Department of HUMAN SERVICES

October 25, 2019

GENERAL LETTER NO. 3-B-12

ISSUED BY: Division of Mental Health and Disability Services

SUBJECT: Employees' Manual, Title 3, Chapter B, ***State Resource Centers***, Title page, revised; Contents (pages 1, 4, and 5), revised; and pages 1, 4 through 10, 12, 14 through 33, 37, 38, 39, 44, 45, 58, 66, 69, 72, 75, 81, 84, 86, and 95 through 120, revised.

Summary

Chapter 3-B is revised to:

- Make minor clarifications to terms.
- Update definitions for consistency.
- Update the code and application process to repeal the central point of coordination language and funding, and additional regional approval.
- Remove involuntary admission due to repeal of code.
- Reflect changes in general facility policies regarding internal reporting procedures, reporting deaths, and autopsies.
- Make necessary changes to update manual to current operations.

Effective Date

Immediately.

Material Superseded

This material replaces the following pages from Employees' Manual, Title 3, Chapter B:

Page	Date
Title page	April 4, 2014
Contents (pages 1 and 4)	April 4, 2014
Contents (page 5)	November 27, 2009
1	April 4, 2014
4	November 27, 2009
5	April 4, 2014
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7-10, 12, 14-32	April 4, 2014
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37	November 27, 2009
38	May 14, 2010
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104-118	November 27, 2009
119	April 4, 2014
120	November 27, 2009
121	May 14, 2010
122, 123	November 27, 2009

Additional Information

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Department of HUMAN SERVICES

Employees' Manual
Title 3, Chapter B

Revised October 25, 2019

State Resource Centers

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Overview

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"**Board of supervisors**" means the elected governing body of a county as defined in Iowa Code Chapter 331.

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

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

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

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

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

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

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

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

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

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

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

"**Corporal punishment**" means the use of any physical force to inflict punishment for an individual's actions.

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

"**County of residence**" means as defined in Iowa Code section 331.394(1)(a).

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

"**Date of application**" means the date that the Division administrator receives the application by the county board of supervisors or the court's request for a diagnostic evaluation.

"**Declaration of county of residence**" means the declaration made by an applicant at the time of application or admission stating which Iowa county the applicant declares to be the applicant's county of residence.

"**Department**" means the Iowa Department of Human Services (DHS).

"**Division**" means the division of mental health and disability services in the Iowa Department of Human Services.

"**Division administrator**" means the administrator of the division of mental health and disability services as assigned by the Director in Iowa Code section 218.3(1).

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

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

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

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

"**Elopement**" occurs when:

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

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

"**Entities responsible for funding**" means the individual's county of residence, Medicaid Managed Care Organization or the Iowa Department of Human Services.

"**Essential supports**" means the medical, mobility, nutritional, and behavioral supports that are essential to an individual's health and safety. Absence of an essential support would immediately negatively compromise the individual's health, safety, or behavior. Essential supports are to be in place before an individual is transferred from a resource center.

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

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

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

"**Facility admission**" means the determination that the individual meets all the admission requirements and has been accepted for admission for an overnight stay to receive support and treatment services.

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

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

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

"**Family contact**" means:

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

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

"**Guardian**" means the person other than a parent of a minor who has been appointed by the court to have custody of person of the individual as provided under Iowa Code section 232.2(21) or 633.3(20).

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

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

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

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

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

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

"**Intellectual disability**" means a disability of children and adults who, as a result of inadequately developed intelligence, have a significant impairment in ability to learn or to adapt to the demands of society, and, if a diagnosis is required, "intellectual disability" means a diagnosis of mental retardation prior to the age of 18, as defined in the diagnostic and statistical manual of mental disorders, fourth edition, text revised, published by the American Psychiatric Association.

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

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

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

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

"**Non-Medicaid payment eligible**" means an individual who is not eligible for Medicaid funding for the services provided by a state resource center.

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

"**Outpatient admission**" means a person is provided a service but is not accepted for an overnight admission, except the term includes individuals accepted for overnight admission for a diagnostic evaluation for determining the appropriateness of a court ordered admission.

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

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

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

"**Physical injury**" means:

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

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

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

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

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

"**Qualified intellectual disabilities professional**" or "**QIDP**" means the leader of the interdisciplinary team (IDT), also referred to as the treatment program manager (TPM). The Qualified Intellectual Disabilities Professional is ultimately responsible for ensuring individuals receive all needed bio-psycho-social services and supports in an integrated and coordinated fashion.

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

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

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

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

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

"**Regional administrator**" means the administrative office, organization, or entity formed by agreement of the counties participating in the region as defined in Iowa Code section 331.390.

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

"**Restrictive intervention**" means an act, program, process, method, or response limiting or infringing upon an individual's rights.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"**Suspicious injury**" means:

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

"**Temporary admission**" means the voluntary admission of an individual to overnight facility admission on a time-limited basis for evaluation or treatment.

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

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

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

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

Policy on Admissions

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

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

Applications for voluntary admission of adults shall be made through the Department and the superintendent of any state resource center or the county's designated regional administrator. Applications for minors shall be made through the county board of supervisors or the county's designated regional administrator.

General Principles

Resource center written policies and procedures shall assure that:

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

- The voluntary admission of a minor individual is made only with:
  - An application from a county board of supervisors or the county's designated regional administrator signed by the board of supervisors or the board's officially designated agent, and
  - A diagnostic evaluation that determines the individual's need for and eligibility for admission based on generally accepted professional standards of care.
- Minor individuals are accepted for a voluntarily admission only after the individual has been informed of the individual's right to object to a voluntary admission and, if the minor objects, a court has authorized the individual's admission.
- Involuntary admissions are made only after a diagnostic evaluation indicates that an admission is appropriate and a court has issued an order for commitment.
- The applicant, or the applicant's parent, guardian, or legal representative, has declared the applicant's county of residence and the application has been signed by appropriate regional administrator.
- The individual's rights are protected throughout the admission process.
- The individual or the individual's parent, guardian, or legal representative is involved in the admission process.
- The individual or the individual's guardian understands that the resource center's goal will be to return the individual to community services and that the discharge process begins with admission.
- The local state and regional employees involved in the admission understand that the resource center's goal will be to return the individual to community services and that the discharge process begins with admission.
- The local state and regional employees who are responsible for assisting in developing the appropriate community resources for the individual are strongly encouraged to be a part of the individual's individual support plan process.

Application Submittal Process

Resource center written policies and procedures shall assure that:

- Applications for admission, temporary admission, or outpatient admission shall be accepted only from an individual, or the individual's parent, guardian, or legal representative, through the individual's county of residence or the county's designated regional administrator.
- The applicant submits adequate information to determine that:
  - The individual for whom application is made is a person with an intellectual disability,
  - All reasonable community resources have been considered and it has been professionally determined that the resource center is the most integrated setting to meet the individual's current needs, and
  - Appropriate information regarding the individual's history, previous services and supports, and current service and support needs has been provided.

Individuals Without a County of Residence

Resource center written policies and procedures for individuals without a county or residence shall assure that:

- The application shall be made by the county where the person is present using the same process as an application for an individual with a county of residence.
- The division administrator or the division administrator's designee shall approve the application.

Individuals Non-Medicaid Payment Eligible

Resource center written policies and procedures shall assure that when an application for admission is made for an individual who is non-Medicaid payment eligible:

- That the regional administrator of the county of application shall certify the individual's county of residence;
- Disputes of county of residence shall be resolved using the dispute resolution process in Iowa Code subsection 331.394(5);
- The cost of care shall be billed to the county of residence in accordance with Iowa Code section 222.60.

Voluntary Facility Admission for Adult

Resource center written policies and procedures shall assure that:

- All applications for admission shall be approved as appropriate for admission by the residential technical assistance team before the resource center processes the application.
- An application for admission shall be accepted only when the application has been received from the county's designated regional administrator for the board of supervisors of the individual's county of residence.
- The application shall be made using form 470-4402, *Application for Admission to a State Resource Center*.
- The applicant, the applicant's parent, guardian, or legal representative consents to release of all information the resource center needs to determine the appropriateness of the admission, using form 470-4402, *Application for Admission to a State Resource Center*.
- The board of supervisors or the board's officially designated agent shall sign the application.
- When a county disputes the individual's declaration of county of residence the disputing county has initiated the dispute resolution process in Iowa Code subsection 331.394(5).
- When the division disputes the county's determination of an applicant's county of residence the division shall initiate the dispute resolution process in Iowa Code subsection 331.394(5).

  When the individual has been determined or alleged to be a state case, the division administrator or the division administrator's designee shall also sign the application.
- The application shall provide information supporting a diagnosis or possible diagnosis of intellectual disability and will include an evaluation by a licensed psychologist within three months prior to admission.
- When the individual for whom application is made is not competent to give consent to admission or treatment, the individual's guardian or legal representative shall give consent.

Voluntary Facility Admission for Minor

Resource center written policies and procedures shall assure that:

- All applications for admission shall be approved as appropriate for admission by the residential technical assistance team before the resource center processes the application.
- An application shall be accepted only when the application has been received from the board of supervisors or the county's designated regional administrator of the individual's county of residence.
- The applicant's county of residence has been determined.
- When a county disputes the individual's declaration of county of residence the disputing county has initiated the dispute resolution process in Iowa Code subsection 331.394.
- When the division disputes the county's determination of an applicant's county of residence the division shall initiate the dispute resolution process in Iowa Code subsection 331.394.
- An application shall be made using form 470-4402, *Application for Admission to a State Resource Center.*
- The board of supervisors or the board's officially designated agent shall sign the application.
- When the individual has been determined or alleged to be a state case, the division administrator or the division administrator's designee shall also sign the application.
- The application provides information supporting a diagnosis or possible diagnosis of intellectual disability.

Temporary Admission

Resource center written policies and procedures shall assure that:

- Voluntary application for a temporary admission shall be made in the same way as an application for a voluntary facility admission except:
  - The application is exempt from the residential technical assistance team process; and
  - A diagnostic evaluation is not required.

- The person or agency seeking temporary admission for an individual shall provide a written and signed understanding that:
  - The request is for a temporary admission for a specified limited period;
  - The person or agency agrees to take the individual back; and
  - Application for facility admission requires a separate process.

Outpatient Admission

Resource center written policies and procedures shall assure that:

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

Admission Approval

Facility Admission Approval

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

- The individual clearly meets the definition of intellectual disability;
- The preadmission diagnostic evaluation clearly shows that community resources have been considered and it has been determined that the resource center is determined to be the most integrated setting according to the individual's current needs, based on generally accepted professional standards of care;
- The resource center has adequate facilities to serve the individual;
- The resource center has determined that it has the available services and supports the individual currently needs;
- The admission will not result in overcrowding;
- The applicant's county of residence has been determined.
- When a county disputes the individual's declaration of county of residence the disputing county has initiated the dispute resolution process in Iowa Code subsection 331.394(5).

- When the division disputes the county's determination of an applicant's county of residence the division shall initiate the dispute resolution process in Iowa Code subsection 331.394(5).
- Funding responsibility for non-Medicaid payment eligible individuals has been clearly established or, when in dispute, the process for resolving disputes is being followed;
- The individual, the individual's guardian, or legal representative has given informed consent to treatment;
- A minor has given consent to the admission during the preadmission diagnostic evaluation, or, if consent was not given, the admission was approved by a juvenile court in accordance with Iowa Code subsection 222.13A; and
- For commitments:
  - An individual shall be accepted for facility admission once the superintendent has recommended the admission and the court has issued an order.
  - The superintendent shall acknowledge to the court receipt of the individual, upon receipt of an individual's order of commitment from the court.

Temporary Admission Approval

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

- An application has been submitted using form 470-4402, *Application for Admission to a State Resource Center*.
- An application has been approved through a county's designated regional administrator, when required, and by a county board of supervisors.
- An application has been signed by the board of supervisors or the board's officially designated agent.
- The applicant's county of residence has been determined.
- When a county disputes the individual's declaration of county of residence the disputing county has initiated the dispute resolution process in Iowa Code subsection 331.394(5).

- When the division disputes the county's determination of an applicant's county of residence the division shall initiate the dispute resolution process in Iowa Code subsection 331.394(5).
- The applicant, the applicant's guardian, or legal representative consents to release of all information the resource center needs to determine the appropriateness of the admission, using form 470-4402, *Application for Admission to a State Resource Center*.
- When the individual has been determined or alleged to be a state case, the division administrator or the division administrator's designee shall also sign the application.
- The application provides information supporting a diagnosis or possible diagnosis of intellectual disability.
- The individual, the individual's guardian, or legal representative has given informed consent for care, treatment, and training.

Outpatient Admission Approval

Resource center written policies and procedures shall assure that:

- Voluntary outpatient admission approval is given only when:
  - An application has been submitted using form 470-4402, *Application for Admission to a State Resource Center*.
  - The application has been approved through the county's designated regional administrator, when required, and by a county board of supervisors.
  - The application has been signed by the board of supervisors or the board's officially designated agent.
  - The applicant's county of residence has been determined.
  - When a county disputes the individual's declaration of county of residence the disputing county has initiated the dispute resolution process in Iowa Code subsection 331.394(5).
  - When the division disputes the county's determination of an applicant's county of residence the division shall initiate the dispute resolution process in Iowa Code subsection 331.394(5).

- The applicant, the applicant's guardian, or legal representative consents to release of all information the resource center needs to determine the appropriateness of the admission, using form 470-4402, *Application for Admission to a State Resource Center*.
- The division administrator or the division administrator's designee has signed the application when the individual is or is alleged to be a state case.
- The application provides information supporting a diagnosis or possible diagnosis of intellectual disability.
- The individual or the individual's guardian has given informed consent for care, treatment, and training.

♦ Involuntary outpatient admission approval is given only when a district court has requested that a diagnostic evaluation of an individual be made.

Informed Consent

Resource center written policies and procedures shall assure that:

♦ Informed consent for care, treatment, and training shall be given by:

- The individual if the individual is competent to give informed consent, or
- If the individual is not competent to give informed consent, by the individual's parent, guardian, or legal representative.

♦ A general informed consent for services shall be obtained using form 470-4403, *Resource Center Agreement and Consent for Services*.

♦ The general informed consent shall be renewed no less frequently than every 12 months.

♦ Specific informed consent shall be obtained for participation in treatment that includes:

- Invasive or potentially harmful procedures,
- Programmatic use of restraints,
- Use of a behavior modifying medication,
- Non-emergency transfer to another facility,
- Programmatic use of aversive stimuli or response cost,
- Programmatic use of time out,
- Medical consents that are restrictive based on a medical condition, or
- Participation in experimental research.

Application Denial

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

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

Readmission

Resource center written policies and procedures shall assure that:

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

Performance Improvement

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

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

Data Collection and Review

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

- Data collected shall include, at a minimum, the following categories:
  - Name of each individual for whom application or court order was received
  - Date the application or court order was received
  - Residential Technical Assistance Team (RTAT) approval decision (yes, no, or not applicable)
  - Type of application:
    - Voluntary adult
    - Voluntary minor
    - Involuntary court order
    - Time limited
    - Outpatient
    - First admission
    - Readmission
  - Resource center's admission decision
  - Reason application was denied, if applicable
  - County of legal settlement
  - Barriers to community living that have led to the need for admission
- Data gathered from data analysis shall be used consistently for identifying and addressing individual or systemic issues to improve the application process.

- The resource center quality council shall review data from all admissions to assure that:
  - Problems are timely and adequately detected and appropriate corrective actions are implemented, and
  - When possible, root causes are identified that lead to corrective action.

Reporting Requirements

The resource center written policies and procedures shall assure that:

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

Employee Training and Education on Admissions

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

- The philosophy and policies that:
  - Individuals will be accepted for admission only when a professional determination has been made that the community does not have adequate services to meet the needs of the individual and the resource center has been determined to be the least restrictive setting, and
  - The goal of all admissions is to return the individual to a less restrictive community setting, and
  - Discharge planning starts with admission.

- State laws and rules that govern voluntary and involuntary admissions including but not limited to:
  - Voluntary application process,
  - Involuntary court process,
  - Differences between adult and minor admissions,
  - Application of catchment areas,
  - Availability of adequate space and services,
  - Role of RTAT in admissions,
  - County of residence, and
  - Required diagnosis and evaluation (D&E).
- The policies and procedures for processing and approving admissions including but not limited to:
  - The rights of the individual seeking or for whom admission is sought
  - The types of possible admission
  - Admission approval requirements
  - Informed consent
  - Data collection on admissions
  - Reporting requirements

Employees Trained on Admissions

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

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

Continuing Education on Admissions

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

General Training Policies on Admissions

Resource center written policies and procedures shall assure that:

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

Policy on Human Rights

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

- **Information**. An individual receiving care from a state resource center shall have the right to:
  - Receive an explanation and written copy of the rules of the facility.
  - Receive an explanation of the individual's medical condition, developmental status, and behavior status, and be informed as to treatment plans and the attendant risks of treatment.
- **Care and treatment**. An individual receiving care from a state resource center shall have the right to:
  - Receive appropriate treatment, services, and habilitation for the individual's disabilities, including appropriate and sufficient medical and dental care.
  - Have the confidentiality of the individual's personal resource center records maintained and have access to those records within a reasonable period.
  - Work, when available and desired and as appropriate to the individual's plan of treatment, and be compensated for that work in accordance with federal and state laws.

- **Living conditions**. An individual receiving care from a state resource center shall have the right to:
  - Receive care in a manner that respects and maintains the individual's dignity and individuality.
  - Have opportunities for personal privacy, including during the care of personal needs.
  - Keep and use appropriate personal possessions, including wearing the individual's own clothing.
  - Share a room with a spouse when both live in the same facility.
  - Be free from unnecessary drugs and restraints.
  - Be free from physical, psychological, sexual, or verbal abuse, neglect and exploitation.
- **Communication**. An individual receiving care from a state resource center shall have the right to:
  - Communicate with people and access services at the facility and in the community, including organizing and participating in resident groups while at the facility.
  - Receive visits of the individual's choice from parents, guardians, legal representatives, or family without prior notice given to the facility unless the visits have been determined inappropriate by the individual's treatment team or by court order.
  - Communicate and meet privately with persons of the individual's choice without prior notice given to the facility unless the communication is determined inappropriate by the individual's treatment team or by court order.
  - Send and receive unopened mail.
  - Make and receive private telephone calls unless the calls have been determined inappropriate by the individual's treatment team or by court order.
- **Self-determination**. An individual receiving care from a state resource center shall have the right to:
  - Have a dignified existence with self-determination, making choices about aspects of the individual's lives that are significant to them.
  - Give informed consent including the right to withdraw consent at any given time.

Human Rights Committee

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

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

Reporting of Violations

Resource center written policies and procedures shall assure that:

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

Response to Report

Resource center written policies and procedures shall assure that:

- Notification of grievances filed shall be provided to the Treatment Program Administrator, the Director of Quality Management, and the human rights committee.
- All allegations and rights violation allegations shall be immediately reported to the Superintendent or the Superintendent's designee.
- The Superintendent or the Superintendent's designee shall provide a monthly report of rights violations to the division administrator as outlined in the Reporting Requirements on Rights Data section of this policy.

Allegations of Abuse

Resource center written policies and procedures shall assure that:

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

Grievance Filing Process

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

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

Investigation Process

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

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

    If the complaint isn't resolved at this level, the findings shall be submitted to the treatment program administrator.
  - The Treatment Program Administrator. Within five business days of receipt of the grievance, the treatment program administrator shall meet with the individual filling the grievance. If the grievance cannot be resolved at this level, the findings shall be submitted to the human rights committee.
  - The Human Rights Committee. Within ten business days the committee shall complete its investigation and then within five business days shall develop recommendations for resolution and make a written report.

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

Employee Training and Education on Rights

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

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

Employees Trained on Human Rights

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

- All new employees,
- All volunteers, who will work regularly with individuals, and
- All contractors.

Continuing Education on Human Rights

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

- All employees;
- All volunteers, who work regularly with individuals; and
- All contractors.

General Training Policies on Human Rights

Resource center written policies and procedures shall assure that:

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

Policy on Clinical Care

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

Clinical Care Principles

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

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

Risk Management Principles

Resource center written policies and procedures shall assure that:

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

Risk Screening

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

Resource center risk factors include:

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

- Employment history,
- Criminal history,
- Child abuse history,
- Dependent adult abuse history,
- Inclusion on the federal list of excluded individuals and entities, and
- Inclusion on the Sex Offender Registry.

♦ Any person seeking employment or reinstatement to employment who has a record of founded child or dependent adult abuse or denial of critical care or has any conviction based on those offenses shall be denied employment unless:

- The person submits form 470-2310, *Record Check Evaluation*, for screening by the Department, and
- The Department determines that the person is employable.

♦ Any person seeking a personal services contract or seeking to volunteer regularly who has a record of a founded child, dependent adult abuse, or denial of critical care or has any conviction based on these offenses shall be denied the contract or the opportunity to volunteer.

♦ All personnel actions resulting from investigations shall follow state personnel policy and procedures.

♦ Any employee, volunteer, or contractor shall report within 24 hours or on the next scheduled business day any allegation or founding of abuse or being arrested for, charged with, or convicted of any felony or misdemeanor against the person arising from the person's actions outside the work place.

Employees shall make the report to the employee's direct-line supervisor, human resources supervisor or department head. Volunteers or contractors shall report to their facility contact person.

♦ When such a report is made, the employee, volunteer, or contractor shall complete form 470-2310, *Record Check Evaluation*, and the resource center shall submit the form for screening by the Department under Iowa Code section 218.13 to determine if the person continues to be employable.

♦ The resource center shall follow up on any information it receives that indicates that an employee, volunteer, or contractor has not reported any allegation or founding of abuse or arrest, charge, or conviction for any felony or misdemeanor.

Individual Safety

Resource center written policies and procedures shall assure that:

- The health and safety needs of an individual involved in an incident shall be an immediate priority.
- All employees, volunteers, and contractors shall take immediate steps to assure that an individual involved in an incident receives needed appropriate treatment and protection from further harm. Such actions shall include but are not limited to:
  - Providing first aid,
  - Calling for emergency medical services,
  - Removing the individual from an environment that threatens further harm,
  - Removing an aggressor from further contact with the individual,
  - Immediately removing a caretaker from contact with the individual when the caretaker has allegedly abused the individual and maintaining the separation until the Department of Inspections and Appeals (DIA) determines an investigation will not be completed, a DIA investigation has been completed and the abuse determination made, or
  - Any other appropriate action.
- The supervisor responding to the incident shall document the health and safety needs that the individual had because of the incident and the actions take in response to those identified needs.

Elopement

Resource center written policies and procedures shall assure that:

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

Employee Reporting Requirements

Resource center written policies and procedures shall assure that:

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

Reporting Requirements for Volunteers and Contractors

Resource Center written policies and procedures shall assure that:

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

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

Type 1 Incident Investigations

Resource center written policies and procedures shall assure that:

♦ Type 1 investigations shall be done for:

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

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

General Training Policies on Incidents

Resource center written policies and procedures shall assure that:

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

Policy on Transition and Discharge

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

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

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

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

Transition Principles

Resource center written policies and procedures shall assure that:

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

Notice of Discharge Planning

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

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

Discharge Planning

Resource center written policies and procedures shall assure that:

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

Physician Responsibilities

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

- For all deaths occurring in the resource center, a physician, physician assistant, or advanced registered nurse practitioner shall:
  - Pronounce death.
  - Provide immediate notice to the superintendent or administrator or the superintendent or administrator's designee.
  - Identify the body.
  - Care for the body and secure the death scene including any possible evidence related to the death pending instructions from the medical examiner.
  - Assure that the details and circumstances surrounding the death and the actions employees took in response to the death are documented, including but not limited to the facts used to establish death, the time of death, and apparent cause of death (in the physician's best professional judgment).
  - Certify cause of death and complete the death certificate as required in Iowa Code section 144.28 within 72 hours of receipt of the death certificate from the undertaker or other person responsible for filing the death certificate.
- For all deaths occurring outside the resource center, a physician, physician assistant, or advanced registered nurse practitioner shall contact the hospital where the death occurred or the physician attending the decedent at the time of death to:
  - Confirm date, time, and place of death.
  - Determine the apparent cause and circumstances of the death,
  - Determine if the death meets any of the reporting requirements in this policy,
  - Determine if the county medical examiner was notified of the death, and
  - Document the findings in the individual's facility record.

Nursing Responsibilities

Resource center written policies and procedures shall assure that:

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

Reporting Deaths

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

County Medical Examiner

See Employees' Manual 3-G, *General Facility Policies*.

Resource center written policies and procedures shall assure that for a death occurring in the facility, the body, clothing, and any articles upon or near the body shall not be disturbed or removed from the position in which they are found. Physical or biological evidence shall not be obtained or collected from the body without authorization of the county or state medical examiner. Exceptions may be made:

- For the purpose of preserving the body from loss or destruction, or
- To permit the passage of traffic on a highway, railroad, or airport, or
- If failure to immediately remove the body might endanger life, safety, or health.

Individual's Next of Kin

See Employees' Manual 3-G, *General Facility Policies*.

Department of Inspection and Appeals

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

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

Division Administrator

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

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

Involuntary Commitments

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

- The county board of supervisors of the county of commitment,
- The judge of the court that had jurisdiction over the commitment, and
- The designated regional administrator of the individual's county of residence.

Voluntary Admissions

Resource center written policies and procedures shall assure that for a death of an adult individual voluntarily admitted, notice shall be sent within three business days to the designated regional administrator for the individual's county of residence.

Disability Rights Iowa

Resource center written policies and procedures shall assure that:

- Written notification shall be provided to Disability Rights Iowa for all Conner class members within five business days of the death. The notice shall include the treatment team's summary of the death.
- A copy of the notice to the Disability Rights Iowa shall be provided to the resource center's facility liaison.
- Documentation of the notice shall be placed in the individual's facility record and shall include at a minimum the date and time the death was reported to the Disability Rights Iowa.

Independent Review

Resource center written policies and procedures shall assure that a request for a death review is submitted to the entity contracted to complete an independent review as soon as the individual's file contains the information needed for the review.

Autopsy

See Employees' Manual 3-G, *General Facility Policies*.

Seeking Next of Kin Authorization

See Employees' Manual 3-G, *General Facility Policies*.

Autopsy Reports

See Employees' Manual 3-G, *General Facility Policies*.

Property of Deceased Individual

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

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

Property of Small Value

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

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

No Administrator or Heirs

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

- The superintendent shall convert the decedent's property to cash. Upon doing so, the superintendent has the powers possessed by a general administrator of an estate.
- As soon as practicable after one year, the funds shall be transmitted to the treasurer of the state.

- The superintendent shall keep a permanent record of all funds transmitted to the treasurer that includes:
  - By whom and with whom the funds were left,
  - The amount of the funds,
  - The date of death of the owner,
  - The reputed place where the owner had lived before admission,
  - The date the funds were transmitted to the state treasurer, and
  - Any other facts that would identify the intestate and explain the case.
- A copy of the record shall be transmitted to the state treasurer.

Mortality Administrative Reviews

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

Type 1 Incident Investigation

Resource center written policies and procedures shall assure that:

- A Type 1 investigation shall be conducted of each death.
- The investigation shall review the events leading up to and surrounding the death.
- A report of the investigation shall be made using form 470-4366, *Type 1 Incident Investigation Report*. (See 3-B-Appendix for a sample and instructions.)
- A preliminary investigation and report shall be completed within five business days after the death and submitted to the superintendent and quality management director.
- A full investigation shall be completed within 15 business days after death incorporating the physician mortality review and the nursing peer review information, which are due within ten business days after the death.
- The full report shall be submitted to the superintendent and quality management director.
- If the investigation determines that abuse or neglect may have been involved, the policies and procedures for investigating and reporting abuse and neglect shall be followed.

Physician's Death Review

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

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

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

Nursing Peer Death Review

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

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

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

Mortality Review Committee

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

- The superintendent shall appoint, within five business days of the death, a morality review committee. The purpose of the committee shall be, as part of the resource centers quality improvement process, to:
  - Conduct a thorough review all of documentation and the circumstances of the death,
  - Assess the quality and appropriateness of the services provided to the individual,
  - Identify any concerns about the quality of services provided, and
  - Recommend opportunities for improvement of the policies, procedures, or service delivery system of the resource center with the goal of improved service delivery.

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

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

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

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

Professional Peer Review of Unexpected Death

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

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

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

Independent Physician Peer Review

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

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

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

Employee Training and Education on End of Life

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

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

Employees Trained on End of Life

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

Continuing Education on End of Life

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

General Training Policies on End of Life

Resource center written policies and procedures shall assure that:

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

Policy on Peer Review

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

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

Peer Review Principles

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

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

- Professional development occurs most readily in a strength-based environment that:
  - Is driven by recognized strengths and abilities of the individuals served as opposed to recognized deficits,
  - Fully utilizes and builds upon those strengths and abilities to meet personal and organizational goals, and
  - Emphasizes and encourages learning and responsibility.
- Properly implemented, peer review processes will result in integration and multidisciplinary learning through team building.

Peer Review Required

Resource center written policies and procedures shall assure that:

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

Peer Review Performance Improvement

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

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

Data Collection and Review

Resource center written policies and procedures shall assure that:

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

Staff Training and Education on Peer Review

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

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

Continuing Education on Peer Review

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

General Training Policies on Peer Review

Resource center written policies and procedures shall assure that:

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

Policy on Quality Management

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

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

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

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

Quality Management Principles

Resource center written policies and procedures shall assure that:

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

- The pursuit of "quality" has no final destination as it is fluid, changing with an ever-growing knowledge base.
- Employees operate through processes developed within a system. Therefore, to ensure positive change, systems and their processes must be thoroughly assessed and taken into account before employee performance is evaluated.

♦ All employees shall be committed to continuous improvement of care for each individual and are directly responsible for the quality of services provided to individuals served by the resource center.

♦ Leadership shall be committed to and foster multi-disciplinary teamwork including all employees working with individuals.

♦ Leadership shall understand and recognize the interdependence of allied health services and the skill base each brings to quality health care.

♦ Leadership shall utilize and build upon the strengths and abilities of each employee to meet personal and organizational goals.

♦ Leadership shall create a culture of continuous improvement and shall emphasize and encourage learning and responsibility.

Facility Leadership Responsibilities

Resource center written policies and procedures shall assure that:

♦ Facility leadership is knowledgeable of current best practice standards.

♦ Facility leadership is responsible for ensuring that facility practices are consistent with current standards of care for individuals with developmental disabilities.

♦ Facility leadership is committed to the institution of quality and shall foster this throughout the organization with all employees.

Structures and Process

Resource center written policies and procedures shall assure that:

♦ Structures and processes shall be established to implement quality improvement initiatives effectively.

♦ A quality council shall be established to oversee the quality assurance and performance improvement practices facility wide. The council shall meet no less than monthly.

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

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

Environment

Resource center written policies and procedures shall assure that:

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

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

Quality Performance Improvement

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

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

Quality Reporting Requirements

Resource center written policies and procedures shall assure that:

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

Employee Training and Education on Quality Management

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

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

Employees Trained on Quality Management

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

Continuing Education on Quality Management

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

General Training Policies on Quality Management

Resource center written policies and procedures shall assure that:

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