual indicates their preferences/choices				
Barriers to achieving preferred lifestyle are identified				
Goals are directly related to barriers and/or preferred lifestyle				
***All Support Sections* – Supports should be specific to the needs of the person. These sections should indicate the individual's preferences and explain how they would like to be supported for each need.**				
Support at Home				
Support with Work, School & Daily Activity				
If unemployed, barriers to community employment are identified				
If community employment is not being pursued, informed choice is clearly documented				
Community and Social Support				
Wellness Support				
Medical Support				
Legal and/or Financial Support				

Transition from school to adulthood (age 14-18): guardianship has been established and/or documented				
Communication/Decision Making Support				
Areas to Review	***Yes***	***No***	***N/A***	***Comments***
Plan describes the need for restrictions or limitations of the individual's rights or possessions				
If limitations or restrictions are present, Behavior Management Committee approval has been obtained				
Behavior Support Plan/documentation is in place (complete checklist)				
Psychotropic Medication Plan/documentation is in place (complete checklist)				
Plan signed by individual and guardian (within 365 days)				
Upon review, support plan accurately reflects the individuals' current situation				
If No explain:				

Reviewer Comments:

SEDGWICK COUNTY
DEVELOPMENTAL DISABILITY ORGANIZATION

Support Plan Review

Name of Individual Reviewed: _____ Effective Date of Plan: _____

Areas to Review	***Yes***	***No***	***N/A***	***Comments***
Lead Coordinator of Plan and Lead Medical Coordinator are identified				30-63-21 (b)
What I Have Now: includes current lifestyle- residential setting, individuals they live with, work or valued activity, who they socialize with, and social/leisure/religious activities				30-63-21 (2)(A-E)
What I Want in the Future: includes dreams for the future, changes in current circumstances, or inclusion in things they do not currently participate in				Content should reflect what the individual wants
Opportunities for Choice and Control: it is clear how the individual indicates their preferences/choices				30-63-21 (4) (A-C)
Barriers to achieving preferred lifestyle are identified				30-63-21 (5) (A-D)
Goals are directly related to barriers and/or preferred lifestyle				30-63-21 (a)(7) - evidence that the plan contributes to the continuous movement towards preferred lifestyle
***All Support Sections* – Supports should be specific to the needs of the person. These sections should indicate the individual's preferences and explain how they would like to be supported for each need.**				
Support at Home				
Support with Work, School & Daily Activity				
If unemployed, barriers to community employment are identified				Employment First Initiative; contractual obligation
If community employment is not being pursued, informed choice is clearly documented				Employment First Initiative; contractual obligation
Community and Social Support				
Wellness Support				
Medical Support				30-63-24 (c) training required to be identified, if needed
Legal and/or Financial Support				

Transition from school to adulthood (age 14-18): guardianship has been established and/or documented				
Communication/Decision Making Support				
Areas to Review	***Yes***	***No***	***N/A***	***Comments***
Plan describes the need for restrictions or limitations of the individual's rights or possessions				
If limitations or restrictions are present, Behavior Management Committee approval has been obtained				30-63-23 Needed when there is restrictive intervention used to manage behavior
Behavior Support Plan/documentation is in place (complete checklist)				
Psychotropic Medication Plan/documentation is in place (complete checklist)				
Plan signed by individual and guardian (within 365 days)				30-63-21 (8) - reasonable measures to obtain approval need to be documented
Upon review, support plan accurately reflects the individuals' current situation				
If No explain:				

Reviewer Comments:

SEDGWICK COUNTY
DEVELOPMENTAL DISABILITY ORGANIZATION

Behavior Support Plan/Documentation Review

Name of Individual Reviewed: _____ Date of Plan: _____

Areas to Review	*Yes*	*No*	*Comments*
Purpose for Behavior Support Plan is documented through a description of targeted/maladaptive behaviors			
Safeguards are in place to minimize risk: could include Environmental Modifications and/or evidence of attempts of less restrictive alternatives			
Plan is signed by individual and guardian (within 365 days)			
If restrictive elements are present, evidence of review/approval by a Behavior Management Committee is obtained and current (within 365 days)			

Psychotropic Medication Plan/Documentation Review

Date of Plan: _____

Areas to Review	*Yes*	*No*	*Comments*
Purpose of Psychotropic Medication Plan is documented through a description of diagnosis			
Description of behavior related to diagnosis is listed			
Safeguards are in place to minimize risk: could include Positive Behavior Programming and/or Environmental Modifications			
Plan describes possible side effects of medication (signs/symptoms)			
Plan describes how staff will respond to side effects (signs/symptoms)			
Reviewed by Behavior Management Committee annually			
Informed consent signed by individual and guardian (within 365 days)			

Regulation (Article 63) does not require a "plan"; rather the expectation is that there is documentation of the above mentioned items with approval from BMC/HRC if there are psychotropic medications or restrictive interventions being utilized.

Reviewer Comments:

SEDGWICK COUNTY
DEVELOPMENTAL DISABILITY ORGANIZATION

Behavior Support Plan/Documentation Review

Name of Individual Reviewed: _____ Date of Plan: _____

Areas to Review	*Yes*	*No*	*Comments*
Purpose for Behavior Support Plan is documented through a description of targeted/maladaptive behaviors			30-63-23 (2)(A)(i)
Safeguards are in place to minimize risk: could include Environmental Modifications and/or evidence of attempts of less restrictive alternatives			30-63-23 (1) (A-D) - initial and ongoing assessment and responsive modifications that may be needed; evidence of least restrictive
Plan is signed by individual and guardian (within 365 days)			30-63-23 (3)(c) - reasonable efforts to obtain signature must be documented
If restrictive elements are present, evidence of review/approval by a Behavior Management Committee is obtained and current (within 365 days)			30-63-23 (3)(B)

Psychotropic Medication Plan/Documentation Review

Date of Plan: _____

Areas to Review	*Yes*	*No*	*Comments*
Purpose of Psychotropic Medication Plan is documented through a description of diagnosis			30-63-23 Required for individuals on medication to manage behaviors or to treat diagnosed mental illnesses
Description of behavior related to diagnosis is listed			30-63-23 (2)(A)(i)
Safeguards are in place to minimize risk: could include Positive Behavior Programming and/or Environmental Modifications			30-63-23 (1) (A-D) - initial and ongoing assessment and responsive modifications that may be needed; evidence of least restrictive
Plan describes possible side effects of medication (signs/symptoms)			30-63-23 (1, C)
Plan describes how staff will respond to side effects (signs/symptoms)			30-63-24
Reviewed by Behavior Management Committee annually			30-63-23 (3)
Informed consent signed by individual and guardian (within 365 days)			30-63-23 (3)(c) - reasonable efforts to obtain signature must be documented

Regulation (Article 63) does not require a "plan"; rather the expectation is that there is documentation of the above mentioned items with approval from BMC/HRC if there are psychotropic medications or restrictive interventions being utilized.

June 2019

SEDGWICK COUNTY DEVELOPMENTAL DISABILITY ORGANIZATION

Name of Individual:_____

Life Enrichment

If the individual uses a communication method other than verbalization, please indicate how these questions were answered (i.e. family/staff answered questions, individual indicated with non-verbal cues, etc.)

_____

Questions to ask the individual receiving services:

1. I understand that you like to _____
   List preferred activities from support plan
   Do you get to do these as often as you like? YES NO
2. Do you get to help choose the activities that you do? YES NO
3. Do you get to do something different if you don't like what the others are doing? YES NO
4. What do you like about this program? _____
5. What do you not like about this program? _____
6. What do you do:
   a. In case of a tornado?_____
   b. In case of a fire?_____
   c. In case the electricity goes out?_____
   d. If someone hurts/mistreats/is mean to you?_____
7. Is your staff nice to you? YES NO
   If no, explain:_____
8. Does anyone ever take or keep things from you? YES NO
   If yes, what/who?_____
9. Do you feel safe coming here? YES NO
   If no, explain:_____
10. Tell me what goals you are working on. _____
    How does staff help you with that? _____
11. Do you have any questions or is there anything else that you would like to tell me?
    _____
    _____

SEDGWICK COUNTY DEVELOPMENTAL DISABILITY ORGANIZATION

Questions to ask staff

Staff Name: _____
How long has staff been working with this individual? _____
How long has staff been working for this agency? _____

1. How did you learn how to support this individual? _____

2. Does this individual have special diet needs? (calories, food allergies, low sodium, etc.) YES NO
   If yes, what? _____
   Require special food preparation/eating supports? (pureed, food cutting, etc.) YES NO
   If Yes, what? _____
   Is he or she OK with this diet? YES NO
   What do you do if the individual refuses to follow the diet? _____

3. The plan describes that the individual uses (list the assistive equipment/ technology_____
   _____).
   What support do they need for these items? _____
   _____
   _____

4. What are the individuals' medical needs? _____
   How do you support these needs? _____
   If health services are needed, whom do you contact? _____
   Do you receive follow up as to the outcome? YES NO

5. Does this individual have any rights or restrictive procedures? YES NO
   If yes, what? _____
   Is this addressed in the individuals plan? YES NO

6. What behavior does this individual display? _____
   How do you support this need? _____

7. Does this individual take psychotropic medications? YES NO
   If so, what are the potential side effects or where do you go to find them? _____
   _____

8. Where do you keep the support plan? _____

9. According to the plan, what are the individual's Day Services goals? _____
   _____

10. What do you do:
    a. In case of a tornado?_____
    b. In case of a fire?_____
    c. In case of a power outage?_____

11. What are this agency's reporting procedures if you suspect abuse, neglect, or exploitation? _____
    _____

12. Do you know how to make an ANE report directly to APS? (skip if mentioned above) YES NO

13. Do you have any questions or is there anything else that you would like to tell me? _____
    _____

Questions the reviewer answers based on their observation/ interviews:

Interactions were positive between the individual and others in services.	YES	NO	N/A
Interactions were positive between staff and the individual.	YES	NO	N/A
The individual expressed their own opinions.	YES	NO	
The services are consistent with the support plan.	YES	NO	

If no, please explain: _____
_____

The individual was free of rights restrictions or restrictive interventions.	YES	NO

If no, please explain: _____
_____

The property:		
• Reasonably clean and well maintained.	YES	NO
• Safe and secure.	YES	NO
• Has adequate lighting inside and out.	YES	NO
• Has adequate space.	YES	NO
• Accessible to meet the individuals needs.	YES	NO

Kudos (positive observations that the reviewer has noted about the staff, the individual receiving services, the site, etc.): _____
_____
_____

Comments/Concerns:_____
_____
_____
_____

SEDGWICK COUNTY DEVELOPMENTAL DISABILITY ORGANIZATION

Name of Individual:_____

Work Services & Supported Employment

If the individual uses a communication method other than verbalization, please indicate how these questions were answered (i.e. family/staff answered questions, individual indicated with non-verbal cues, etc.)

_____

Questions to ask the individual receiving services:

1. I understand that you like to work at _____
   Name of agency / program
   Do you get to work on things you enjoy doing here? YES NO

2. How do you change it if you want to work on something else? _____
   _____

3. Do you have enough work? YES NO
   If no, explain: _____
   If you do not have work, what do you do during this time? _____
   _____
   Do you like doing that? YES NO
   If no, what would you rather be doing? _____

4. Does your staff help you learn your job if you need help? YES NO
   If no, explain: _____

5. What do you do:
   a. In case of a tornado?_____
   b. In case of a fire?_____
   c. In case the electricity goes out?_____
   d. If someone hurts/mistreats/is mean to you?_____

6. Is your staff nice to you? YES NO
   If no, explain:_____

7. Does anyone ever take or keep things from you? YES NO
   If yes, what/who?_____

8. Do you feel safe working here? YES NO
   If no, explain:_____

9. Tell me what goals you are working on. _____
   How does staff help you with that? _____

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10. Do you have any questions or is there anything else that you would like to tell me?

_____

_____

Questions to ask staff

Staff Name: _____

How long has staff been working with this individual? _____

How long has staff been working for this agency? _____

1. How did you learn how to support this individual? _____

2. Does this individual have special diet needs? (calories, food allergies, low sodium, etc.) YES NO
   If yes, what? _____
   Require special food preparation/eating supports? (pureed, food cutting, etc.) YES NO
   If Yes, what? _____
   Is he or she OK with this diet? YES NO
   What do you do if the individual refuses to follow the diet? _____

3. The plan describes that the individual uses (list the assistive equipment/ technology_____
   _____).
   What support do they need for these items? _____
   _____
   _____

4. What are the individuals' medical needs? _____
   How do you support these needs? _____
   If health services are needed, whom do you contact? _____
   Do you receive follow up as to the outcome? YES NO

5. Does this individual have any rights or restrictive procedures? YES NO
   If yes, what? _____
   Is this addressed in the individuals plan? YES NO

6. What behavior does this individual display? _____
   How do you support this need? _____

7. Does this individual take psychotropic medications? YES NO
   If so, what are the potential side effects or where do you go to find them? _____
   _____

8. Where do you keep the support plan? _____

9. According to the plan, what are the individual's Work/ Supported Employment Services goals? _____
   _____

10. What do you do:
    a. In case of a tornado?_____
    b. In case of a fire?_____
    c. In case of a power outage?_____

11. What are this agency's reporting procedures if you suspect abuse, neglect, or exploitation? _____
    _____

12. Do you know how to make an ANE report directly to APS? (skip if mentioned above) YES NO

13. Do you have any questions or is there anything else that you would like to tell me? _____
    _____

Questions the reviewer answers based on their observation/ interviews:

Interactions were positive between the individual and others in services.	YES	NO	N/A
Interactions were positive between staff and the individual.	YES	NO	N/A
The individual expressed their own opinions	YES	NO	
The services are consistent with the support plan.	YES	NO	

If no, please explain: _____
_____

The individual was free of rights restrictions or restrictive interventions.	YES	NO

If no, please explain: _____
_____

The property:

• Reasonably clean and well maintained.	YES	NO
• Safe and secure.	YES	NO
• Has adequate lighting inside and out.	YES	NO
• Has adequate space.	YES	NO
• Accessible to meet the individuals needs.	YES	NO

Kudos (positive observations that the reviewer has noted about the staff, the individual receiving services, the site, etc.): _____
_____
_____

Comments/Concerns:_____
_____
_____
_____

SEDGWICK COUNTY DEVELOPMENTAL DISABILITY ORGANIZATION

Name of Individual:_____

Residential Services

If the individual uses a communication method other than verbalization, please indicate how these questions were answered (i.e. family/staff answered questions, individual indicated with non-verbal cues, etc.)

_____

Questions to ask the individual receiving services:

1. I understand that you like to _____
   List community and other preferred activities from support plan
   Do you get to do these as often as you like? YES NO

2. Do you do shopping for groceries and other things that you need? YES NO
   If no, who does? _____ Are you OK with that? YES NO

3. Do you choose what you eat (i.e. for breakfast, lunch, dinner, snacks)? YES NO
   If no, who does? _____ Are you OK with that? YES NO
   If you do not like what you have for a meal, do you get other choices? YES NO

4. In your home, what do you do:
   a. In case of a tornado?_____
   b. In case of a fire?_____
   c. In case the electricity goes out?_____
   d. If someone hurts/mistreats/is mean to you?_____
   e. If your staff does not show up for work? _____

5. Is your staff nice to you? YES NO
   If no, explain:_____

6. Does your staff answer your questions? YES NO
   If no, explain:_____

7. Does anyone ever take or keep things from you? YES NO
   If yes, what/who?_____

8. Do you feel safe living here? YES NO
   If no, explain:_____

9. Tell me what goals you are working on. _____
   How does staff help you with that? _____

10. Do you have any questions or is there anything else that you would like to tell me?
    _____

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SEDGWICK COUNTY DEVELOPMENTAL DISABILITY ORGANIZATION

Questions to ask staff

Staff Name: _____
How long has staff been working with this individual? _____
How long has staff been working for this agency? _____

1. How did you learn how to support this individual? _____

2. Does this individual have special diet needs? (calories, food allergies, low sodium, etc.) YES NO
   If yes, what? _____
   Require special food preparation/eating supports? (pureed, food cutting, etc.) YES NO
   If Yes, what? _____
   Is he or she OK with this diet? YES NO
   What do you do if the individual refuses to follow the diet? _____

3. The plan describes that the individual uses (list the assistive equipment/ technology_____
   _____).
   What support do they need for these items? _____
   _____
   _____

4. What are the individuals' medical needs? _____
   How do you support these needs? _____
   If health services are needed, whom do you contact? _____
   Do you receive follow up as to the outcome? YES NO

5. Does this individual have any rights or restrictive procedures? YES NO
   If yes, what? _____
   Is this addressed in the individuals plan? YES NO

6. What behavior does this individual display? _____
   How do you support this need? _____

7. Does this individual take psychotropic medications? YES NO
   If so, what are the potential side effects or where do you go to find them? _____
   _____

8. Where do you keep the support plan?_____

9. According to the plan, what are the individual's Residential Services goals? _____
   _____

10. What do you do:
    a. In case of a tornado?_____
    b. In case of a fire?_____

c. In case of a power outage? _____
d. If the next shift does not show up? _____

11. What are this agency's reporting procedures if you suspect abuse, neglect, or exploitation? _____

12. Do you know how to make an ANE report directly to APS? (skip if mentioned above) YES NO

13. Do you have any questions or is there anything else that you would like to tell me? _____

Questions the reviewer answers based on their observation/ interviews:

Interactions were positive between the individual and others in services.	YES	NO	N/A
Interactions were positive between staff and the individual.	YES	NO	N/A
The individual expressed their own opinions.	YES	NO	
The services are consistent with the support plan.	YES	NO	

If no, please explain: _____

The individual was free of rights restrictions or restrictive interventions (i.e. alarms on doors, locked refrigerator or cabinets, etc). YES NO

If no, please explain: _____

The property:

- Reasonably clean and well maintained. YES NO
- Safe and secure. YES NO
- Has adequate lighting inside and out. YES NO
- Has adequate space. YES NO
- Accessible to meet the individuals needs. YES NO

Kudos (positive observations that the reviewer has noted about the staff, the individual receiving services, the site, etc.): _____

Comments/Concerns: _____

SEDGWICK COUNTY DEVELOPMENTAL DISABILITY ORGANIZATION

Name of Individual:_____

Personal Care Services for Adults

If the individual uses a communication method other than verbalization, please indicate how these questions were answered (i.e. family/staff answered questions, individual indicated with non-verbal cues, etc.)

_____

Questions to ask the individual receiving services:

1. I understand that you like to _____
   List preferred activities from support plan
   Do you get to do these as often as you like? YES NO

2. I understand that you like to spend time with _____
   List from support plan
   Do you get to spend as much time with them as you like? YES NO
   If no, why? _____

3. Do you go shopping for the things that you need? YES NO
   If no, who does? _____ Are you OK with that? YES NO

4. If you do not like what you have for a meal, do you get other choices? YES NO
   If no, explain: _____

5. Is there anything you would change about where or with whom you are living? YES NO
   If yes, what? _____

6. Is there anything you would change about what you do during the day? YES NO
   If yes, what? _____

7. What do you do:
   a. In case of a tornado?_____
   b. In case of a fire?_____
   c. In case the electricity goes out?_____
   d. If someone hurts/mistreats/is mean to you?_____
   e. If you are hurt/ sick? _____
   f. If your staff does not show up for work? _____

8. Tell me what goals you are working on. _____
   How does staff help you with that? _____

9. Do you have any questions or is there anything else that you would like to tell me?
   _____
   _____

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SEDGWICK COUNTY DEVELOPMENTAL DISABILITY ORGANIZATION

Questions to ask staff

Staff Name: _____
How long has staff been working with this individual? _____
How long has staff been working for this agency? _____

1. How did you learn how to support this individual? _____

2. Does this individual have special diet needs? (calories, food allergies, low sodium, etc.) YES NO
   If yes, what? _____
   Require special food preparation/eating supports? (pureed, food cutting, etc.) YES NO
   If Yes, what? _____
   Is he or she OK with this diet? YES NO
   What do you do if the individual refuses to follow the diet? _____

3. The plan describes that the individual uses (list the assistive equipment/ technology_____
   _____).
   What support do they need for these items? _____
   _____
   _____

4. What are the individuals' medical needs? _____
   How do you support these needs? _____
   If health services are needed, whom do you contact? _____
   Do you receive follow up as to the outcome? YES NO

5. Does this individual have any rights or restrictive procedures? YES NO
   If yes, what? _____
   Is this addressed in the individuals plan? YES NO

6. What behavior does this individual display? _____
   How do you support this need? _____

7. Does this individual take psychotropic medications? YES NO
   If so, what are the potential side effects or where do you go to find them? _____
   _____

8. Where do you keep the support plan? _____

9. According to the plan, what are the individual's Personal Care Services goals?_____
   _____

10. What do you do:
    a. In case of a tornado? _____
    b. In case of a fire? _____
    c. In case of a power outage? _____
    d. If the next shift does not show up? _____
    e. If you suspect abuse, neglect or exploitation? _____

11. Do you know how to make an ANE report directly to APS? (skip if mentioned above) YES NO

12. Do you have any questions or is there anything else that you would like to tell me? _____

_____

Questions the reviewer answers based on their observation/ interviews:

Interactions were positive between the individual and parent/ family.	YES	NO	N/A
Interactions were positive between staff and the individual.	YES	NO	N/A
The individual expressed their own opinions.	YES	NO	
The services are consistent with the support plan.	YES	NO	

If no, please explain: _____

_____

The individual was free of rights restrictions or restrictive interventions (i.e. alarms on doors, locked refrigerator or cabinets, etc). YES NO

If no, please explain: _____

_____

The property:

- Reasonably clean and well maintained. YES NO
- Safe and secure. YES NO
- Has adequate lighting inside and out. YES NO
- Has adequate space. YES NO
- Accessible to meet the individuals needs. YES NO

Kudos (positive observations that the reviewer has noted about the staff, the individual receiving services, the site, etc.): _____

_____

_____

Comments/Concerns: _____

_____

_____

_____

SEDGWICK COUNTY DEVELOPMENTAL DISABILITY ORGANIZATION

Name of Individual: _____

Personal Care Services for Children (under the age of 18)

The review is to be completed in the child's home with the child present.

Name of family member who participated in review: _____

Questions to ask the family:

1. Does the service meet your family's needs? YES NO
   Comments: _____
   _____

2. Do you feel comfortable with the person(s) who cares for your child? YES NO
   Comments: _____
   _____

3. What other services or support items will your child need this year? _____
   _____

4. Does your child have any unmet medical needs? YES NO
   Comments: _____

5. Does your child have any unmet mental health needs? YES NO
   Comments: _____

6. Have you been given information on what to do if you believe your child have been abused, neglected or exploited? YES NO

7. Is there anything you would like your case manager to follow up with? YES NO
   Comments: _____
   _____

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SEDGWICK COUNTY DEVELOPMENTAL DISABILITY ORGANIZATION

Questions to ask staff

Staff Name: _____
How long has staff been working with this individual? _____
How long has staff been working for this agency? _____

1. How did you learn how to support this individual? _____

2. Does this individual have special diet needs? (calories, food allergies, low sodium, etc.) YES NO
   If yes, what? _____
   Require special food preparation/eating supports? (pureed, food cutting, etc.) YES NO
   If Yes, what? _____
   Is he or she OK with this diet? YES NO
   What do you do if the individual refuses to follow the diet? _____

3. The plan describes that the individual uses (list the assistive equipment/ technology_____
   _____).
   What support do they need for these items? _____
   _____
   _____

4. What are the individuals' medical needs? _____
   How do you support these needs? _____
   If health services are needed, whom do you contact? _____
   Do you receive follow up as to the outcome? YES NO

5. What behavior does this individual display? _____
   How do you support this need? _____

6. Does this individual take medications? YES NO
   If so, what are the potential side effects or where do you go to find them? _____
   _____

7. Where do you keep the support plan?_____

8. According to the plan, what are the individual's Personal Care Services goals?_____
   _____

9. What do you do:
   a. In case of a tornado?_____
   b. In case of a fire?_____
   c. In case of a power outage?_____
   d. If the next shift does not show up? _____
   e. If you suspect abuse, neglect or exploitation? _____

10. Do you know how to make an ANE report directly to APS? (skip if mentioned above) YES NO

11. Do you have any questions or is there anything else that you would like to tell me? _____

_____

Questions the reviewer answers based on their observation/ interviews:

Interactions were positive between the individual and parent/ family. YES NO N/A
Interactions were positive between staff and the individual. YES NO N/A
The services are consistent with the support plan. YES NO
If no, please explain: _____

_____

The individual was free of rights restrictions or restrictive interventions (i.e. alarms on doors, locked refrigerator or cabinets, etc). YES NO
If no, please explain: _____

_____

The property:

- Reasonably clean and well maintained. YES NO
- Safe and secure. YES NO
- Have adequate lighting inside and out. YES NO
- Have adequate space. YES NO
- Accessible to meet the individuals needs. YES NO

Kudos (positive observations that the reviewer has noted about the staff, the individual receiving services, the site, etc.): _____

_____

_____

Comments/Concerns: _____

_____

_____

_____

Child Protective Services (CPS) Fact Sheet

If you suspect a child is being abused, neglected or exploited please telephone Kansas Protection Report Center (PRC) at **1-800-922-5330**. Every call is taken seriously and every effort will be made to protect your identity. Telephone lines at the Protection Report Center are staffed 24 hours a day**.** In the event of an emergency contact your local law enforcement or call 911. When a report of abuse or neglect is made to CPS, it is first screened to determine if CPS should become involved. If the report meets the criteria for CPS involvement, a social worker or special investigator investigates it. Law enforcement may also investigate concerns if a social worker is not available or a joint investigation is warranted. If it is determined that the child's safety is at risk, then a recommendation is made to the court regarding the necessary action that should be taken.

The court is ultimately responsible for the decision to remove a child from the home. This may require placing the child in foster care or with a relative. When making a recommendation to remove a child, CPS has to weigh the emotional harm of being removed from the home, with the likelihood of harm if the child stays.

Child Protective Services (CPS) may also be provided in non-abuse or neglect situations, such as an out-of-control child, truancy, overwhelmed parents, and runaways. Investigations often result in families receiving an array of services such as family preservation, foster care, or other services available in the community.

Adult Protective Services Fact Sheet

Program Description

Adult Protective Services (APS) are intervention activities directed towards safeguarding the well-being and general welfare of adults in need of protection. Intervention is available to adults age 18 and above who are unable to protect themselves and who need assistance in dealing with abusive, neglectful or exploitative situations.

Adult Protective Services Social Workers investigate reports and provide protective services to adults, **with their consent**, who reside in the community, adults residing in facilities licensed/certified by Kansas Department for Aging and Disability Services (KDADS), and to adults residing in adult care homes and other facilities licensed by the Kansas Department of Health and Environment. Emergency Support Services and Guardianship and Conservatorship services are also available. The intent of Adult Protective Services is to protect the most vulnerable adults from harm while safeguarding their civil liberties.

Definitions

Adult: individuals age 18 or older who are alleged to be unable to protect their own interests and who are harmed or threatened with harm through action or inaction by either another individual or themselves.
Abuse: any act or failure to act performed intentionally or recklessly that causes or is likely to cause harm, including: infliction of physical or mental injury; sexual abuse; unreasonable use of physical or chemical restraints, isolation, medications; threats or menacing conduct; fiduciary abuse or omission or deprivation by a caretaker or another person of goods or services which are necessary to avoid physical or mental harm or illness.
Neglect: failure or omission by one's self, caretaker or another person to provide goods or services which are reasonably necessary to ensure safety and well-being and to avoid physical or mental harm or illness.
Exploitation: misappropriation of an adult's property or intentionally taking unfair advantage of an adult's physical or financial resources**.**
Fiduciary Abuse: occurs when any person who is the caretaker of, or who stands in a position of trust to an adult takes, secretes or appropriates their money or property to any use or purpose not in the due and lawful execution of the adult's trust.

Who Should Report?:

The Kansas statute (K.S.A. 39-1431) requires the following persons to report suspected abuse, neglect, exploitation or fiduciary abuse immediately:

- any person licensed to practice any branch of the healing arts
- a licensed psychologist
- a licensed master level psychologist
- the chief administrative officer of a medical care facility
- a licensed social worker
- a licensed professional nurse
- a licensed dentist
- a licensed practical nurse
- a licensed clinical psychotherapist

- a licensed marriage and family therapist
- a licensed clinical marriage and family therapist
- a licensed professional counselor
- a licensed clinical professional counselor
- a registered alcohol and drug abuse counselor
- a law enforcement officer
- a teacher
- a case manager
- guardian or conservator
- bank trust officer
- rehabilitation counselor
- holder of power of attorney
- an owner or operator of a residential care facility
- an independent living counselor
- a chief administrative officer of a licensed home health agency
- a chief administrative officer of an adult family home
- a chief administrative officer of a provider of community services and affiliates thereof operated or funded by the KDADS or licensed under K.S.A. 7503307b.

It is a class B misdemeanor for a mandatory reporter to knowingly fail to report if they suspect a vulnerable adult is being neglected, abused, or exploited.
Any other person who suspects or believes abuse, neglect or exploitation may also report.

Immunity of Reporter

Persons who report, participate in any follow-up activity or who testify in any administrative or judicial proceeding as a result of the report are immune to any civil or criminal liability unless the reporter made a malicious report. The statute prohibits an employer from imposing sanctions on an employee for making a report or cooperating with an investigation.

Confidentiality of Reporter

The name of the reporter or any person mentioned in the report will not be disclosed without the reporter's permission in writing, or through court order.

How To Report

Telephone the local APS toll-free hotline at **1-800-922-5330**. The hotline is staffed twenty-four hours a day, seven days a week. The statute also makes provision for reports to be made to law enforcement when DCF offices are closed. Law enforcement should submit the report and appropriate information to DCF on the first working day that DCF is open.

What to Report

Name and address of the person who is reported to be abused, neglected or exploited; name of the reporter and how to contact him/her; any information which the reporter believes might be helpful in the investigation and protection of the alleged victim. This includes specific addresses, telephone numbers and directions to the home(s) of relatives, caretakers, the alleged perpetrators, other collaterals. Risk factors to the alleged victim or social worker.

Information regarding the nature and extent of the abuse, neglect, exploitation, such as what the reporter saw, why the reporter considers it to be abuse, neglect or exploitation, and does the reporter believe the alleged victim is in immediate danger.

Report Suspected Abuse, Neglect, Exploitation or Fiduciary Abuse When:

- the adult is in a harmful situation or is in danger of being harmed.
- the adult is unable to protect him/herself.
- a specific incident or pattern of incidents suggests abuse, neglect or exploitation.
- the adult us unable to provide for or obtain the services necessary to ensure safety and well- being and to avoid physical or mental harm or illness.

What APS Will Do When a Report Is Received

- Initiate a personal visit with the adult within 24 hours to five working days depending on the risk of imminent danger to the individual.
- With the consent of the adult, interview the alleged perpetrator if one has been named.
- Interview collaterals when appropriate (service providers, relatives, neighbors, etc.).
- Discuss with the adult, guardian, conservator, and/or caretaker what actions are needed and, **with the adult's consent,** develop service plans or corrective action plans with recommendations to prevent further harm.
- With the adult's consent, assist in locating services which are necessary to maintain physical or mental health: i.e., legal services, medical care, appropriate living arrangements, assistance in personal hygiene, food, clothing, adequately heated and ventilated shelter, protection from maltreatment, and transportation.
- Provide advocacy to assure protection of personal rights.

Article 64 – Developmental Disabilities
Community Developmental Disability Organizations

Excerpt
30-64-27. Quality assurance.

(a) Each contracting CDDO shall ensure the quality of the services being provided to persons being served by the CDDO or by an affiliate. Ensuring quality shall include providing for on-site monitoring by a local committee made up of persons served, their families, guardians, interested citizens, and providers. The type and intensity of on-site review shall be determined by the local committee and shall include at least a determination of all of the following:

(1) Services that are paid for are delivered.

(2) Services that are delivered are paid for in accordance with the terms of any agreement or contract in force, including any payment requirement that the person being served or a third party acting on behalf of the person being served has the responsibility to meet.

(3) Services are being provided in a manner meeting applicable requirements provided for in article 63.

(4) The CDDO or affiliate is affording the person being served all of the person's legally protected rights.

(5) The CDDO or affiliate meets both of these requirements:

(A) Is reporting any suspicions of abuse, neglect, or exploitation to the appropriate state agency; and

(B) has corrected or is actively in the process of correcting the cause of any confirmed violation.

(b) This regulation shall take effect on and after October 1, 1998. (Authorized by and implementing K.S.A. 1997 Supp. 39-1801, et seq.)

Sedgwick County
Developmental Disability Organization

Policy Section	**Quality Assurance**	Policy Number	**G-01**
Policy Name	**Quality Assurance Committee**	Revision Date	**09/2017**
Former Number	**H-08-01**	SRS Approval Date	**7/2011**
		KDADS Approval Date	**01/24/2018**

PURPOSE:

This policy outlines the membership and procedures for the Sedgwick County Developmental Disability Organization (SCDDO) Quality Assurance Committee (QAC) consistent with K.A.R. 30-64-27.

POLICY:

Community service providers (CSP) delivering targeted case management (TCM) services shall develop an on-site monitoring team to work in collaboration with members of the QAC. The members will ensure that quality services are being provided to individuals served by any CSP as required by the provisions of K.A.R 30-64-27.

PROCEDURES:

1. The QAC members will be comprised of the SCDDO QA Coordinator, TCM representatives, on-site monitoring teams, and Community Council members representing the following categories: individuals receiving services, their family members and/or guardians, and interested citizens.

2. Each CSP delivering TCM services will designate a representative from their organization to participate in the local quality review process. This individual shall be the individual who maintains oversight of the agency's quality assurance and/or TCM department.

3. The representative is responsible for the following:

a. Establish and maintain an on-site monitoring team to complete on-site reviews. The team may include individuals receiving services, their family members and/or guardians, and interested citizens.

b. Provide training to the on-site review committee on the SCDDO QAC manual and review tools.

c. Collect, assess, and submit review packets to SCDDO designated QA staff by the due date assigned.

d. Provide copies of completed review tools to the reviewed CSPs.

4. SCDDO will assign a sample, quarterly, of individuals randomly selected for QAC review as defined in the QAC manual, available upon request.

5. The on-site review will consist of the following activities:

    a. Review of the Person Centered Support Plan (PCSP), Behavior Support Plan (BSP), and Psychotropic Medication Plan (PMP) for quality.

    b. Evaluate the delivery of each service as defined in the above mentioned documents.

    c. Complete site visit with the individual and their paid staff which may include family at the location of service.

    d. Complete the review tools specified in the QAC manual and include additional documentation of comments, questions, or concerns identified by the review team.

6. The representative or their designee and at least one other member, not paid by the agency, will be involved throughout the entire review process for the individual assigned to that team. In lieu of the representative or designee, the TCM may assist the non-paid team member during the site visit at the request of the family.

7. The representative will submit all QAC review tools and corresponding documentation to SCDDO designated QA staff by the due date assigned. Submitting late QAC reviews may result in a request for an agency continuous quality improvement plan.

8. SCDDO will evaluate each QAC review using a standardized tool and provide feedback to the CSP whose performance was reviewed during the quarter.

a. If concerns are identified regarding an individual's services, the CSP will receive notification requesting improvement. The CSP is responsible for assuring improvements are made to address the deficiencies through the agency's internal quality assurance policy and procedures. The CSP is responsible for submitting within 30 days documentation of service modifications based on the review.

b. If systemic quality concerns are identified, the CSP will receive written notification identifying the deficient area. The CSP is responsible for submitting a continuous quality improvement plan. The written plan shall be submitted within 30 days for review and agreement by SCDDO.

9. Upon review, SCDDO may request additional information which will be due no later than 15 days or as specified by SCDDO staff.

10. SCDDO will meet quarterly with all designated representatives to review local trend data including, but not limited to the following:

    a. Services that are paid for are delivered;

    b. Services that are delivered are paid for in accordance with the terms of any agreement or contract in force;

    c. Services are provided consistent with Article 63;

    d. The CSP is affording the individual being served all of the individual's legally protected rights;

    e. The CSP is reporting any suspicions of abuse, neglect or exploitation and taking corrective action when needed;

    f. Services are provided consistent with the PCSP;

    g. Services are provided in a manner that offers opportunities of choice to the individual being served.

11. The Community Council will review quarterly trend data, consider CSP recommendations and provide additional observations to ensure that any identified concerns are addressed through follow up by SCDDO QA staff.

SEDGWICK COUNTY
DEVELOPMENTAL DISABILITY ORGANIZATION
Quality Assurance Committee

Scoring the Reviews

To score the reviews, the SCDDO QA Department reviews each individual packet to determine that the requirements from SCDDO Affiliate Service Agreement, SCDDO policy and Article 63 are being followed. Such as:

K.A.R. 30-63-21

- Has the support plan been reviewed in the last 365 days? Was there team involvement along with signatures to show team and guardian's approval? Are there any contradictions in the plan? Is competitive community employment and barriers easily found in the plan? Is there a description of the individual living their preferred lifestyle?

K.A.R. 30-63-21,22

- Does the support plan state any violations in rights as being okay to follow without review and approval by a behavior management committee (BMC) or other explanation? During the interviews with direct care staff, is it reported things are taken away from the individual as a punishment without approval? When the individual is being interviewed do they state they don't feel respected or safe in the environment in question?

K.A.R. 30-63-21, 23

- Are all the restrictions and psychotropic medications approved by the BMC and individual/guardian? Are signature pages included to show approval? Do the medications prescribed match between the support plan and consents? Is the direct care staff aware of all the psychotropic medications, side effects, and other approved restrictions?

K.A.R. 30-63-25

- If there is a diet in place, how is it managed? Is it approved by the doctor? Is the direct care staff aware of the diet specifics? If staff report specific diets, are they found in the support plan? Does the direct care staff relay all nutritional modifications/ supports? Are calorie restrictions accurate?

K.A.R. 30-63-27

- Are the emergency procedures known?

K.A.R. 30-63-28

- Does the support plan state that the individual and/or guardian understand how to report abuse, neglect or exploitation? Does direct care staff understand the agency's reporting process?

K.A.R. 30-63-21/ K.A.R. 30-64-26

- Are there clear instructions in the support plan to help staff provide all the needed supports? Are the needed medical devices mentioned? During the review does it appear that staff know and understand the support and the medical needs? Does the staff know the goals which the individual is working towards?

K.A.R. 30-63-21

- Does the support plan describe the choices the person can and likes to make? Are choices regularly offered? Does the individual feel like they have the opportunity to choose different appropriate activities? Can the individual choose to go shopping or what they want to have for dinner?

File Review Form

Yes	No	N/A	Item	Comments	
			Records required (Article 30-63-29)		**Regulations under review**
			Incident/Accident Reports, if applicable	applicable if in the file, needed if other information in the file reflects the need for a report	30-63-29 (a) (3)
			Health Profile/Physical (q 2yrs)	health profile reviewed every 2 years and includes health status, medication list, and any other medical/health considerations	30-63-29 (a) (4) (A-C)
			Current BASIS - Functional Assessment	BASIS documents and other evaluation materials	30-63-29 (a) (5)
			Financial / Services Agreement	any financial agreement between person and provider	30-63-29 (a) (2)
			Current Releases of Information	releases of information, authorizations for publication, and consents for emergency and other medical treatment as applicable	30-63-29 (a) (8)
			ISP)	the plan of care for recipients of HCBS	30-63-29 (a) (7)
			Guardianship documentation is in place, when applicable	looking for court documentation if guardian is noted within file	
			General Information		
			Identification; Social Security Card, Birth Certificate	best practice; will not be scored in totals	
			Proof of Insurance	best practice; will not be scored in totals	
			Comments		
			Support Plan	**Date:**	
			Evidence of regular review/revisions	Records regulation requires plan to be in the file; evaluating if the plan is current, within 365 days, reflects current supports provided	30-63-29 (a) (6) and 30-63-21 (c)
			Lead coordinator of plan / health care identified	Are they designated in the plan?	30-63-21 (b) - designation of the lead coordination role shall be noted in the plan
			Evidence of support team consultation / participation	information about support team participation - to include PCS worker	30-63-21 (a)(1)(A-C) - plan shall be developed only after consultation with designated individuals
			Current lifestyle (What I have Now); setting person wants to live, who person wants to live with, work or other activity, who person wants to socialize with, activities to participate in	is the information provided consistent with the descriptions needed based on the crosswalk	description of current lifestyle provided
			Preferred lifestyle (What I Want in the Future)	is preferred lifestyle present; needs to reflect what the individual wants	30-63-21 (2)(A-E) - plan shall contain a description of the person's preferred lifstyle, including specific information
			Barriers to achieving preferred lifestyle identified	are barriers identified	
			Support needs identified to overcome barriers	what support is needed to assist individual in moving towards preferred lifestyle	
			Describe how opportunities of choice will be provided	Is the information provided consistent with regulations?	30-63-21 (4) (A-C)
			GOALS		
			Are the goals specific and directly related to preferred lifestyle and / or barriers?	evidence that the goal is directly related	evidence that the plan meets 30-63-21 (a)(7) - contribute to the continous movement towards preferred lifestyle; providers will do this by using goals with measurable outcomes
			Training / support needs identified	How is the person going to achieve the outcome?	
			Are there measurable outcomes included in all goals?	steps identified to reach the goal	

			Monitoring of goals includes reasonable time frames (evaluation at 2-4 months)	monitoring of goal is documented - yearly is not appropriate	
			SUPPORTS		30-63-21 (a)(3) - Lists/describes necessary activities, training, materials, equipment, assistive technology, and services needed to achieve preferred lifestyle. 30-63-21 (a)(5) (A-D) describe when it is necessary to do so, to the person and person's support network how the preferred lifestyle might be limited because of imminent significant danger to the person's health, safety, or welfare
			Support at home is addressed	Supports are to be specific to the individual. These are descriptions of the specifics regarding how the support is to be provided, what should should do or not do, and include participation level of the individual. Any behaviors that do not require restrictive interventions should be included within support sections of the plan.	
			Support with work, school, and daily activity		
			Community / Social Support		
			Wellness support		
			Medical support		
			Legal / Financial Support		
			Communication / Decision Making Support		
			EMPLOYMENT		
			If unemployed, are barriers to community employment identified	looking at barriers for employment	Employment First Initiative; contractual obligation
			Strategies to overcome these barriers are identified	Is there discussion about how to overcome the barriers for employment?	Employment First Initiative; contractual obligation
			If community employment is not being pursued, is informed choice clearly documented?	Is it documented that barriers cannot be overcome or is there sufficient documentation about informed choice?	Employment First Initiative; contractual obligation
			TRANSITION SERVICES FROM SCHOOL TO ADULTHOOD (14-18 years old)		
			Has guardianship been established and/or documented?	is guardianship done; are there discussions about it	30-63-31 (b) (5) (A) - assisting transition and portability, including planning of and arranging for services to follow the person when the person moves between any of the following: from school to adult world
			Preferred lifestyle as an adult / access to services	what does the individual want when they become an adult related to services; is this identified within the plan	
			Discussion about access to SSI	has information been shared about SSI	
			Information regarding employment	documentation about employment after school	
Yes	**No**	**N/A**	**Item**	**Comments**	
			Risk Assessment / Intervention Plans section	If BSP is in place, this box should be checked	30-63-23
			Restrictive Procedures, Limitations, and Modifications section	does the information provided meet KDADS guidelines provided in June 2020	30-63-23
			Rights and Responsibilities training completed (will review supporting documentation)	acknowledgment form or info in plan; box on signature page needs to be checked	30-63-22 (c) - provider shall offer training at least annually regarding these rights to individuals and/or guardians
			ANE training completed and information shared about how to report (will review supporting documentation)	acknowledgment form or info in plan; box on signature page needs to be checked	30-63-28 (c) - regular training and ensure individual is advised how to contact for ANE
			Approval in writing by the person or guardian	has appropriate signatures or 2 attempts to obtain	30-63-21 (a) (8) - reasonable measures to obtain approval need to be documented

Item	Comments
Psychotropic Medication Plan / Documentation	
Psychotropic Medication Plan / required documentation is in place	30-63-23 Required for individuals on medication to manage behaviors or to treat diagnosed mental illnesses
Psychotropic Medications listed	not regulatory, best practice
Psychotropic Medication prescribed by a psychiatrist	30-63-23 (2)(B)
Psychiatric Diagnosis is indicated	not regulatory, best practice
Description of behaviors related to diagnosis are provided	30-63-23 (2)(A)(i)
Safeguards in place to minimize risk; which could include Positive Behavior Programming / Environmental modifications considered	30-63-23 (1) (A-D) - initial and ongoing assessment and responsive modifications that may be needed; evidence of least restrictive
Description of how staff will respond to Side Effects	30-63-24
If medication is prescribed to manage specific behaviors, a titration plan is documented	30-63-23 (2) (A) (iii)
If medication is prescribed as PRN, when to use the medication is clearly documented	30-63-23 (1) (D)
Plan describes how the provider will document effectiveness and recommend potential reduction in the medication	30-63-23 (2)(A)(ii), (2)(A)(iii)
Informed consent signed by individual/guardian (within 365 days)	30-63-23 (3)(c) - reasonable efforts to obtain signature must be documented
If the medication is not taken, potential risks have been identified	30-63-23 (1, C)
Possible side effects are identified	30-63-23 (1, C)
Benefits of taking the medication are identified	30-63-23 (1, C)
Reviewed by Behavior Management Committee at least annually	30-63-23 (3)
Behavior Support Plan / Documentation	
Behavior Support Plan / required documentation is in place	30-63-23 Needed when there is restrictive intervention used to manage behavior
Approved by individual/guardian	30-63-23 (3)(c) - reasonable efforts to obtain signature must be documented
Safeguards in place to minimize risk; to include Environmental modifications and evidence of less restrictive alternatives tried	30-63-23 (1) (A-D) - initial and ongoing assessment and responsive modifications that may be needed; evidence of least restrictive
Targeted / Maladaptive Behaviors	
Behaviors are identified and clearly defined for the individual	30-63-23 (2)(A)(i)
Frequency and severity of behaviors are documented	30-63-23 (2)(A)(i)
Desired alternative behaviors identified	not regulatory, best practice
Methods for teaching alternative behaviors documented	not regulatory, best practice
Description of staff response to target behaviors	not regulatory, best practice
Plan describes how the provider will document effectiveness and recommend potential reduction in the restrictive intervention	30-63-23 (2)(A)(ii), (2)(A)(iii)
Evidence of periodic review and needed revisions throughout year	30-63-23 (3)(B) - at least annual, 3-4 times a year is better
If restrictive elements are present - is there evidence of approval by a Behavior Management Committee?	30-63-23 (3)(B)

NOTES

Regulations do not require a "plan", they require documentation of the above mentioned items with approval from BMC/HRC if there are psychotropic medication or restrictive interventions being utilized.

Sedgwick County
Developmental Disability Organization
Quality Assurance Review Report

	Quarter,		Sample Size
Agency Name:		T = TCM Services	
Individuals' Names:		D = Day Services	
		R = Res Services	

Score key: 0=Not Met 1=Partially Met 2=Met

KAR#	Requirement	Document	Score	QAC Comments
30-63-21	Person Centered Support Planning: Developed after consultation with the person, guardian, others from the support network which describes the persons preferred lifestyle, is regularly reviewed for needed revisions	- Review current PCP and look for movement towards preferred lifestyle - Evidence of reviews and revisions if needed - Consider if all necessary elements are present	T:	
30-63-21 (3), 22	Individual Rights and Responsibilities: Free of abuse, control of resources, having privacy, choice of visitors, religion, pay for work, free from inappropriate restraints, treated with dignity and respect	- Evidence of training considerations in PCSP - Site visit review tools, evidence of upholding rights	T:	
			D:	
			R:	
30-63-21 (5), 23	Restrictive interventions, medications, BMC: Only if all else failed, safeguards, management, informed consent, BMC committee review	- PCP/BSP/PMP review - Evidence of Behavior Management Committee review - Site visit review tools, evidence of proper use and knowledge of restrictions	T:	
			D:	
			R:	

30-63-25	Nutrition assistance: Well balanced diet w/choice, meeting modifications and medical directions	- Diet needs documented in PCSP - Site visit review tool, staff aware of diet needs	T:	
			D:	
			R:	
30-63-27	Emergency preparedness: Training in procedures for evacuation, designated meeting place, emergency shelter	- Site visit review tool, staff knowledge of response to emergency situations	T: N/A	
			D:	
			R:	
30-63-28	Abuse, Neglect, Exploitation: prevention, training, reporting procedures in accordance with agency policy	- Consideration of training needs in PCSP - Evidence of staff knowledge of agency reporting procedures	T:	
			D:	
			R:	
30-63-21(8)(3)(d) 30-64-26	Services are being provided consistent to Person Centered Support Plan and needed supports	- PCSP describes needed supports - Site visit review tool - Evidence of staff knowledge of consumer	T:	
			D:	
			R:	
30-63-21(4)	Opportunities for choice are provided	- PCSP describes opportunities for choices - Site visit review tool	T:	
			D:	
			R:	

SEDGWICK COUNTY
DEVELOPMENTAL DISABILITY ORGANIZATION
Quality Assurance Committee

Service Modifications and Agency Intervention Plans

Once SCDDO has evaluated each Quality Assurance Committee (QAC) packet, scored and identified trends, the community service provider (CSP) will receive a summary of their agency reviews for the quarter. If deficiencies are identified, the CSP will receive a request for individual service modifications and/or an agency intervention plan.

Each section of the review is assigned a score upon evaluation. Scores are assigned as follows:
2- all information is present
1- some information is missing
0- all information is missing

Service Modifications

Scores below 2 indicate that a service modification is being requested for at least one deficiency within a review section. Deficiencies will be identified within the QAC review report and the CSP is responsible for assuring improvements are made through use of the agency's internal quality assurance policy and procedures.

Each service modification shall be returned within 30 days or by the assigned due date; one service modification form per individual. If there are multiple deficiencies identified for an individual, each deficiency should be addressed within the plan. The service modification and supporting documentation will be added to the original QAC packet and maintained in the individual's records at the SCDDO.

Agency Intervention Plan

An intervention plan is requested when there is an average agency score of 1.5 or below in any section of the review for 2 consecutive quarters, as this outcome identifies a negative systemic trend within the agency. The CSP will identify needed improvements by reviewing the assigned deficiencies and submitting a written intervention plan within 30 days, demonstrating action steps to address the identified trend. The intervention plan will be reviewed and monitored by the SCDDO.

Individual's Name

Service Modification Plan

DUE DATE:

Location of Concern	Concern	Actions to be Taken Activities/ Tasks/Monitoring	Responsible Person	Date of Completion	Additional Documentation
PCSP, Rights, Restrictions, Nutrition, Emergency Preparedness, ANE, Services, Choice	What concern was noted during the review?	List detailed tasks which will occur to address concern. What are you going to do? How will it be done? How will progress be monitored? List methods/tools which will be used.	Who will be assigned each task? Who will monitor?	When will the improvement take place? List projected dates for each task.	Is there any additional documentation attached to show action was taken? Examples would include PCSP changes, staffing notes, follow up documentation, etc.

Agency Intervention Plan

An Intervention Plan is outlining a specific set of activities that the agency will complete to address deficiencies observed through Quality Assurance activities.

The first step in any intervention plan is to diagnose the situation. One strategy to diagnosing the situation is to distinguish between technical and adaptive work.

Technical problems are problems that can be solved by experts or authorities, which can usually be solved quickly and easily. The technical elements include things such as: imagining different organizational charts, changing where people sit, creating new processes, crafting termination agreements, etc. These technical elements are important, not necessarily easy and are far from the complete picture.

Adaptive challenges require a different level of effort and generally learning is required. We usually need to learn—to the best of our ability—exactly what the problem is and then how to proceed in the best way. Stakeholders must work on adaptive challenges, not just authority figures. With no clear roadmap, you must experiment to test possible ways of moving forward. The adaptive elements include things such as: shifting loyalties from the old manager to the new, helping the staff to see their part in the failed reorganization, generating high morale despite shrinking the department and increasing productivity in the face of significant disequilibrium.

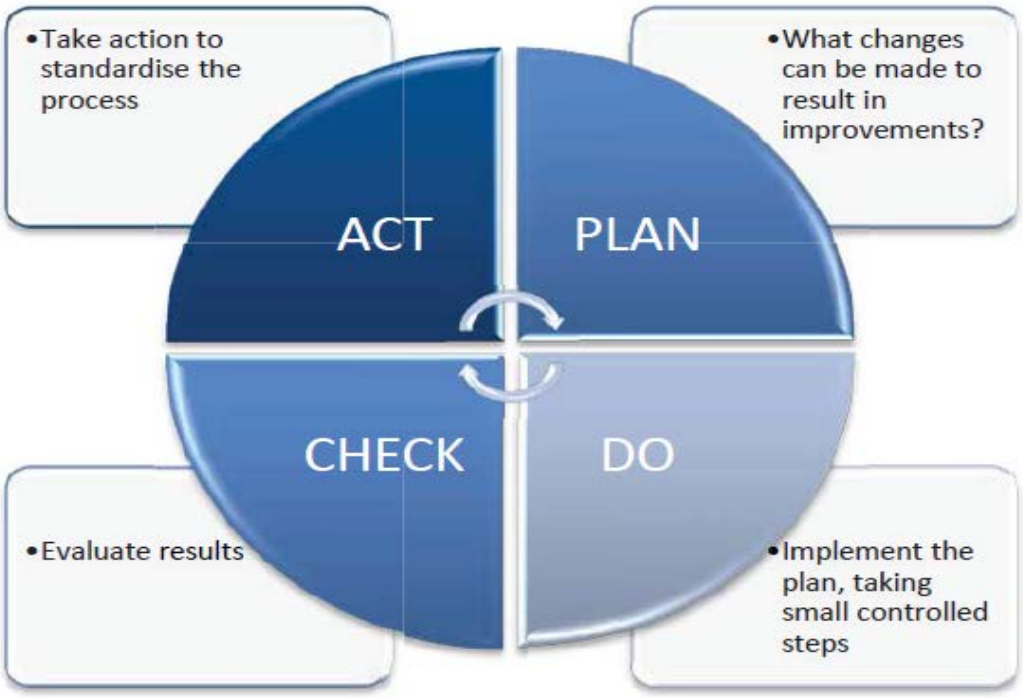
Reflect on the following questions if you're trying to explore the idea distinguish technical and adaptive work.

- What could the right person fix right now? (These are the technical aspects of the challenge.)
- What feels really, really difficult? (That's probably adaptive.)
- What values, behaviors or attitudes might be in conflict with the work that needs to be done? (The changing of behaviors, attitudes and values is adaptive.)
- Of our current company or team practices, what is essential? What is expendable? (Deciding what's essential and what's expendable is adaptive work.)

Utilizing observations and interpretations is another strategy for diagnosis. Observations are facts with no interpretations and should not be disputable. Interpretations are a way of assigning meaning to an observation, or in other words, making sense of what is going on. Interpretations are the means of informing interventions.

Utilize the Observations and Interpretations as a way to explore what is going on with the deficiency noted. Once that is complete, then move to the Intervention Plan to develop action steps to make corrections.

The model shown below is the four phase, Plan-Do-Check-Act cycle



Plan the improvement	Analyse the current situation of your organisation, gather information and research different ways to make improvements. Seek input and feedback from stakeholders. Establish goals and identify actions to implement the plan.
Implement the improvement	• Test the suggested alternatives to identify the preferred improvement. • Allocate resources to ensure the improvement is a success. • Keep your stakeholders informed and involve those with a direct benefit from the outcome. • Document the decisions made during the implementation phase.
Evaluate the improvement activity	Evaluate if the improvement is delivering what you intended; are changes required or should an alternative improvement be used. Measure the improvements for example, audits, assessments and surveys. Document the evaluation methods and results. Take your time; incremental steps may deliver better results.
Take action to standardize the process	There are two possible situations in this step: • If the improvement isn't successful, analyse what can be done differently next time and go through the cycle again with a different plan. • If successful, ensure all stakeholders are informed of the new process, all necessary staff are trained and educated, policies and procedures are implemented and change within the organisation is managed.

References:
Retrieved from Kansas Leadership Center: www.yourleadershipedge.com
Australian Government: Aged Care Quality and Safety Commission - Retrieved from https://www.agedcarequality.gov.au

Observations and Interpretations

Observations: Describe each observation that was made during the review.	1.
	2.
	3.
	4.
	5.
Interpretations: Provide interpretation(s) of why each observation is occurring. Benign Interpretations are comfortable and easier to accept. They fit into the current way of thinking and often put the agency in the best light. Conflictual Interpretations may be more difficult to accept or admit. They point out inconsistencies in what is believed and how the agency behaves.	

Once this information is complete, please develop the <u>Agency Intervention Plan</u>.

Agency Intervention Plan

Agency Name: **Due Date:**

Trend Identified through Observations and Interpretations:
Objective *(What is the goal)*:

Activities to Achieve Objective *What will be done?*	**Lead Accountability** *Who will do it?*	**Target Date** *By When?*
1.		
2.		
3.		
4.		
5.		

Measure of Success: *(How will the agency know that progress is being made? What are the benchmarks?)*
Monitoring of Plan: *(How will the agency determine that the goal has been reached? In what ways should the plan be monitored and for what timeframe?)*

Trend Identified through Observations and Interpretations:
Objective *(What is the goal)*:

Activities to Achieve Objective *What will be done?*	**Lead Accountability** *Who will do it?*	**Target Date** *By When?*
1.		
2.		
3.		
4.		
5.		

Measure of Success: *(How will the agency know that progress is being made? What are the benchmarks?)*
Monitoring of Plan: *(How will the agency determine that the goal has been reached? In what ways should the plan be monitored and for what timeframe?)*

Appendix A

The following documents were used during the Quality Assurance Committee review during the COVID-19 pandemic. These documents may be utilized at the direction of SCDDO should there be any pandemics in the future.

SEDGWICK COUNTY DEVELOPMENTAL DISABILITY ORGANIZATION

Name of Individual: Click here to enter name.

Life Enrichment- Pandemic

If the individual uses a communication method other than verbalization, please indicate how these questions were answered (i.e. family/staff answered questions, individual indicated with non-verbal cues, etc.) Click here to enter text.

Questions to ask the individual receiving services:

1. What do you like about this program? Click here to enter text.

2. What do you not like about this program? Click here to enter text.

3. What do you do:
   a. In case of a tornado? Click here to enter text.
   b. In case of a fire? Click here to enter text.
   c. In case the electricity goes out? Click here to enter text.
   d. If someone hurts/mistreats/is mean to you? Click here to enter text.

4. Is your staff nice to you? ☐YES ☐NO
   If no, explain: Click here to enter text.

5. Does anyone ever take or keep things from you? ☐YES ☐NO
   If yes, explain: Click here to enter text.

6. Do you feel safe coming here? ☐YES ☐NO
   If no, explain: Click here to enter text.

7. Tell me what goals you are working on. Click here to enter text.
   How does staff help you with that? Click here to enter text.

8. Do you have any questions or is there anything else that you would like to tell me? Click here to enter text.

Questions to ask staff

Staff Name: Click here to enter name.
How long has staff been working with this individual? Click here to enter text.
How long has staff been working for this agency? Click here to enter text.

1. How did you learn how to support this individual? Click here to enter text.

2. Does this individual have special diet needs? (calories, food allergies, low sodium, etc.) ☐YES ☐NO
   If yes, what? Click here to enter text.

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Require special food preparation/eating supports? (pureed, food cutting, etc.) ☐YES ☐NO
If Yes, what? **Click here to enter text.**
Is he or she OK with this diet? ☐YES ☐NO
What do you do if the individual refuses to follow the diet? **Click here to enter text.**

3. The plan describes that the individual uses (assistive equipment/ technology **Click here to enter description.**)
   What support do they need for these items? **Click here to enter text.**

4. What are the individuals' medical needs? **Click here to enter text.**
   How do you support these needs? **Click here to enter text.**
   If health services are needed, whom do you contact? **Click here to enter text.**
   Do you receive follow up as to the outcome? ☐YES ☐NO

5. Does this individual have any rights or restrictive procedures? ☐YES ☐NO
   If yes, what? **Click here to enter text.**
   Is this addressed in the individuals plan? ☐YES ☐NO

6. What behavior does this individual display? **Click here to enter text.**
   How do you support this need? **Click here to enter text.**

7. Does this individual take psychotropic medications? ☐YES ☐NO
   If so, what are the potential side effects or where do you go to find them? **Click here to enter text.**

8. Where do you keep the support plan? **Click here to enter text.**

9. According to the plan, what are the individual's Day Program goals? **Click here to enter text.**

10. What do you do:
    a. In case of a tornado? **Click here to enter text.**
    b. In case of a fire? **Click here to enter text.**
    c. In case of a power outage? **Click here to enter text.**

11. What are this agency's reporting procedures if you suspect abuse, neglect, or exploitation? **Click here to enter text.**

12. Do you know how to make an ANE report directly to APS? (skip if mention above)
    ☐YES ☐NO

13. Do you have any questions or is there anything else that you would like to tell me? **Click here to enter text.**?

Questions the reviewer answers based on their observation/interview:

Interactions were positive between the individual and others in services?
☐YES ☐NO ☐N/A

Interactions were positive between staff and the individual?
☐YES ☐NO ☐N/A

The individual expressed their own opinions? ☐YES ☐NO ☐N/A

Kudos (positive observations that the reviewer has noted about the staff, the individual receiving services, the site, etc.): **Click here to enter text.**

Comments/Concerns: **Click here to enter text.**

Name and role of QAC member(s) completing interview: **Click here to enter name(s).**

How did the interview take place? (Ex: Zoom, WebEx, Phone, Etc.) **Click here to enter text.**

SEDGWICK COUNTY DEVELOPMENTAL DISABILITY ORGANIZATION

Name of Individual: Click here to enter text.

Work Services & Supported Employment- Pandemic

If the individual uses a communication method other than verbalization, please indicate how these questions were answered (i.e. family/staff answered questions, individual indicated with non-verbal cues, etc.) **Click here to enter text.**

Questions to ask the individual receiving services:

1. I understand that you like to work at Click here to enter name of agency/ program.
   Do you get to work on things you enjoy doing here? ☐ YES ☐NO

2. How do you change it if you want to work on something else? Click here to enter text.

3. Do you have enough work? ☐YES ☐NO
   If no, explain: Click here to enter text.
   If you do not have work, what do you do during this time? Click here to enter text.
   Do you like doing that? ☐YES ☐NO
   If no, what would you rather be doing? Click here to enter text.

4. Does your staff help you learn your job if you need help? ☐YES ☐NO
   If no, explain: Click here to enter text.

5. What do you do:
   a. In case of a tornado? Click here to enter text.
   b. In case of a fire? Click here to enter text.
   c. In case the electricity goes out? Click here to enter text.
   d. If someone hurts/mistreats/is mean to you? Click here to enter text.

6. Is your staff nice to you? ☐YES ☐NO
   If no, explain: Click here to enter text.

7. Does anyone ever take or keep things from you? ☐YES ☐NO
   If yes, explain: Click here to enter text.

8. Do you feel safe working here? ☐YES ☐NO
   If no, explain: Click here to enter text.

9. Tell me what goals you are working on. Click here to enter text.
   How does staff help you with that? Click here to enter text.

10. Do you have any questions or is there anything else that you would like to tell me? Click here to enter text.

SEDGWICK COUNTY DEVELOPMENTAL DISABILITY ORGANIZATION

Questions to ask staff

Staff Name: Click here to enter text.
How long has staff been working with this individual? Click here to enter text.
How long has staff been working for this agency? Click here to enter text.

1. How did you learn how to support this individual? Click here to enter text.

2. Does this individual have special diet needs? (calories, food allergies, low sodium, etc.) ☐YES ☐NO
   If yes, what? Click here to enter text.
   Require special food preparation/eating supports? (pureed, food cutting, etc.) ☐YES ☐NO
   If Yes, what? Click here to enter text.
   Is he or she OK with this diet? ☐YES ☐NO
   What do you do if the individual refuses to follow the diet? Click here to enter text.

3. The plan describes that the individual uses (assistive equipment/ technology Click here to enter description.).
   What support do they need for these items? Click here to enter text.

4. What are the individuals' medical needs? Click here to enter text.
   How do you support these needs? Click here to enter text.
   If health services are needed, whom do you contact? Click here to enter text.
   Do you receive follow up as to the outcome? ☐YES ☐NO

5. Does this individual have any rights or restrictive procedures? ☐YES ☐NO
   If yes, what? Click here to enter text.
   Is this addressed in the individuals plan? ☐YES ☐NO

6. What behavior does this individual display? Click here to enter text.
   How do you support this need? Click here to enter text.

7. Does this individual take psychotropic medications? ☐YES ☐NO
   If so, what are the potential side effects or where do you go to find them? Click here to enter text.

8. Where do you keep the support plan? Click here to enter text.

9. According to the plan, what are the individual's (insert applicable service: Click here to enter text.) goals? Click here to enter text.

10. What do you do:
    a. In case of a tornado? Click here to enter text.
    b. In case of a fire? Click here to enter text.
    c. In case of a power outage? Click here to enter text.
11. What are this agency's reporting procedures if you suspect abuse, neglect, or exploitation? Click here

to enter text.

12. Do you know how to make an ANE report directly to APS? (skip if mention above) ☐YES ☐NO

13. Do you have any questions or is there anything else that you would like to tell me? Click here to enter text.

Questions the reviewer answers based on their observation/interview:

Interactions were positive between the individual and others in services?	☐YES	☐NO	☐N/A
Interactions were positive between staff and the individual?	☐YES	☐NO	☐N/A
The individual expressed their own opinions?	☐YES	☐NO	☐N/A

Kudos (positive observations that the reviewer has noted about the staff, the individual receiving services, the site, etc.): Click here to enter text.

Comments/Concerns: Click here to enter text.

Name and role of QAC member(s) completing interview: Click here to enter text.

How did the interview take place? (Ex: Zoom, WebEx, Phone, Etc.) Click here to enter text.

SEDGWICK COUNTY DEVELOPMENTAL DISABILITY ORGANIZATION

Name of Individual: Click here to enter text.

Residential Services- Pandemic

If the individual uses a communication method other than verbalization, please indicate how these questions were answered (i.e. family/staff answered questions, individual indicated with non-verbal cues, etc.) **Click here to enter text.**

Questions to ask the individual receiving services:

1. Do you choose what you eat (i.e. for breakfast, lunch, dinner, snacks)? ☐YES ☐NO
   If no, who does? Click here to enter text. Are you OK with that? ☐YES ☐NO
   If you do not like what you have for a meal, do you get other choices? ☐YES ☐NO

2. In your home, what do you do:
   a. In case of a tornado? Click here to enter text.
   b. In case of a fire? Click here to enter text.
   c. In case the electricity goes out? Click here to enter text.
   d. If someone hurts/mistreats/is mean to you? Click here to enter text.
   e. If your staff does not show up for work? Click here to enter text.

3. Is your staff nice to you? ☐YES ☐NO
   If no, explain: Click here to enter text.

4. Does your staff answer your questions? ☐YES ☐NO
   If no, explain: Click here to enter text.

5. Does anyone ever take or keep things from you? ☐YES ☐NO
   If yes, what/who? Click here to enter text.

6. Do you feel safe living here? ☐YES ☐NO
   If no, explain: Click here to enter text.

7. Tell me what goals you are working on. Click here to enter text.
   How does staff help you with that? Click here to enter text.

8. Do you have any questions or is there anything else that you would like to tell me? Click here to enter text.

Questions to ask staff

Staff Name: Click here to enter text.
How long has staff been working with this individual? Click here to enter text.
How long has staff been working for this agency? Click here to enter text.

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1. How did you learn how to support this individual? Click here to enter text.

2. Does this individual have special diet needs? (calories, food allergies, low sodium, etc.) ☐YES ☐NO
   If yes, what? Click here to enter text.
   Require special food preparation/eating supports? (pureed, food cutting, etc.) ☐YES ☐NO
   If Yes, what? Click here to enter text.
   Is he or she OK with this diet? ☐YES ☐NO
   What do you do if the individual refuses to follow the diet? Click here to enter text.

3. The plan describes that the individual uses (assistive equipment/ technology Click here to enter description.).
   What support do they need for these items? Click here to enter text.

4. What are the individuals' medical needs? Click here to enter text.
   How do you support these needs? Click here to enter text.
   If health services are needed, whom do you contact? Click here to enter text.
   Do you receive follow up as to the outcome? ☐YES ☐NO

5. Does this individual have any rights or restrictive procedures? ☐YES ☐NO
   If yes, what? Click here to enter text.
   Is this addressed in the individuals plan? ☐YES ☐NO

6. What behavior does this individual display? Click here to enter text.
   How do you support this need? Click here to enter text.

7. Does this individual take psychotropic medications? ☐YES ☐NO
   If so, what are the potential side effects or where do you go to find them? Click here to enter text.

8. Where do you keep the support plan? Click here to enter text.

9. According to the plan, what are the individual's (insert applicable service: Click here to enter text.) goals? Click here to enter text.

10. What do you do:
    a. In case of a tornado? Click here to enter text.
    b. In case of a fire? Click here to enter text.
    c. In case of a power outage? Click here to enter text.
    d. If the next shift does not show up? Click here to enter text.

11. What are this agency's reporting procedures if you suspect abuse, neglect, or exploitation? Click here to enter text.

12. Do you know how to make an ANE report directly to APS? (skip if mention above) ☐YES ☐NO

13. Do you have any questions or is there anything else that you would like to tell me? Click here to enter

text.

Questions the reviewer answers based on their observation/interview:

Interactions were positive between the individual and others in services?	☐YES	☐NO	☐N/A
Interactions were positive between staff and the individual?	☐YES	☐NO	☐N/A
The individual expressed their own opinions?	☐YES	☐NO	☐N/A

Kudos (positive observations that the reviewer has noted about the staff, the individual receiving services, the site, etc.): Click here to enter text.

Comments/Concerns: Click here to enter text.

Name and role of QAC member(s) completing interview: Click here to enter text.

How did the interview take place? (Ex: Zoom, WebEx, Phone, Etc.) Click here to enter text.

SEDGWICK COUNTY DEVELOPMENTAL DISABILITY ORGANIZATION

Name of Individual: Click here to enter text.

Personal Care Services for Adults- Pandemic

If the individual uses a communication method other than verbalization, please indicate how these questions were answered (i.e. family/staff answered questions, individual indicated with non-verbal cues, etc.) **Click here to enter text.**

Questions to ask the individual receiving services:

1. If you do not like what you have for a meal, do you get other choices? ☐ YES ☐NO
   If no, explain: Click here to enter text.

2. Is there anything you would change about where or with whom you are living? ☐YES ☐NO
   If yes, explain: Click here to enter text.

3. What do you do:
   a. In case of a tornado? Click here to enter text.
   b. In case of a fire? Click here to enter text.
   c. In case the electricity goes out? Click here to enter text.
   d. If someone hurts/mistreats/is mean to you? Click here to enter text.
   e. If you are hurt/ sick? Click here to enter text.
   f. If your staff does not show up for work? Click here to enter text.

4. Tell me what goals you are working on. Click here to enter text.
   How does staff help you with that? Click here to enter text.

5. Do you have any questions or is there anything else that you would like to tell me? Click here to enter text.

Questions to ask staff

Staff Name: Click here to enter text.
How long has staff been working with this individual? Click here to enter text.
How long has staff been working for this agency? Click here to enter text.

1. How did you learn how to support this individual? Click here to enter text.

2. Does this individual have special diet needs? (calories, food allergies, low sodium, etc.) ☐YES ☐NO
   If yes, what? Click here to enter text.
   Require special food preparation/eating supports? (pureed, food cutting, etc.) ☐YES ☐NO
   If Yes, what? Click here to enter text.
   Is he or she OK with this diet? ☐YES ☐NO
   What do you do if the individual refuses to follow the diet? Click here to enter text.

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3. The plan describes that the individual uses (assistive equipment/ technology Click here to enter description.).
   What support do they need for these items? Click here to enter text.

4. What are the individuals' medical needs? Click here to enter text.
   How do you support these needs? Click here to enter text.
   If health services are needed, whom do you contact? Click here to enter text.
   Do you receive follow up as to the outcome? ☐YES ☐NO

5. Does this individual have any rights or restrictive procedures? ☐YES ☐NO
   If yes, what? Click here to enter text.
   Is this addressed in the individuals plan? ☐YES ☐NO

6. What behavior does this individual display? Click here to enter text.
   How do you support this need? Click here to enter text.

7. Does this individual take psychotropic medications? ☐YES ☐NO
   If so, what are the potential side effects or where do you go to find them? Click here to enter text.

8. Where do you keep the support plan? Click here to enter text.

9. According to the plan, what are the individual's (insert applicable service: Click here to enter text.) goals? Click here to enter text.

10. What do you do:
    a. In case of a tornado? Click here to enter text.
    b. In case of a fire? Click here to enter text.
    c. In case of a power outage? Click here to enter text.
    d. If the next shift does not show up? Click here to enter text.
    e. If you suspect abuse, neglect or exploitation? Click here to enter text.

11. Do you know how to make an ANE report directly to APS? (skip if mention above) ☐YES ☐NO

12. Do you have any questions or is there anything else that you would like to tell me? Click here to enter text.

Questions the reviewer answers based on their observation/interview:

Interactions were positive between the individual and others in services?	☐YES	☐NO	☐N/A
Interactions were positive between staff and the individual?	☐YES	☐NO	☐N/A
The individual expressed their own opinions?	☐YES	☐NO	☐N/A

Kudos (positive observations that the reviewer has noted about the staff, the individual receiving services, the site, etc.): Click here to enter text.

Comments/Concerns: Click here to enter text.

Name and role of QAC member(s) completing interview: Click here to enter text.

How did the interview take place? (Ex: Zoom, WebEx, Phone, Etc.) Click here to enter text.

SEDGWICK COUNTY DEVELOPMENTAL DISABILITY ORGANIZATION

Name of Individual: Click here to enter text.

Personal Care Services for Children (under the age of 18)- Pandemic

The review is to be completed in the child's home with the child present.

Name of family member who participated in review: **Click here to enter text.**

Questions to ask the family:

1. Does the service meet your family's needs? ☐ YES ☐NO
   Comments: Click here to enter text.

2. Do you feel comfortable with the person(s) who cares for your child? ☐ YES ☐NO
   Comments: Click here to enter text.

3. What other services or support items will your child need this year? Click here to enter text.

4. Does your child have any unmet medical needs? ☐ YES ☐NO
   Comments: Click here to enter text.

5. Does your child have any unmet mental health needs? ☐ YES ☐NO
   Comments: Click here to enter text.

6. Have you been given information on what to do if you believe your child have been abused, neglected or exploited? ☐ YES ☐NO

7. Is there anything you would like your case manager to follow up with? ☐ YES ☐NO
   Comments: Click here to enter text.

Questions to ask staff

Staff Name: Click here to enter text.
How long has staff been working with this individual? Click here to enter text.
How long has staff been working for this agency? Click here to enter text.

1. How did you learn how to support this individual? Click here to enter text.

2. Does this individual have special diet needs? (calories, food allergies, low sodium, etc.) ☐YES ☐NO
   If yes, what? Click here to enter text.
   Require special food preparation/eating supports? (pureed, food cutting, etc.) ☐YES ☐NO
   If Yes, what? Click here to enter text.
   Is he or she OK with this diet? ☐YES ☐NO

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What do you do if the individual refuses to follow the diet? Click here to enter text.

3. The plan describes that the individual uses (assistive equipment/ technology Click here to enter description.).
   What support do they need for these items? Click here to enter text.

4. What are the individuals' medical needs? Click here to enter text.
   How do you support these needs? Click here to enter text.
   If health services are needed, whom do you contact? Click here to enter text.
   Do you receive follow up as to the outcome? ☐YES ☐NO

5. Does this individual have any rights or restrictive procedures? ☐YES ☐NO
   If yes, what? Click here to enter text.
   Is this addressed in the individuals plan? ☐YES ☐NO

6. What behavior does this individual display? Click here to enter text.
   How do you support this need? Click here to enter text.

7. Does this individual take medications? ☐YES ☐NO
   If so, what are the potential side effects or where do you go to find them? Click here to enter text.

8. Have you received a copy of the support plan? Click here to enter text.

9. According to the plan, what are the individual's (insert applicable service: Click here to enter text.) goals? Click here to enter text.

10. What do you do:
    a. In case of a tornado? Click here to enter text.
    b. In case of a fire? Click here to enter text.
    c. In case of a power outage? Click here to enter text.
    d. If the next shift does not show up? Click here to enter text.
    e. If you suspect abuse, neglect or exploitation? Click here to enter text.

11. Do you know how to make an ANE report directly to APS? (skip if mention above) ☐YES ☐NO

12. Do you have any questions or is there anything else that you would like to tell me? Click here to enter text.

Questions the reviewer answers based on their observation/interview:

Interactions were positive between the individual and parent/family? ☐YES ☐NO ☐N/A
Interactions were positive between staff and the individual? ☐YES ☐NO ☐N/A

Kudos (positive observations that the reviewer has noted about the staff, the individual receiving services, the site, etc.): Click here to enter text.

Comments/Concerns: Click here to enter text.

Name and role of QAC member(s) completing interview: Click here to enter text.

How did the interview take place? (Ex: Zoom, WebEx, Phone, Etc.) Click here to enter text.