DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)

Children's Licensed Staffed Residential Quality Assurance Assessment

DATE	VISIT TYPE (ANNUAL OR BY REQUEST)	DDA REVIEWER'S NAME
DCYF / LD REGIONAL LICENSOR'S NAME		REGIONAL LICENSOR'S TELEPHONE NUMBER

Assessor should obtain information below from regional Voluntary Placement Services (VPS) Coordinator and Resource Manager prior to conducting QA assessment. See DDA MB D18-014.

LICENSED STAFFED RESIDENTIAL AGENCY		HOUSE NAME		
AGENCY / PROGRAM ADMINISTRATOR NAME		HOUSE / PROGRAM MANAGER NAME		
MAILING ADDRESS		MAILING ADDRESS		
CITY STATE ZIP CODE		CITY STATE ZIP CODE		
TELEPHONE NUMBER	FAX NUMBER	TELEPHONE NUMBER		
CURRENT VALID LICENSE ☐ Yes ☐ No	TOTAL LICENSED CAPACITY	RESPITE CONTRACT ☐ Yes ☐ No	RESPITE CAPACITY	

INDIVIDUALS RESIDING IN THE HOME	AGENCY PROVIDING OVERSIGHT (DDA / DCYF)	SOCIAL WORKER	DATE OF BIRTH	STAFFING RATIO (PER CLIENT RATE ASSESSMENT)

PREVIOUS VISIT DATE	TYPE OF PREVIOUS VISIT (ANNUAL OR BY REQUEST)

Supervisor current issues / concerns

Assessor to consult with regional Voluntary Placement Services (VPS) Coordinator, Resource Manager, and/or Social Workers prior to conducting QA assessment. If home has DDA residents from other regions, a conference call should be scheduled with the other region. See DDA MB D18-014.

Have there been any Licensing Division (LD) compliance agreements since the last QA assessment?

Are there any concerns regarding the level of supervision per current rate and staffing schedule?

Are there concerns regarding community inclusion activities (such as variety, type, and frequency)?

Are there concerns regarding family participation (as identified in the Shared Parenting Plan)?

Is the client receiving therapeutic skill development (teaching and training with ADL's, etc.)?

Is the VPS Social Worker / SSS receiving timely and thorough reports and communication from the provider?

Are there concerns regarding any unmet health care needs (such as ABA, mental health, neurology, etc.)?

Home's Physical Appearance	Yes (date verified)	No (not located or incomplete	N/A	Comments (provide specific information on "No" and "N/A" responses only)
WAC 110-145-1555 Home address clearly visible on facility or mailbox	☐	☐	☐	
WAC 110-145-1555 Exterior in good repair	☐	☐	☐	
WAC 110-145-1555 Yard / lawn maintained	☐	☐	☐	
WAC 110-145-1555 Interior clean and in sanitary condition	☐	☐	☐	
Best Practice Requires Evidence that program reflects client's interests, family involvement, and personal connections.	☐	☐	☐	
Safety Observations	**Yes (date verified)**	**No (not located or incomplete**	**N/A**	**Comments (provide specific information on "No" and "N/A" responses only)**
WAC 110-145-1555 Exit doors easily accessible from inside	☐	☐	☐	
WAC 110-145-1555 Exits unblocked and obstacles are not placed in corridors, aisles, doorways, etc.	☐	☐	☐	
WAC 110-145-1555 Windows operational and no pull-cords present	☐	☐	☐	
WAC 110-145-1580 Cleaning supplies, toxic substances, aerosols, and items with warning labels are inaccessible and properly stored as appropriate	☐	☐	☐	
WAC 110-145-1560 Secure / adequate grab bars, soap and clean towels present in all bathrooms	☐	☐	☐	
WAC 110-145-1850 Prescription and over the counter medications locked	☐	☐	☐	
WAC 110-145-1685 Documentation of monthly emergency preparedness plan (monthly safety checks, fire drills, smoke alarms and carbon monoxide alarms)	☐	☐	☐	
WAC 110-145-1675 and WAC 110-145-1680 Smoke and carbon monoxide alarms located in or near bedrooms and on each level of facility	☐	☐	☐	
WAC 110-145-1690 Serviced and accessible fire extinguisher on each level of the multilevel facility	☐	☐	☐	

WAC 110-145-1585 Running water must not exceed 120° as tested with a thermometer during time of QA assessment	☐	☐	☐	
WAC 110-145-1555 Emergency phone numbers including facility physical address and poison control number are posted near a working landline telephone	☐	☐	☐	
WAC 110-145-1640 First Aid supplies including protective non-latex gloves, bandages, scissors, ace bandages, gauze and non-breakable and mercury free thermometer	☐	☐	☐	
WAC 110-145-1670 Written emergency plan, including action to be taken following a natural disaster or emergency	☐	☐	☐	

Household Observations	Yes (date verified)	No (not located or incomplete	N/A	Comments (provide specific information on “No” and “N/A” responses only)
WAC 110-145-1790 Variety, type, amount of food sufficient (including menus / snacks available)	☐	☐	☐	

Client Records: Document either Yes (include date met) or No if not located or incomplete.				
Client Name				
Best Practice Requires Applied Behavior Analysis (ABA) Behavior Intervention Plan or Functional Analysis (FA) and Positive Behavior Support Plans (PBSP).				
Best Practice Requires Documentation of progress towards obtaining client’s habilitative goals				
Best Practice Requires Staff can identify the client’s challenging behaviors and intervention strategies based upon behavior support plan?				
Best Practice Requires Documentation that data collection and monitoring of behavior support goals is occurring every 30 days				
WAC 110-145-1520 Current Individual Education Plan (IEP)				
Chapter 388-826 WAC Does the child have a Representative Payee?				
Chapter 388-826-0041 WAC Current Shared Parenting Plan or Shared Planning form for clients age 18 and older				

Chapter 388-826-0071 WAC Submitted quarterly reports to DDA regarding client's care timely				
Chapter 388-826-0071 WAC Documentation of weekly parent involvement				
DDA Policy 6.12 Documentation of Incident Reports including notification to DDA, parents, etc.				
Chapter 388-826-0071 WAC Accounting of monthly Community inclusion activities of client choice and dates				
WAC 110-145-1520 Individual property inventory available and updated annually				
WAC 388-845-3055 Current signed DDA Person Centered Service Plan				
Medical / Dental: Document either Yes (include date verified) or No if not located or incomplete.				
Client Name				
DDA Policy 6.19 Medical / Dental Log (includes reason for visit along with date of annual medical and dental exam)				
Best Practice Requires Clients are supported with medical and dental services, follow up appointments, including emergent needs, without delay				
WAC 110-145-1855 Medication Log / MAR available (Includes client's name, time and dosage of medication)				
WAC 110-145-1865 Medications (including PRN's) given as prescribed (MAR initialed by staff, documentation of missed / refused medication)				
Best Practice Requires Medication refusals are documented on MAR and addressed in a behavior plan if appropriate				
DDA Policy 5.19 Psychoactive medications have an information sheet; including those prescribed as PRNs.				
Best Practices Requires Review past three (3) months of MARs Does the MAR match current meds available?				

WAC 110-145-1800 Modified diet approved by PCP annually				
WAC 110-148-1860 PRN medication protocol available				
WAC 110-145-1520 Seizure record if applicable				
DDA Policy 6.15 Nurse Delegation documentation for clients age 18-20 who require assistance with medication administration				
Best Practice Requires Clients appear clean, with weather appropriate clothing, hair brushed, etc.				
Bedrooms: Document either Yes (include date verified) or No if not located or incomplete.				
Client Name				
WAC 110-145-1625 Any video or audio monitoring in the interior of the facility include required documentation				
Best Practices Required Bedrooms are person centered				
DDA Policy 5.20 Approved use of bedside bed rails if applicable; policy components present				
WAC 110-148-0155 Home clean and free of unpleasant odors				

Meaningful Activities	Yes (date verified)	No (not located or incomplete	N/A	Comments (provide specific information on "No" and "N/A" responses only)
WAC 110-145-1735 Documentation of an activity program that includes variety of age-related and client specific activities to integrate each client in the community?	☐	☐	☐	

Out of the past seven (7) full calendar days, how many days has the client left their home (defined as going beyond their yard, regardless of where and with whom)?

Client Name	Days 1 through 7							Total Days	If client did not access the community five or more days; what was the primary barrier?	
	☐	☐	☐	☐	☐	☐	☐		☐ Transportation unavailable ☐ Lack of interest ☐ Behavioral issues	☐ Staffing ☐ Physical issues ☐ Other
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	☐	☐	☐	☐	☐	☐	☐		☐ Transportation unavailable ☐ Lack of interest ☐ Behavioral issues	☐ Staffing ☐ Physical issues ☐ Other

Other (if “Other” checked above, explain):

Observations: Briefly discuss interactions that were observed during the visit including client’s appearance, staff engagement, teaching and training strategies, skill development, medication administration, etc.

Client name:

Comments:

Client name:

Comments:

Client name:

Comments:

Client name:

Comments:

Interviews: Conduct a random sample of a minimum of two direct care staff (staff present during the time of the visit), two clients (if able, dependent on the household size), and two parents or family members

Direct Care Staff Interview

Staff Name:

How long have you worked here?

What kind of training have you had in the following areas:

- Supervising youth:
- Behavior Support / Restraints:
- Medical Emergencies:
- Treatment area (youth who are sexually aggressive, suicidal, or have a developmental disability, etc.):
- Mandatory Reporting (completed annually):

What does it mean to be a mandatory reporter?

Do you know how to report incidents of abuse, neglect, exploitation or abandonment of a child / youth (i.e. directly to CPS and law enforcement)?

Do you know the timeline for reporting suspected incidents (i.e., **immediately but within 48 hours** if related to sexual or physical abuse, neglect or exploitation, etc.; **as soon as possible but within 48-hours to DDA** if related to suicidal / homicidal behavior, medication error, emergency medical care, etc.)?

What are some significant support needs you face here at work (challenging behaviors / medical issues)? How do you typically respond to them?

Do you think there is an adequate number of staff to provide supervision?

Does your agency provide you the support and training you need to do this job?

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Client Interview: Assessor should indicate if the client is able to participate in the interview. Mark "N/A" if client is unable to do so.

Client Name:

What chores do you do on a regular basis? What new skills are you learning?

What activities do you like to participate in during the week? What activities do you like to do on the weekends?

What happens when you get into trouble? What are the consequences?

If you needed help, who would you go to?

Do you go to the store with staff to pick out things you want?

Do you have a DDA Social Worker? What is your Social Worker's name?

Client Name:

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Parent / Family: Assessor to contact parents/family of child/youth receiving VPS only to get feedback on current issues, questions or concerns pertaining to services to their child/youth)

Parent Name:

How long has your child been living at this residence?
How do you stay in touch with your child?
How often have you visited and when did you last visit?

Do you have any health and safety concerns regarding your child's residence? ☐ Yes ☐ No; if "Yes," what are your concerns?

Do you think your child receives adequate supervision? ☐ Yes ☐ No; if "No," what are your concerns?

Has your child ever expressed having problems at the home, with staff or other residents? ☐ Yes ☐ No
If yes, how were the concerns addressed and resolved?

Do you feel your child's medical needs are being met? ☐ Yes ☐ No; if "No," what are your concerns?

Do you feel your child's educational needs are being met? ☐ Yes ☐ No; if "No," what are your concerns?

Have you been included in the IEP conferences? ☐ Yes ☐ No

Do you feel your child's behavioral needs are appropriately supported? ☐ Yes ☐ No; if "No," what are your concerns?

Is there anything else you would like me to know?

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Do you think your child receives adequate supervision? ☐ Yes ☐ No; if "No," what are your concerns?

Has your child ever expressed having problems at the home, with staff or other residents? ☐ Yes ☐ No
If yes, how were the concerns addressed and resolved?

Do you feel your child's medical needs are being met? ☐ Yes ☐ No; if "No," what are your concerns?

Do you feel your child's educational needs are being met? ☐ Yes ☐ No; if "No," what are your concerns?

Have you been included in the IEP conferences? ☐ Yes ☐ No

Do you feel your child's behavioral needs are appropriately supported? ☐ Yes ☐ No; if "No," what are your concerns?

Is there anything else you would like me to know?

Corrections, Consultations, and Follow-Up
Summary of corrective actions requiring provider follow-up.