

## Children's State Operated Living Alternatives (SOLA) Quality Assurance Assessment



DATE	VISIT TYPE (ANNUAL OR BY REQUEST)	DDA REVIEWER'S NAME	
Assessor should obtain information below from regional Voluntary Placement Services (VPS) Coordinator and resource manager prior to conducting Quality Assurance (QA) assessment.			
HOME NAME			
MAILING ADDRESS		CITY	STATE ZIP CODE
TELEPHONE NUMBER (INCLUDE AREA CODE)		NUMBER OF CURRENT RESIDENTS	
<b>*ASTERISK THOSE RESIDENTS PRESENT DURING VISIT</b>			
INDIVIDUALS RESIDING IN THE HOME		SOCIAL WORKER	DATE OF BIRTH
PREVIOUS VISIT DATE		TYPE OF PREVIOUS VISIT (ANNUAL OR BY REQUEST)	
<b>Supervisor current issues / concerns</b>			
<p><b>(Assessor to consult with regional VPS Coordinator, Resource Manager, and assigned Social Worker prior to the QA assessment. If home has DDA residents from other regions a conference call should be scheduled with other region.</b></p> <p>Are there concerns regarding community inclusion activities (such as variety, type, and frequency)?</p> <p>Are there concerns regarding family participation (as identified in the Shared Parenting Plan)?</p> <p>Is the client receiving therapeutic skill development (teaching and training with ADL's, etc.)?</p> <p>Is the VPS Social Worker / Social Service Specialist (SSS) receiving timely and thorough reports and communication from the program?</p> <p>Are there concerns regarding any unmet health care needs (such as ABA, mental health, neurology, etc.)?</p> <p>Additional Comments:</p>			

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

<a href="#">WAC 110-145-1585</a> Running water must not exceed 120° as tested with a thermometer during time of QA assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<a href="#">WAC 110-145-1555</a> Emergency phone numbers including home physical address and poison control number are posted near a working landline telephone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<a href="#">WAC 110-145-1640</a> First Aid supplies including protective non-latex gloves, bandages, scissors, ace bandages, gauze and non-breakable and mercury free thermometer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<a href="#">WAC 110-145-1670</a> Written emergency plan, including action to be taken following a natural disaster or emergency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Household Observations</b>	<b>Yes (date verified)</b>	<b>No (not located or incomplete)</b>	<b>N / A</b>	<b>Comments</b>
<a href="#">WAC 110-145-1790</a> Variety, type, amount of food sufficient (including menus / snacks available)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Client Records: Document either Yes (include date verified) or No if not located or incomplete.</b>				
Client Name				
<b><u>Best Practice Requires</u></b> Applied Behavior Analysis (ABA) Behavior Intervention Plan or Functional Analysis (FA) and Positive Behavior Support Plans (PBSP).				
<b><u>Best Practice Requires</u></b> Documentation of progress towards obtaining client's habilitative goals				
<b><u>Best Practice Requires</u></b> Staff can identify the client's challenging behaviors and intervention strategies based upon the behavior support plan				
<b><u>Best Practice Requires</u></b> Documentation that data collection and monitoring of behavior support goals is occurring every 30 days				
<a href="#">WAC 110-145-1520</a> Current Individual Education Plan (IEP)				
<a href="#">Chapter 388-826 WAC</a> Does the child have a Representative Payee?				
<a href="#">Chapter 388-826-0041 WAC</a> Current Shared Parenting Plan or Shared Planning form for clients age 18 and older				
<b><u>Best Practice Requires</u></b> Submitted reports to DDA quarterly regarding client's care timely				
<a href="#">Chapter 388-826-0071 WAC</a> Documentation of weekly parent involvement				

<b><u>DDA Policy 6.12</u></b> Documentation of Incident Reports including notification to DDA, parents, etc.			
<b><u>Chapter 388-826-0071 WAC</u></b> Accounting of monthly Community inclusion activities of client choice and dates			
<b><u>WAC 110-145-1520</u></b> Individual property inventory available and updated annually			
<b><u>WAC 388-845-3055</u></b> Current signed DDA / Person Centered Service Plan			
<b>Medical / Dental: Document either Yes (include date verified) or No if not located or incomplete.</b>			
Client Name			
<b><u>DDA Policy 6.19</u></b> Medical / Dental Log (includes reason for visit along with dates of annual medical and dental exam)			
<b><u>Best Practice Requires</u></b> Clients are supported with medical and dental services, follow up appointments, including emergent needs, without delay			
<b><u>WAC 110-145-1855</u></b> Medication Log / MAR available (Includes client's name, time and dosage of medication)			
<b><u>WAC 110-145-1865</u></b> Medications (including PRN's) given as prescribed (initialed by staff, documentation of missed / refused medications)			
<b><u>Best Practice Requires</u></b> Medication refusals are documented on MAR and addressed in a behavior plan if appropriate			
<b><u>DDA Policy 5.19</u></b> Psychoactive medications have an information sheet; including medications prescribed as PRNs.			
<b><u>Best Practices Requires</u></b> Review past three (3) months of MARs Does the MAR match current meds available?			
<b><u>WAC 110-145-1800</u></b> Modified diet approved by PCP annually			
<b><u>WAC 110-148-1860</u></b> PRN medication protocol available			
<b><u>WAC 110-145-1520</u></b> Seizure record if applicable			
<b><u>DDA Policy 6.15</u></b> Nurse Delegation documentation for clients age 18-20 who require assistance with medication administration			

<b>Best Practice Requires</b> Clients appear clean, with weather appropriate clothing, hair brushed, etc.									
<b>Bedrooms: Document either Yes (include date verified) or No if not located or incomplete.</b>									
Client Name									
<b>WAC 110-145-1625</b> Any video or audio monitoring in the interior of the facility include required documentation									
<b>Best Practices Required</b> Bedrooms are person centered									
<b>DDA Policy 5.20</b> Approved use of bedside rails if applicable; policy components present									
<b>WAC 110-148-0155</b> Home clean and free of unpleasant odors									
<b>Meaningful Activities</b>	<b>Yes (date verified)</b>	<b>No (not located or incomplete)</b>	<b>N / A</b>	<b>Comments</b>					
<b>WAC 110-145-1735</b> Documentation of an activity program that includes variety of age-related and client specific activities to integrate each client in the community?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
<b>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)?</b>									
<b>Client Name</b>	<b>Days 1 through 7</b>						<b>Total Days</b>	<b>If client did not access the community five or more days; what was the primary barrier?</b>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Transportation unavailable <input type="checkbox"/> Lack of interest <input type="checkbox"/> Behavioral issues	<input type="checkbox"/> Staffing <input type="checkbox"/> Physical issues <input type="checkbox"/> Other
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Transportation unavailable <input type="checkbox"/> Lack of interest <input type="checkbox"/> Behavioral issues	<input type="checkbox"/> Staffing <input type="checkbox"/> Physical issues <input type="checkbox"/> Other
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<b>Observations: Briefly discuss interactions that were observed during the time of the visit including client's appearance, teaching and training techniques, skill development, medication administration, etc.</b>									
Client name:									
Comments:									
Client name:									
Comments:									
Client name:									
Comments:									

**Interviews: Should conduct a random sample of a minimum of two staff (those present during the time of the visit) and two clients (if able), dependent on the household size, and two parents or family members.**

**Attendant Counselor Staff Interview**

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):

Have you seen the mandatory reporting video?  Yes  No

Have you had to use a physical intervention technique or a “quiet room”? Can you describe what happened?

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?

Have you ever made a CPS referral? What happened?

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

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.):
  
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Have you seen the mandatory reporting video?  Yes  No

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

Have you ever made a CPS referral? What happened?

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

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

Name of client:

What chores do you do on a regular basis?

What activities do you like to participate in during the week? What activities do you like to do on 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 and pick out your own food?

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

Name of client:

What chores do you do on a regular basis?

What activities do you like to participate in during the week? What activities do you like to do on 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 and pick out your own food?

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

**Parent Interview**

**(Assessor to contact parents of clients residing in the home. Content should provide feedback on current issues, questions or concerns pertaining to the care and supports for their child).**

Name of parent:

How long has your child been living at this residence?

Do you have any health and safety concerns regarding your child's residence?

How do you stay in touch with your child?

How often have you visited and when did you last visit?

Do you think your child receives adequate supervision?  Yes  No

If not, what are your concerns?

Has your child ever expressed to you any problems in regards to the residential home?  Yes  No

If yes, provide explanation including how the concerns were addressed and resolved.

Do you feel your child's medical needs are being met?

Do you feel your child's educational needs are being met? Have you been included in the IEP conferences?

Do you feel your child's behavioral needs are appropriately managed?

Is there anything else you would like me to know?

Name of parent:

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How do you stay in touch with your child?

How often have you visited and when did you last visit?

Do you think your child receives adequate supervision?  Yes  No

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Do you feel your child's educational needs are being met? Have you been included in the IEP conferences?

Do you feel your child's behavioral needs are appropriately managed?

Is there anything else you would like me to know?

### **Corrections, Consultations, and Follow-Up**

Summary of corrective actions requiring provider follow-up.