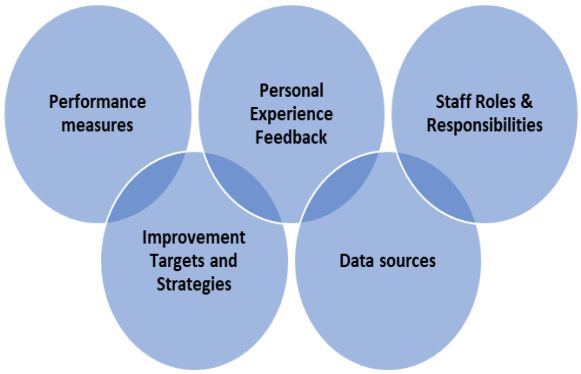
South Carolina Department of Disabilities & Special Needs
Quality Management Bulletin
March 2023

SCDDSN Revision to Administrative Agency Standards

The DDSN Administrative Agency Standards were revised, effective January 1, 2023. The revision includes a reorganization of the information and several new standards. Among those new standards, DDSN Qualified Providers must have a Quality Management Plan to include the following information:



- Performance measures.
- Performance improvement targets and strategies.
- Methods to obtain feedback relating to personal experience from individuals, staff persons and other affected parties.
- Data sources used to measure performance.
- Roles and responsibilities of the staff persons related to the practice of quality management.

The Agency shall revise the quality management plan no less than every three (3) years. A comprehensive quality management plan should draw ideas, standards, and measures from multiple sources and align with the Mission, Vision, Values, Principles, and Priorities of DDSN. Providers are encouraged to seek consultation and accreditation from nationally recognized leaders in the field.

Residential Reminders

- At no time should the maximum licensed occupancy of a residence be exceeded by persons receiving Residential Habilitation. CTH IIs, specifically, are licensed for no more than 4 residents. If the number of Residential Habilitation participants exceeds 4, then the DDSN license is not valid. DDSN does not have the authority to license settings for more than 4 residents. At that point, a CRCF license from DHEC must be obtained. If the setting does not have a current license, Residential Habilitation cannot be claimed. Waiver requirements for Residential Habilitation require the provision of services in an appropriately licensed setting.
- Visitors are permitted at residential settings and do not contribute to the setting's maximum licensed occupancy. Please keep in mind that Residential Habilitation should not be claimed for a "visitor."
- Each resident has an individual lease with the provider agency. The terms of the lease must be honored.
- Families should be kept apprised of the person's location, according to their preferences.
- With the transition of the ADT process to the Residential Needs Committee, the Key Indicator requirement within the provider's Contract Compliance Reviews will be deemed Non-Applicable. Alliant will not be requesting copies of ADT forms going forward.
- SLP I Assessments should be sent to the SComm box for Residential Needs Assessment as part of that team's review for placement.

Medication Technician Oversight Requirements

Provider Non-Compliance with Medication Technician Oversight Requirements is frequently cited during the current Administrative Compliance and Individual Service Reviews (Contract Compliance Reviews). Medication Technician Oversight is an important protection for participants in DDSN Contracted Day and Residential Service Settings. It is also a requirement to implement a Medication Technician Program.

Providers must review their Medication Technician Certification process and ensure oversight is provided as required. The following information is noted in DDSN Directive 603-13-DD: Medication Technician Certification:

A. Polices:

- Each facility operator utilizing Certified Medication Technicians shall have a written policy governing the provision of medications by Certified Medication Technicians. The policy shall specify activities that will be performed by Certified Medication Technicians, the process to review, monitor and oversee the work of the Certified Medication Technicians, the frequency of the activities to be performed, and by whom.
- Providers utilizing Certified Medication Technicians shall identify a health-care professional who will, as needed, answer questions posed by or provide directions to the Certified Medication Technicians. The health-care professional identified shall be a physician, pharmacist, or nurse. The process for contacting the healthcare professional shall be included in the Medication Administration policy.

B. Nursing Responsibilities: Review, oversight, and monitoring activities shall be conducted by an RN or an LPN under the supervision of an RN who has verified in writing that the LPN is capable of effectively conducting such activities.

These activities shall include:

- Teaching the 16-hour curriculum as an approved instructor.
- Conducting the annual two (2) hour refresher course.
- Review of medication records (medication administration records and medication error reports) on a regular basis.
- On-site, quarterly visits to a facility/setting in which Certified Medication Technicians are utilized.
- Conducting quarterly quality assurance consultation meeting and follow-up based on review of medication records, errors, and trends.
- Training and technical assistance based on the review of medication records, medication error reports, and when new medications or routes of medications are prescribed.
- Monitoring that may include observation of medication passes to ensure ongoing competence of the Certified Medication Technician.
- Review of consumer's ability to self-administer medications
- Providing and documenting one-on-one instruction to specific staff members for the administration of regularly scheduled insulin and prescribed anaphylactic treatments for individual consumers. Follow-up monitoring to occur at least every six (6) months.
- Rescinding medication technician certificates if it is determined that a Certified Medication Technician is no longer competent to safely provide medication to consumers.
- Ongoing efforts to ensure that Certified Medication Technicians only perform within the scope of the statutory authority and within their competency.

Providers must ensure the nurses providing oversight to the Medication Technicians perform each of the activities noted above. Providers shall maintain documentation with supporting evidence of the review, monitoring and/or oversight activities. The records should include the location, date, time of the activity, content covered, and the name of the RN, LPN, or other medical professional performing the activity.

Risk Management Committees

DDSN requirements for all service providers include a Risk Management Committee that meets on a ***quarterly*** basis to review data collection, training and monitoring activities, and the completion of tracking/trending/analysis.

I. The Risk Management Committee must review reporting requirements and track/trend/analyze **Allegations of Abuse, Neglect or Exploitation** on a quarterly basis using the following information:
   1. The total number of allegations made;
   2. The types of allegations, including a trend of when and where they were reported;
   3. The number of substantiated allegations, as determined by local law enforcement, SLED, DSS, or the Attorney General's Office;
   4. The number of Administrative Findings, as determined by verified Standard of Care allegations, through DSS or the State Long Term Care Ombudsman's Office or a Regional Ombudsman. A distinction should be made between allegations with known and unknown perpetrators and the types of violations cited (i.e., Administrative Oversight, Dignity & Respect, Supervision, etc.);
   5. The number of initial reports submitted in compliance with policy; and
   6. The number of final reports submitted in compliance with policy.

II. The Risk Management Committee must follow reporting requirements and track/trend/analyze **Critical Incidents and General Event Reports** on a quarterly basis using the following information:
   1. The type and frequency of incidents reported, including a trend of when and where they were reported, and ensuring the appropriate reporting category has been selected;
   2. The number of initial reports submitted in compliance with policy; and
   3. The number of final reports submitted in compliance with policy.

   With all types of Incident Management Reports, the Risk Management Committee may also include narrative information in order to identify more specific trends.

III. In addition to the Incident Management Reports, the Risk Management Committee must monitor reporting requirements and track/trend/analyze **Medication Errors/Events** on a quarterly basis using the definitions and procedures contained in DDSN Directive 100-29-DD: Medication Error/Event Reporting.

   Three (3) categories of errors/events will be analyzed:

   A. Medication errors;
   B. Transcription/documentation errors; and
   C. Red flag events.

   Providers are required to maintain a monthly medication error rate, per service location, to identify trends related to specific settings.

IV. The Risk Management Committee must monitor reporting requirements and track/trend/analyze the use of **restraints and/or other restrictive interventions** on a quarterly basis by reviewing documentation of each restraint employed, by type, to include the staff implementing the restraint, the duration of the restraint, notification provided to the Human Rights Committee, and notification provided to the Behavior Supports provider. When planned restraints are included in the Behavior Support Plans, the provider ensures the Behavior Support Plans are submitted to DDSN for approval.

   When restrictive interventions are employed as a default action because other measures in the Behavior Support Plan were not effective, the restraint/restrictive intervention must be reported as a Critical Incident. Consumer/staff injury resulting from the use of restraints must be tracked and analyzed. Narrative information may also be analyzed in order to identify more specific trends with a continual emphasis on restraint reduction and elimination. If there are no restraints or restrictive interventions reported for the prior review period, the provider must document their monitoring efforts to ensure unauthorized restraints were not implemented.

Mortality Reviews

Conducting mortality reviews is a component of the SCDDSN Incident Management Process that seeks to identify trends/patterns and help inform SCDDSN of areas that may need systemic quality improvement, such as managing chronic health conditions, preventing or mitigating adverse medical conditions, accessing appropriate healthcare services in a timely manner, and preventing injuries and death due to abuse and/or neglect.

The review is not investigative in nature. Rather, the purpose is to facilitate continuous quality improvement by gathering information to identify systemic issues to make system improvements and provide organizational learning opportunities.

Intended Outcomes for Mortality Reviews

- Identification of corrective actions that may eliminate or lessen the likelihood of circumstances and events that contribute to or are associated with the causes related to specific deaths.
- Identification of the immediate and longer-term circumstances and events that contributed to or were associated with deaths.
- Identification of trends and patterns in deaths that indicate needed systemic changes or reforms in community-based services that may reduce the risk of death and other adverse outcomes for service recipients.
- Appropriate and timely implementation of identified corrective actions and systemic changes and reforms to reduce the risk of death and other adverse outcomes for service recipients.
- Ongoing evaluation to ensure that implemented corrective actions and systemic changes or reforms have been effective in reducing the risk of death and other adverse outcomes for service recipients.
- Periodic public reporting on the number, causes, and circumstances of deaths to ensure public transparency regarding the health, welfare, and safety of beneficiaries of community-based services.
- Identification of service providers having a pattern of delayed or failed death reporting or of filing reports that are misleading or incomplete.

Mortality Review Recommendations

- Providers should review the person's need for increased supervision immediately following an acute care visit. We have a standard that requires follow-up within 24 hours, but depending on the issue, the person may need closer supervision due to an acute illness.
- Providers should ensure supervision levels are consistent in all documents related to persons supported.
- Staff may need training to ensure they are appropriately pacing their assistance with feeding participants altered diets.
- Within SLP I or SLP II Settings, roommates should know how/when to contact 911 in an emergency.

Incident Management Reporting

Please be sure staff are submitting Addenda to Incident Reports. As part of an end of year reconciliation effort, DDSN QM “cleaned up” about 150 records where providers did not submit an addendum. This included reports from the Ombudsman and 5 reports resulting in an arrest. Upon receipt of the Ombudsman’s closure letter, the provider must submit an addendum that indicates the correct disposition. Do not indicate “Case Closed” if there was a Standard of Care finding. The addendum with the finding should be submitted to the Ombudsman when sending any training records or other materials they may request in the closure letter. This process will be more clearly stated in an upcoming revision to the Directives.

A lot of reports are returned for additional information and clarification. There is a specific security role within the IMS for Executive Directors and/or their designees. When reports are submitted, the ED/designee must “Attest” (by use of their PIN as an electronic signature) they are submitting complete and correct reports. Please ensure the staff to whom you may have delegated this responsibility are fully reviewing the reports for content and clarity prior to submission.

Questions to Consider Prior to Submitting Incident Management Reports:

- ✓ Does the report list all residents and staff who were present at the time of the incident and/or may have knowledge of the incident?
- ✓ Were statements collected from all staff with direct knowledge of the event?
- ✓ Was a statement collected from the person receiving services?
- ✓ Was the family notified of the incident?
- ✓ Were the appropriate state agencies informed of the allegations?
- ✓ Was a statement collected from other residents that may have witnessed the event?
- ✓ Did staff participate in required OJT and/or annual training?
- ✓ When were staff last trained on the ANE/CI Policy?
- ✓ When were staff last trained on Resident Rights and dignity/respect issues?
- ✓ When were staff last trained in Crisis Mgmt?
- ✓ Are the Crisis Management techniques effective in redirecting the person’s behavior?
- ✓ Was a GER appropriately completed?
- ✓ Date of last BSP revision: Date of last observation by the Psychologist/plan author:

Stability Surveys for Calendar Year 2023

The South Carolina Department of Disabilities & Special Needs (DDSN) will participate in the annual Staff Stability Survey as a part of the National Core Indicators (NCI) for calendar year 2022. DDSN has partnered with National Association of State Directors of Developmental Disabilities Services (NASDDDS) and Human Services Research Institute (HSRI) for the past several years to administer the National Core Indicators (NCI) survey. This survey has provided DDSN with data about the strengths and weaknesses of our system and valuable information about our direct support workers.

Increasing attention has been paid to the role that the Direct Support Professional (DSP) workforce plays in the provision of supports for adults aged 18 and over with intellectual and developmental disabilities (ID/DD) and the staffing challenges of the past year. The Staff Stability Survey will give us reliable measures for the average length of DSP employment, number of DSPs employed by various types of agencies, vacant positions, wages, benefits and recruitment and retention strategies. The data gathered through this survey is very important as DDSN and the provider network in South Carolina continue to make progress in educating stakeholders about our workforce and the need to increase hourly wages. There is also a special section this year to assess the impact of the public health emergency of staffing availability.

Executive Directors for each agency providing direct services to adults have received an email from NCI with instructions on how to complete this survey using their online data entry system. Results of the survey will only be reported in the aggregate and your organization will not be identified in any way. The survey should be completed by your Human Resources or Payroll offices and reflect DSPs who were on the payroll during any period between January 1, 2022, and December 31, 2022. *This survey must be completed by June 30, 2023.*

DDSN is aware of the many competing interests for staff time and resources. We appreciate your time and feedback as we participate in this statewide survey.

National Core Indicators (NCI) In-Person Surveys

The National Core Indicators Project (NCI®) is a collaborative effort between the National Association of State Directors of Developmental Disabilities Services (NASDDDS) and the Human Services Research Institute (HSRI). The purpose of the program, which began in 1997, is to support NASDDDS member agencies to gather a standard set of performance and outcome measures that can be used to track their own performance over time, to compare results across states, and to establish national benchmarks.

DDSN will be participating in the National Core Indicators' In-Person Adult Surveys in 2023. DDSN is among 45 other states participating in this process Alliant staff will begin completing interviews in February 2023. In order for Alliant to conduct the in-person survey, a background survey must be completed prior to the visit from Alliant.

DDSN recognizes the thorough completion of the background survey can take time and there are many competing priorities. This year, as an incentive for participation, DDSN will reimburse providers for time spent completing valid surveys. The background surveys will be sent to the Case Management provider unless the person receives residential habilitation. In that case, the residential provider will receive the background survey. In either case, each provider staff will complete the surveys to the best of their abilities. Once all surveys are completed, the provider will submit an invoice to DDSN Quality Management for review and payment.

Each provider agency should expect to receive an approximate 5% sample for adults receiving at least one service in addition to case management. There will be maximum of 25 surveys for any one provider agency. The samples will be pulled and initial communications with providers will be sent in the coming weeks. Upon receipt of the provider sample, each organization will be asked to complete an initial interest survey by the deadline established. Participation interest responses will be required for each person in the sample.

If you have questions, please contact us at Qualitymanagement@ddsn.sc.gov.

DDSN QUALITY MANAGEMENT OVERSIGHT ACTIVITIES

DDSN employs a Quality Management system that includes the cycle of design, discovery, remediation, and improvement. Through its Risk Management and Quality Assurance/Quality Improvement processes, DDSN ensures that individual services are being implemented as planned and based on the needs of the person supported, compliance with contract and/or funding requirements, and implementation of best practices. In addition, the provider's administrative and operational capabilities are routinely reviewed to ensure compliance with DDSN standards, contracts, policies, and procedures.

Meeting service standards and employing qualified staff are basic expectations for service delivery. In addition, DDSN and its provider network have the responsibility to prevent, as much as possible, the occurrence of unfavorable events in the lives of people served. Examples of unfavorable events for people supported include the following: abuse, mistreatment, exploitation, critical incidents, accidents/injuries, medication errors, preventable illnesses, preventable restraints, and preventable deaths. It is very important that service providers have reliable systems for reporting, analyzing, and following up on unfavorable events for people supported. Each of these systems should be governed by policies and procedures and have sufficient resources at their disposal to assure that corrective actions are undertaken to prevent the reoccurrence of unfavorable events in the future. As additional oversight, DDSN has implemented Administrative Reviews, Material Deficiencies Notices, Corrective Action Plans, and Sanctions to prompt corrective actions necessary for quality improvement.

DDSN ADMINISTRATIVE REVIEWS

The DDSN Risk Management Division may conduct an Administrative Review of Incident Management Report(s) or conduct a review in response to significant concerns related to service delivery. The level of Administrative Review will be determined using the following criteria:

- Significant Injury: Incidents involving significant injury.
- Significant risk: Concerns resulting from the supervision and supports rendered being inconsistent with those outlined in the person's Plan.
- Multiple reports of unauthorized activities, gaps in oversight, or concerns regarding the physical condition of the service settings.
- Complaints and/or observations noted through OA/QI activities, or through contacts with, or contacts related to, the provider.
- Inconsistent documentation related to incident reports.
- A noticeable change in reporting trends.
- Upon the request of the provider agency or another state agency.

The Administrative Review is designed to ensure appropriate safeguards for DDSN service recipients and that compliance with DDSN Standards/Directives/policies is maintained.

POST-PAYMENT CLAIMS REVIEW

Performance Measures in the DDSN-operated HCBS Waivers require DDSN and DHHS to assure that services are provided in accordance with the service definitions and/or are supported by documentation of service delivery. To that end, DDSN will conduct Post Payment Claims Reviews (PPCR). The PPCR is used to verify that service authorized to a person was delivered by the provider on every date reimbursement for the service was sought. This Review will include a determination of whether:

1. The person was eligible for services at the time of the claim;
2. The service was authorized in the person's Case Management Plan;
3. The units of service align with the authorized units in the plan; and
4. There is sufficient documentation to support the service was delivered in accordance with the applicable service standards and service definitions. Supporting documentation will vary depending on the service delivered. Documentation may include, but is not limited to: evidence of training goal/objective implementation, evidence of implementation of supervision plan, service notes, T-Logs, evidence of recreation/leisure activities, behavior support data, meeting notes, medication administration records, medical appointment records, etc.

Provider agencies must have an established internal monitoring processes to ensure the integrity of the services provided meets the scope of the defined service(s), DDSN, and Medicaid requirements. The agencies must also have policies/procedures for documenting service delivery, consistent with the scope of the defined service(s), DDSN, and Medicaid requirements. Discrepancies found within the service documentation and actual service delivery will be reported to SCDHHS Program Integrity for further investigation.

MATERIAL DEFICIENCIES and CORRECTIVE ACTION PLANS

When providers fail to meet compliance through the typical remediation process, or when there are documented trends adversely affecting service delivery, a notice of material deficiencies will be issued. When such notice is issued, the provider must submit a Corrective Action Plan (CAP) to the Quality Management Division outlining the actions it will take to thoroughly remediate the areas of deficiency, including, but not limited to, updates in policy(ies), procedures, training(s) by appropriately-credentialed entities or individuals, and/or increased oversight by the agency management.

Criteria for issuing a Notice of Material Deficiencies may include, but are not limited to, the following:

- Incident Management Reports demonstrating a trend of significant injuries or staff actions/inactions that pose a risk to individuals supported;
- 86% (or below) compliance with timely submission of Incident Management Reports for two consecutive quarters;
- Two (2) or more Class I Deficiencies cited for any settings operated by the provider within a 12-month review period;
- 75% (or below) compliance with licensing requirements at two (2) or more settings operated by the provider within a 12-month review period. The compliance score will be determined by the final Report of Findings;
- 60% (or below) compliance with Staff Qualifications and Staff Training requirements as determined through the appropriate review tool for a service (e.g., Contract Compliance or Licensing Reviews). The compliance score will be determined by the final Report of Findings;
- 60% (or below) compliance with service specific requirements as determined through the Contract Compliance Review for a service (e.g., Day Service, Residential Habilitation, Early Intervention, etc.). The compliance score will be determined by the final Report of Findings;
- Evidence of systemic non-compliance in maintaining service delivery documentation to support claims for services rendered; and/or
- Evidence of systemic non-compliance in monitoring participant funds and personal property.

DDSN will specify requirements for a CAP, but will not provide its content.
Each provider will be expected to rely upon or develop their internal capacities to reach compliance.

The CAP must identify, with specificity, each of the following elements:

- The dates by which each component will be completed;
- Specific topics and goals of any staff trainings;
- The credentials and experience of the person/entity conducting any staff training that were basis for selection;
- What policies, procedures, or practices will be amended and how; and
- The strategies to be employed to ensure the actions identified in the CAP are implemented and effective to both correct the problem noted and prevent reoccurrence.

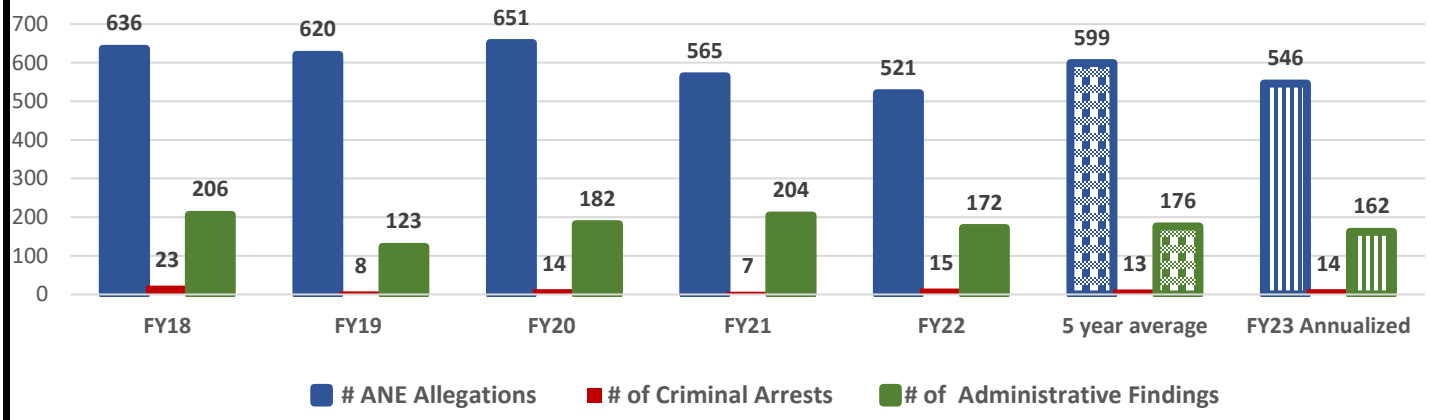
Upon receipt of a CAP, DDSN will accept or reject elements of the proposed CAP or the plan in its entirety. In the event of a rejection, the provider shall be required to resubmit a revised CAP. Upon acceptance of the CAP, the provider shall implement the corrective action plan and submit to DDSN an update of progress toward CAP fulfillment every 90 days. If actions from the CAP are not completed by the date specified in the plan, sanctions may be applied.

SCDDSN Incident Management Report 5-year trend data

for Community-Based Services *(Includes Residential & Day Service Settings) Thru 12/31/2022*

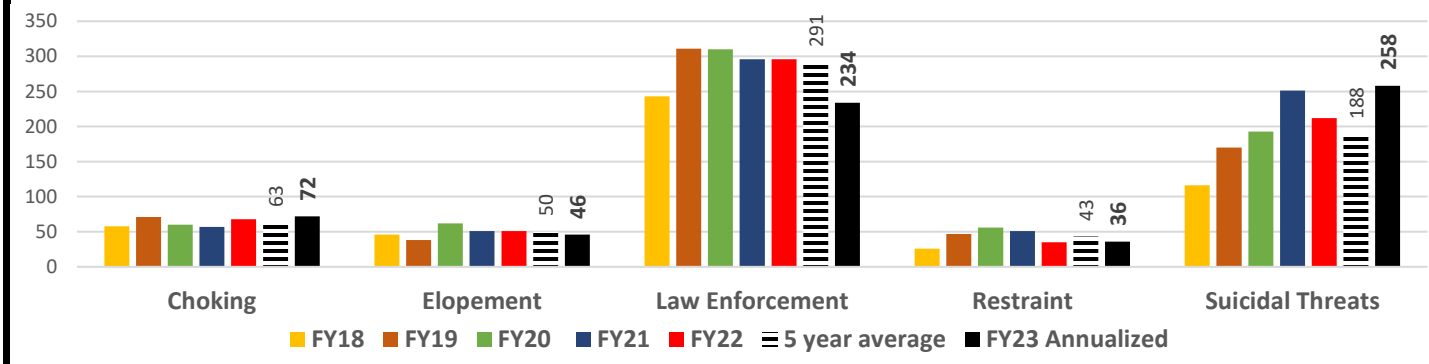
Allegations of Abuse, Neglect, Exploitation	FY18	FY19	FY20	FY21	FY22	5 YEAR Average	FY23 Annualized (Thru Q2)
# of Individual ANE Allegations	636	620	651	565	543	**599**	596 (298)
# of ANE Incident Reports (One report may involve multiple allegations)	450	415	436	388	389	**416**	414 (207)
Rate per 100	11.9	9.6	11.8	10.9	9.3	**10.7**	10.7
# ANE Allegations resulting in Criminal Arrest	23	8	14	7	15	**13**	14 (7)
# ANE Allegations with Administrative Findings from DSS or State Long-Term Care Ombudsman	206	123	182	204	172	**176**	162 (81)

ANE Allegations: Comparison to Arrest Data & Administrative Findings



Critical Incident Reporting	FY18	FY19	FY20	FY21	FY22	5 YEAR Average	FY23 Annualized (Thru Q2)
# Critical Incidents	1071	916	982	974	1245	**1037**	1146 (573)
Rate per 100	11.9	9.6	11.8	10.9	15.4	**11.9**	15.2
# Choking Events	58	71	65	57	68	**64**	72 (36)
# Law Enforcement Calls	243	311	310	296	296	**291**	234 (117)
# Suicidal Threats	116	170	193	251	212	**188**	258 (129)
# Emergency Restraints or Restraints w/ Injury	26	47	56	51	35	**43**	36 (18)

5 Year Critical Incident Trend Report- Community Settings



Death Reporting	FY18	FY19	FY20	FY21	FY22	5 YEAR Average	FY23 Annualized (Thru Q2)
# of Deaths Reported- Community Settings	73	78	86	130	102	**94**	104 (52)
Rate per 100	1.6	1.6	1.9	2.8	2.2	**2.0**	2.2

Data collected 2/10/2023