DUET POLICY AND PROCEDURES
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ESTABLISHING DUET POLICY

Procedure Effective Date: 8/18
Supersedes Procedure Number: 131 (12/06)

Duet staff, individuals, legal representatives, or other stakeholders who wish to propose specific policies, request that policies be established in certain areas, or request changes in present policies, shall follow the procedures outlined below.

A. New proposals or proposed changes shall be presented in writing to the Policy Committee. The Policy Committee will review the proposal and determine if further action is warranted.

B. The Duet Director and Area/Division Directors are responsible for disseminating the proposal to staff and obtaining input, if applicable.

C. The Policy Committee will make changes considering input received. A revised draft is submitted to the Duet Director.

D. Upon recommendation by the Duet Director, the proposed policy may be presented to the Agency attorney for a review and for legal opinion. If the Agency attorney objects to a proposed policy, he/she shall furnish a written opinion incorporating suggestions as to the alternatives open to the agency to allow the intent of the policy to be carried out.

E. The proposed policy is presented to the Governing Board by the Duet Director.

F. Every policy receives Governing Board approval prior to implementation.

G. Once a policy has been adopted by the Governing Board, it will be added to the Duet Policy and Procedures Manual and a summary of changed disseminated to Duet employees.

H. If a proposed policy is rejected at any step of the process, the initial proposer may appeal to the next step higher in the process.

I. The Duet Director has the authority to make procedural changes without Board approval.

J. Duet policies and procedures are available upon request to individuals, families, advocates, and employees; and are available in all agency owned and leased settings.

DUET COMMITTEES

Procedure Effective Date: 12/20
Supersedes Procedure Number: 121 (3/19)

Duet committees meet routinely to review and discuss agency policies and procedures intended to carry out the mission of Duet. Each of the committees may form subcommittees for a specific or immediate resolution of an issue. Meeting minutes for each of the following committees are kept on file.

Human and Legal Rights Committee (HLRC). The committee shall approve, conditionally approve, or not approve, Restrictive Devices, Psychotropic Medications, restrictions, and accessibility plans. If the committee concludes that follow-up is needed (conditionally approve or not approve), these problems will be documented in the minutes. To review incidents and issues relating to the rights of persons supported by reviewing Therap General Event Reports, investigations of alleged abuse/neglect, and issues that may infringe on rights. The Committee provides feedback and recommendations on rights issues, and input on policies and procedures concerning human and legal rights. Committee members shall have an interest in the rights of persons with developmental disabilities, the ability to remain objective, and the ability to maintain confidentiality.

Advisory Committee. The Advisory committee will be kept informed of Duet's proposed strategic plans and will discuss these before they are presented to the Governing Board. The committee will make suggestions and review any proposed policy or procedure changes. The committee will meet a minimum of twice per year and will consist of a minimum of two persons with a developmental disability, two family members/guardian of persons with a developmental disability, and two members of the community at large.

Policy Committee. The Policy Committee's purpose is to review and revise existing policies and procedures and to develop new policies in order to better carry out the mission of Duet. The committee also monitors the adequacy and uniformity of documentation and record keeping of supports provided. Committee composition consists of individuals with a broad range of experience and representing a cross-section of services/departments within Duet, including administration, quality assurance, day services, residential services and support services.

Safety Committee. Each Area in Duet has a standing committee which examines safety issues and makes recommendations for follow-up and corrective or preventative action. The Safety Committee(s) solicits ideas and concerns about safety and attempts to promote and foster a high level of awareness throughout the Area.

PUBLIC EDUCATION AND INFORMATION POLICY

Procedure Effective Date: 5/16
Supersedes Procedure Number: 130 (3/95)

Duet will provide an information system designed to facilitate the social integration and acceptance in the community. A description of the methods to implement the community education program will be in the form of a Community Education Plan. The plan is to include a description of the methods to ensure protection of every individual's privacy when included in community education occurrences. The Community Education Plan will describe methods and activities for encouraging community interaction and a method for disseminating information to the media. A record of Community Education activities will be maintained.

Approved by Duet Director

Duet Director

August 12, 2020

Date

Approved by ENHSA Governing Board

ENHSA Governing Board Chair

August 12, 2020

Date

DUET PUBLIC EDUCATION AND INFORMATION PLAN

Procedure Effective Date: 8/18
Supersedes Procedure Number: 131 (8/14)

Community Education

Objective: To increase the public's understanding of persons with intellectual disabilities and their families to:

1. Facilitate social integration and acceptance of persons supported.
2. Provide the public with information about Duet's mission, programs, strategic plan, and personnel.
3. Communicate effectively and regularly with Duet employees and others who have an interest in the agency.

Targeted groups for Duet Public Education & Information (PEI):

- Individuals
- Parents
- Professionals
- State Officials
- Media
- Advocacy Committees
- Employees
- Service Providers
- Regional Officials
- Elected Officials
- Educators
- Volunteers/Students

Internal Communications

Objective: To communicate relevant information to Duet employees and other interested parties.

Methods:

1. The Duet Website - The website (http://www.Duetne.org) is updated on an ongoing basis. Information on the website includes but is not limited to: facts about support options, a list of agency contacts, Duet's Notice of Privacy Practice, complaint form, current job openings, and Duet Policies and Procedures.

2. Leadership/Staff Meetings - Meetings will be held with various levels. Leadership meetings are held to review referrals, intake, movement, and planning and to discuss relevant agency business.

Media and External Communications

Objective: To create a positive public image and understanding of Duet by providing information about services.

Methods:

1. Media Contacts - Media contacts will be informed about agency activities. Informative reporting of Duet activities increases awareness and promotes a positive image.

2. Tours – Anyone who is interested in knowing more about Duet is invited to visit our locations, meet our employees and learn about services offered.

3. Crisis Management - Dissemination of information to the public or news media in the event of a crisis is consistent with the public's right and need to know, and subject to the individual's right to privacy and confidentiality. The Duet Director and/or the Deputy Director will be responsible for release of information about the crisis incident to the public and news media. There shall be guided agency policies on confidentiality and release of information. All other employees shall not provide information about a crisis incident to the public or news media, an employee will refer the inquiry to the Duet Director or Deputy Director.

4. Public Appearances - Speaking before groups is an opportunity to provide information about Duet. The Agency Director will ensure the Agency is represented by the most qualified speaker(s) depending on the topic and expectations of the request or the event.

5. Special Events - Special Events are intended to attract media attention and/or raise funds for a particular purpose. These events could include open houses, picnics, holiday celebrations and recognition of accomplishments.

6. Fair/Show Participation - Representation at job fairs, health fairs, trade shows, medical exhibits, industrial and other events are ways to increase visibility and a sense of community for both Duet and the sponsoring organizations.

7. Community Activities – Individuals will be provided opportunities and information to facilitate participation in community activities.

General Communications

A. Informative Materials - Duet will have brochures, displays, organization chart, mission statement, strategic plan, and materials available for distribution to promote a broader understanding of Duet's structure, functions and services.

B. Communication Requests - All communication requests with media representatives (e.g., radio, TV, newspaper, speaker) and all public relations requests are to be coordinated with a designated representative.

C. Confidentiality/HIPAA Security and Privacy – Confidentiality of persons involved in Duet programs will be protected by HIPAA policy and procedures.

D. Supervision of Volunteers/Students – Duet will encourage participation of volunteers and practicum students when requested. Requests will be coordinated with a designated representative to identify the most appropriate volunteer/practicum site. If the agency agrees to placement, each student or volunteer will have a criminal background check, a CPS/APS Central Registry check, and other training relevant to duties assigned. The student or volunteer will be assigned an agency supervisor who will oversee volunteer activities. Volunteers/practicum students will not work alone.

EMPLOYEE TRAINING AND CONTINUING EDUCATION POLICY

Procedure Effective Date:
1/19 Supersedes Policy
Number: 140 (8/18)

Duet training classes provide employees with the opportunities to gain the knowledge and skills necessary to fulfill their position objectives and the agency mission, thus facilitating growth and development. Also offered is continuing educational opportunities including three (3) hours per year of higher education from a certified university, college, or community college for courses. In order to be eligible for educational reimbursement, the employee must pursue coursework that is related to employment or satisfies an academic or elective requirement for a job-related degree (Refer to ENHSA Human Resources Policy #4.40[a]).

Approved by Duet Director

Duet Director

August 12, 2020
Date

Approved by ENHSA Governing Board

ENHSA Governing Board Chair

August 12, 2020
Date

PROCEDURES FOR EMPLOYEE TRAINING

Procedure Effective Date: 4/19
Supersedes Procedure Number: 141 (8/18)

Staff Training Plan

The Agency will periodically assess staff training needs, gathering input from individuals/legal representatives, supervisors and direct support professionals using a variety of methods and an agency training plan will be developed. Existing training will then be evaluated and modified as indicated by the Staff Development Coordinator.

Staff Training Participation

A. The agency produces an annual training calendar that identifies required agency training. In addition, employees are periodically notified of ongoing training opportunities.

B. Staff registered to attend training are required to attend. Failure to attend and notify the supervisor of non-attendance will be considered a “no call, no show” and staff will be assessed attendance points. Staff should notify their supervisor or the area administrative assistant if they are unable to attend.

C. Attendance and verification of competency are recorded by the class instructor. Copies are scanned and sent to each area/division and training information is added to the staff training record.

D. Staff are required to be attentive and conduct themselves appropriately during training sessions. Staff are expected to dress in attire that is appropriate for the class. Failure to cooperate (e.g., disruptive behavior, cheating, phone usage, sleeping) may result in expulsion from the session and disciplinary action. Employees must be on time for training or they may not be admitted to class.

Competency

All Duet staff are required to demonstrate competency in core areas by passing a test over the subject matter in specific areas within established time frames. Staff will not be allowed to perform certain duties (writing programs, providing medications, providing first aid) if they have not received either on-the-job or formal training or demonstrated competency. Trainers are required to have the education, training and/or expertise to train staff.

Mandatory Training

All employees will complete requirements in the following areas according to the time frame presented:

A. New Employee Orientation
   a. Pre-Employment Orientation
   b. Support, Encourage, Empower
      - Defining, Recognizing and Reporting Abuse, Neglect and Exploitation

- Universal Language
- Core Values
- Effective Communication
- National Alliance for DSPs Code of Ethics
- Rights of Persons Receiving Services
- Introduction to Positive Behavior Supports and Challenging Behavior
- Habilitation, Socialization and Age-Appropriateness
- Use of Adaptive and Augmentative Devices
- Dignity, Choice and Respectful Interactions

c. Lifting and Transferring
   - Skill Demonstration with PT

d. Online Lezage Training within two weeks of orientation:
   - Bloodborne Pathogens
   - Back Safety
   - HIPAA: What Employees Should Know
   - HIPAA: Your Obligations Under the Privacy Rule
   - 15-Passenger Van Safety (if applicable; must be completed prior to driving an Agency van)
   - 15-Passenger Van Safety (if applicable; must be completed prior to driving a vehicle for Agency business)

e. Employee Acknowledges the Following Forms:
   - Eastern Nebraska Human Services Agency Confidentiality Agreement
   - Duet Security Agreement
   - Hepatitis B Vaccine Acceptance/Declination

f. Policies/Procedures Review
   - Employee Shared Electronic Device User Guidelines
   - Employee Education about False Claims and the Deficit Reduction Act of 2005
   - HIPAA Privacy Policy
   - HIPAA Privacy Procedure
   - Duet Bloodborne Pathogens Exposure Control Plan

B. Within the First 30 Days of Employment or Before Working Alone
   a. Centralized on the Job Training (OJT)
      - Inclusion
      - Water Temperature
      - Procedures for Responding to Life Threatening Situations (#412)
      - Visitors
      - Choice

- Relationships
- No Smoking Policy
- ISP/Programs

b. Online Lezage Training
- Emergency Preparedness for Healthcare Workers (including Fire Safety)
- Your Guide to PPE (Personal Protective Equipment)
- Hazard Communication-GHS and Your Right to Know
- Hazard Communication-Understanding Chemical Labels on GHS

c. Person-Specific Training
- Individual medical Protocols (including the use of adaptive and augmentative communication devices)
- Safety Protocols (including safety plans and approved emergency safety intervention techniques)
- Other Person-Specific Information
- Setting Specific Information

d. Formal Training
- Medication Aide (if providing medications)
- Standard First Aid
- CPR

C. Within 180 Days of Hire

a. On Site Training
- ISP Policy & Procedure (#310-311)
- Individual Programs
- Injury Prevention Plan (day services only)

b. Formal Training
- 15 Passenger Van Training (if driving Agency vans)
- Verbal Intervention and Personal Safety
- Personal Funds
- Using the Support Model

Supervisory Training

Information is disseminated regarding supervisory training opportunities as they become available. In addition, supervisory training is to be completed as offered.

Elective/Assigned/Ongoing Training

In addition to the mandatory training outlined above, other training will be regularly offered by the Agency or made available from other sources. It is the responsibility of every staff and

supervisor to identify individual training needs beyond the mandatory requirements that could contribute to improved performance and the potential for promotion. It is the supervisor's responsibility to require attendance/completion of designated training sessions on an individual basis to meet individual and situational needs. Sessions may include but are not limited to the following:

- FBA
- BSP/Safety Plans

Successful Completion of Training

Staff will be expected to successfully complete training. If necessary, remedial efforts may be initiated. If the employee does not successfully complete required training, that person's employment status will be reviewed, a recommendation for termination of employment may result.

Return of Employees

Employees who have left the agency and returned in good standing will receive credit for previous training competency unless job performance warrants additional training. The only exception is Medication Aide Training. If more than one year has passed since employment and the employee has a current MA certificate, the employee will be required to attend the three-day Medication Aide class prior to giving medications.

Training Records/Credentials

Employee training records are maintained in Therap. All training records are confidential and only designated personnel have access to them. Training records will include:

- Topic
- Date of training and competency
- Name of instructor

PERSONAL FUNDS POLICY

Policy Effective Date: 8/18
Supersedes Policy Number: 150 (7/17)

The purpose of Duet's policy and procedures regarding the management of personal funds is:

1. To provide for as much independence in money management as possible

2. To provide, when Agency support is necessary, a system to document financial transactions and protect the financial interests of the individuals served by Duet

All individuals whose individual funds are accessible to Duet staff, shall have those funds accounted for as specified in the Duet Personal Funds Procedures. Individuals for whom Duet is payee or are responsible for financial transactions are required to cooperate with the Duet Personal Funds Procedures for 1) record keeping, 2) bank accounts, 3) programs related to increasing skills in the area of money management.

Individuals should be involved in all aspects of managing their personal funds, with support from staff, as needed. This includes planning for purchases, buying household and personal items, counting funds and reconciling accounts, and banking. Staff should not engage in any activities involving an individual's personal funds without the individual being present and fully participating in the process.

Approved by Duet Director

Duet Director

August 12, 2020

Date

Approved by ENHSA Governing Board

ENHSA Governing Board Chair

August 12, 2020

Date

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PROCEDURES FOR PERSONAL FUNDS

Procedure Effective Date: 3/2020
Supersedes Procedure Number: 151 (8/18)

Persons supported by Duet are to be responsible for the management of their own funds to the greatest extent possible, according to the person's skills related to money management (within any restrictions placed on them by benefit sources or the courts). Assessment of the individual's skills to manage their own money is to be done by members of the ISP team. The ISP team will determine the level of responsibility to be assumed by the agency for funds. Whenever an individual lacks the ability to manage their own money, opportunities are to be provided for the acquisition of the skills needed.

All personal funds which are managed by Duet are:

- Managed through individual checking and/or saving accounts
- Recorded in detail in Therap
- Supported by detailed receipts, cancelled checks and bank statements
- Filed by individual
- Routinely monitored by managers and coordinators
- Routinely audited by Agency Auditor
- Kept confidential under lock and key for protection against loss

When funds are managed by Duet, a fiduciary relationship shall exist between Duet and the person. The person remains the owner of the funds.

Duet assumes responsibility to provide a financial system to safeguard and monitor all personal funds to which employees have access. When Duet is payee, Duet assumes total responsibility for funds. With the informed choice of the individual, Duet will offer services and supports that temporarily transfer some of the control of handling the individual’s financial resources to Duet. The transfer of control of an individual’s financial resources:

- Must not be for the convenience of staff, or as a substitute for habilitation
- Must be temporary
- Must be based on the choice of the person and the extent to which the person can participate
- Must not be transferred to another entity and the person must not be charged for the service

Duet assumes responsibility in the degree as defined below:

Level I: Use Therap to document ALL transactions for people who have no opportunity or skills to use their money without staff assistance. The person may not have a check card issued on their account.

Level II: Use Therap for people who can develop skills to use their money without staff assistance (receives spending money, bill paying, etc.). The person may have a check card issued in their name on their account, however, the ATM feature on the card must be disabled by the bank.

Level III: Use Level III Financial Report Form for those who have the skills and opportunities to handle their money without assistance but require staff assistance with their financial reconciliations and/or budgeting. The individual may have a check card issued in their name; they control the features allowed on their card. Duet is not payee for Social Security benefits.

Level IV: Person Handles Own Funds. Person has complete control of their funds. Duet is not payee for Social Security benefits; Duet is not involved.

The ISP team will determine the level of responsibility based on the skill level of the person. This should be reviewed at every ISP meeting and documented in the ISP narrative.

When Duet is involved in the management of personal funds, the priority for expending those funds is to meet the basic living expenses of food, shelter, clothing and personal spending. Personal funds shall only be used to pay for goods and services appropriate to the person, desired by the person or charged to the person by the Agency for expenses incurred with ISP team approval. Goods or materials purchased with personal funds are the property of the person.

Prior approval must be obtained by the person, parents (if minor), legal representative and/or the ISP team for use in the following:

- Repair or replacement of damaged/destroyed property (considered on an incident by incident basis)
- Purchases exceeding $100

Approval should be documented in the ISP or in Therap.

Modifications to a home owned, operated or leased by the Agency to accommodate a person's disability are the responsibility of the Agency. If modifications must be made to a rental property, Duet policy should support attempts to negotiate such changes at the landlord's expense or support movement to an accessible setting as appropriate. If the person is the lessee, they may choose to pay for modifications using personal funds. A record must be kept documenting these expenditures, and the modifications must follow the lessee when and if they move, as allowed by law. Modifications to settings owned or leased by the agency are the agency's responsibility and should not be purchased with personal funds.

All persons will receive assistance in identifying, applying for and obtaining benefits they are eligible for.

Duet will accept payeeship for all benefits of people supported residentially unless the parent or legal representative prefers to maintain payeeship. If the parent or legal representative does not

provide for room and board or personal need expenses, the Agency will seek to obtain payeeship. The ISP team may determine the person can handle their own funds.

Employees of Duet will not be payee for any person's benefits.

Abuse of Personal Funds:

Any funds not in the interest of the person constitutes abuse of funds. This may include theft (even small amounts), fraud, embezzlement, property theft, expenditures for staff benefits, expenditures inappropriate to the person, 'borrowing' a person's funds or failure to keep accurate records.

In the event of suspected abuse of personal funds by a Duet employee, an investigation will be conducted by the Agency investigation team. The employee may be relieved of duty during the investigation. If appropriate, alleged infractions will be reported to the appropriate legal authorities. Duet investigations will take place independent of any outside investigation unless information from the external investigation is essential to complete Duet's investigation.

If, after investigation, the evidence supports the alleged abuse of funds, the employee will be disciplined according to ENHSA Human Resource Policy. Theft of funds, if proven, will always result in dismissal.

If a person's funds have been abused by a Duet employee, the person will be reimbursed in the following order:

1. The perpetrator will be required to repay the amount
2. Court action to recover funds will be initiated
3. If recovery isn't achieved within a reasonable time period, Duet will reimburse the person

If an employee absconds with personal funds or property, they may be subject to criminal prosecution charges and could be liable in a civil action.

In the event of abuse of funds by a person other than an employee, the case will be referred to the appropriate legal authorities.

GENERAL INSTRUCTIONS FOR COMPLETING FINANCIAL ENTRIES (Rev. 3/2020)

Therap should be used to document all financial records for an individual.

Therap entries should always be done the day the transaction was completed

If a late entry is necessary, document reason in ‘Comments’

Receipts should be scanned and added to corresponding transaction within 45 days

The person who made or assisted with the transaction must be the one to enter it in Therap

If entering a transaction on behalf of someone else state reason in ‘Comments’

Balanced bank statements need to be scanned and added to Therap monthly, both sides should be visible to show reconciliation has been completed; include any check images

If a mistake is made, the incorrect entry needs to be adjusted with a remark stating reason for adjustment

Cash counts should also be entered in Therap

Forms not required for every location:

Shared Expense Form: completed monthly

All Duet financial forms are to be completed in blue or black ink. (Avoid use of felt tip pens).

Any expenditure $5.00 and over requires a receipt, if no receipt is available a GER must be completed explaining the purchase and reason for no receipt.

Entries in Therap are to be exact. Do not round off.

Each purchase entry should include merchant/vendor and if applicable, a brief explanation of the purchase.

Each transaction needs a separate entry in Therap.

For deposits, provide a detailed description of each item deposited when more than one check is deposited together. All sources of income should be direct deposited when possible and must be shown as individual entries by source in Therap. Staff should use a create a separate entry for each deposit.

To correct an error in Therap, the supervisor will need to update the incorrect entry with an explanation for the correction.

STORAGE (Rev. 4/12)

Financial documents are confidential in nature and will be stored in compliance with the following guidelines:

- Financial documents are kept in a secure location
- Checkbooks, check cards, cash, bank statements and any other piece of financial information must be kept under lock and key
- All documents must be stored for six years from the date of the internal audit
- At the end of the six-year storage period, the financial documents are to be offered to the person and/or parents and/or legal representative
- If nobody wants the records, they are to be destroyed confidentially

Copies of financial records will be provided to the person, legal representative, and/or their fiscal representative as requested, but **at least quarterly**. If the supported person or their fiscal representative does not want quarterly financial information, this must be documented.

CASH ON HAND GUIDELINES (Rev. 3/2020)

To assure accuracy of cash transactions:

The maximum recommended amount of cash on hand to be kept for an individual in an agency-paid setting is $75.00. The maximum amount of cash on hand to be kept for an individual in a shared living placement is $75.00. The only exception would be for a planned major cash purchase which has been approved by the individual and the legal representative (if applicable) and appropriate supervisory staff. A rationale shall be recorded with the cash count entry that records a cash on hand deposit that puts the amount of cash on hand over the $75.00 limit to substantiate the exception.

A. If supported persons are responsible for their own expenses, the $75.00 limit does not apply.

B. Money is to be kept separately for each person and maintained under lock and key.

C. Supported persons will not loan money to employees. Employees **will not** borrow money from supported person. Employees are discouraged from loaning money to supported persons.

D. Employees will not loan one person's money to another person.

E. Generally, supported persons do not pay for employee expenses. Certain employee expenses may be paid for with personal funds with prior approval of the ISP team and documented in the ISP.

F. For a person needing Level II support, the frequency and amount of spending money given to the individual will be approved by the residential supervisor and the ISP team. The person will initial along with the staff for the cash they received. Normally, a receipt will not be required from the person.

G. Unplanned Expenditures in Agency Pay Settings - In agency-pay settings, unplanned expenses should be handled according to purchasing procedures. If urgency does not allow employees to go through the regular purchasing process, with supervisory approval, employees will purchase the necessary item and request reimbursement through petty cash.

H. If money is provided to a parent, legal representative, the day setting or respite/relief provider, employees must obtain a signed receipt showing the amount, date and to whom the money was provided.

CASH COUNT FREQUENCY (Rev. 3/2020)

A. Homes with 24-hour support:

1. For each transaction, a new cash balance is required. The cash counted by staff will be recorded in Therap. An entry in Therap verifies that the actual cash matches the recorded balance.
2. Cash on hand is counted by employees every day and recorded in Therap. An entry in Therap verifies the actual cash matches the recorded balance
3. Cash on hand is counted in recorded in Therap at least weekly by a supervisor.

B. Supported Settings (Homes with less than 24-hour staff support):

1. Cash-on-hand is counted every time money is used/handled. For each cash transaction, a new cash balance is required. The cash counted by staff after each time it is used/handled will be recorded in Therap. An entry in Therap verifies that the actual cash matches the recorded balance.
2. Cash-on-hand is counted once each day that a staff is present and at the home and recorded in Therap.
3. Cash-on-hand is counted and recorded in Therap at least twice monthly by the supervisor.

C. Shared Living Providers:

1. Cash-on-hand is counted every time money is used/handled. For each transaction, a new cash balance is required. The cash counted by staff after each time it is used/handled will be recorded in Therap. An entry in Therap or verifies that the actual cash matches the recorded balance.
2. Cash-on-hand is counted and recorded in Therap by the Shared Living Provider daily.
3. Cash-on-hand is counted and recorded in Therap by the supervisor quarterly during home visits.

D. Day Service and Respite:

1. Cash-on-hand is counted every time money is used/handled for respite. For each transaction, a new cash balance is required. The cash counted by staff after each time it is used/handled will be recorded in Therap. An entry in Therap verifies that the actual cash matches the recorded balance.
2. Cash-on-hand is counted daily for day services, if there is cash on hand. For each transaction, a new cash balance is required. The cash counted by staff after each time it is used/handled will be recorded in Therap. An entry in Therap verifies that the actual cash matches the recorded balance.

RECEIPTS (Rev. 12/14)

To ensure complete documentation of financial transactions, receipts must be maintained according to the following guidelines:

A. Receipts must include:
   1. Name of vendor
   2. Correct date of purchase
   3. Exact amount of purchase
   4. Item(s) purchased

B. Type of Receipts:
   1. Receipts must be obtained for EVERY purchase/expense greater than or equal to $5.00 (includes meals/entertainment). Receipts from sources that do not typically issue receipts are exempt from this requirement (e.g., landlords, utilities, street vendors, etc.) If a receipt is missing, a GER is to be completed. As part of the follow-up, the supervisor will verify that the transaction or purchase was made and note this on the GER.
   2. Supervisor may require receipts on amounts less than $5.00.
   3. If there is a shared receipt for a purchase of more than $5.00, the uploaded receipt is to be attached to the person's financial record in Therap. Individual receipts are encouraged whenever possible.

C. Receipts are to be scanned and uploaded to the corresponding transaction line in Therap. After the supervisor has completed review, the original receipts along with any applicable banking documentation is to be stored by individual in a secure location.

D. Amount on the receipts must exactly match the amount entered in Therap (the only exception being if the receipt is for a shared expense or the individual did not buy all the items listed on the receipt).

E. Receipts will be obtained from banking transactions and uploaded to corresponding entry in Therap.

F. Check stubs will be treated as and stored with receipts. Direct Deposit is to be used whenever possible, however, when not a direct deposit, the deposit receipt from the bank should be attached to the pay stub and scanned into Therap.

G. The bank statement may serve as a receipt for transactions utilizing automatic payments.

GENERAL GUIDELINES FOR BANK ACCOUNTS (TRANSACTIONS AND RECORDING) (Rev. 3/2020)

A. Coordinators must authorize all signers through the format established with the banking institution.

B. In situations where Duet is payee, the bank accounts must be titled in a manner that recognizes this relationship. Two recommended titles are:
   a. (Person's Name) by Duet, Representative Payee
   b. Duet, Representative Payee for (Person's Name)

C. Unless approved by a supervisor, new employees have completed their probationary period and Personal Funds training before becoming a signer on a person's account.

D. All signers must complete required documents at the banking institution.

E. Online banking for purposes of transferring money or bill paying is prohibited (this is different from automatic payment options for bill paying, which is allowed).

F. Online monitoring of accounts may be allowed under the following conditions:
   a. The banking institution but must disable any function that allows money transfers, online bill pay etc.
   b. Only viewing account information is allowed
   c. The chain of command can view account information

G. Check cards will only be issued in the name of the person.

H. ATMs will not be used without ISP team approval. Check cards must have the ATM function disabled.

I. Check cards will not be used to receive cash back from any transaction

J. Check cards will only be issued to those with approval from ISP team and proper documentation explaining the person may need assistance to use the check card.

K. The ISP team should document if the person needs a daily limit and determine the amount. The bank will be contacted to put the limit on the account.

L. Only the Coordinator or Area Director may change the daily limit.

M. In the event of a lost card, the bank will be notified, a new card must be ordered.

N. In the event of unauthorized use of a card, the bank, APS and law enforcement must be notified immediately upon discovery.

O. A Therap GER must be completed for unauthorized use of the card or if the card was lost or stolen.

P. Security codes on the back of a card should be secured in the area office then blacked out

Q. All purchases will be process as ‘credit’ with the person signing for the transaction

R. Paychecks, benefit checks and personal needs checks are to be deposited in their entirety for Level I and Level II only (cash back from a deposit is prohibited)

S. Bank accounts are to be reconciled with the bank statement monthly

T. Service charged an interest are to be recorded in Therap during reconciliation

U. Bank statements must be provided for all accounts

CHECKING AND SAVINGS ACCOUNTS (Rev. 3/2020)

A. Checking Accounts
   a. Checks should not be written out to an employee without supervisory approval. Reason should be noted in the 'Comments' section of Therap.
   b. Checks must be written for the exact amount of purchase
   c. Utilize 'memo' line to note what check was written for
   d. Direct Deposit must be used whenever possible

B. Checking Account Records
   a. All transactions are to be entered in Therap and the checkbook register
   b. When linking checking accounts to an individual in Therap the title of the account should include the cost center
   c. The check number, date, merchant, and amount should be recorded in Therap and checkbook register, if necessary, a brief description of the purchase should be included
   d. All transactions are to be recorded the day they occur, if not, a comment must be made to explain reason for late entry
   e. Automatic payments/withdrawals are to be treated the same as a check
   f. Images of cancelled checks and cancelled checks are to be scanned into Therap along with bank statement
   g. Voided checks are to be stored with receipts and bank statements

C. Savings Accounts
   a. Savings accounts with monthly statements are recommended
   b. Balances, withdrawals and deposits should be documented in Therap
   c. When linking savings accounts to an individual in Therap the title of the account should include the cost center

D. Account Reconciliation
   a. Supervisors are to reconcile bank accounts monthly
   b. All transactions on the bank statement should be recorded in Therap as well as the checkbook register
   c. Ensure all interest deposits, bank fees, service charges etc. are recorded
   d. Follow instructions on back of bank statement to reconcile
   e. Bank statement should be scanned into Therap (originals stored with receipts)
   f. Accounts are to be reconciled to the penny, if any discrepancies occur a GER is to be completed

DISCREPANCIES (Rev. 3/2020)

A. Any time a discrepancy is noted, the supervisor must be notified.

B. A Therap GER (low notification) must be written for the following (attach a copy of the GER to the appropriate transaction):
   a. More than $5.00 discrepancy in cash on hand
   b. Lost income check or paycheck
   c. Check written then lost
   d. Overdrawn account (no fraudulent activity)
   e. Missing receipt for expenditure over $5.00

C. A Therap GER (high notification) is to be written for the following:
   a. Overdrawn account (fraudulent activity)
   b. Altered amount on check
   c. Unauthorized check cashing
   d. Unauthorized use of check card
   e. Any other serious issues that may constitute financial exploitation or theft should be reported to the chain of command, law enforcement, CPS/APS

D. Financial Exploitation can be but is not limited to the following:
   a. Cashing checks without permission/authority
   b. Misusing Power of Attorney/Durable Power of Attorney
   c. ATM withdrawals inconsistent with the person's use/ability
   d. Unpaid bills with adequate income
   e. Bank accounts overdrawn with adequate income

E. In the event of missing cash, the supervisor will attempt to determine who is responsible for reimbursing the person. In cases where it is not possible to determine responsibility, the Agency will reimburse the person. Supervisory review will be completed when the missing cash is more than $5.00.

F. If an employee loses a card or is responsible for an overdrawn account, the Agency will reimburse the person for any fees

MONTHLY REVIEW (Rev. 1/19)

A. Supervisors complete a monthly review of the person's Finance Accounts on Therap in addition to other financial documents.

B. During the monthly review, supervisors should verify that:
   a. Transactions are recorded correctly
   b. Deposits were made within timelines
   c. Required receipts are present
   d. Receipt descriptions and amounts match entry
   e. Bank accounts were reconciled correctly to statements
   f. Adjusting and late entries have an explanation
   g. Purchases exceeding $100 have proper approval
   h. Shared Expense Report filled out (if applicable)

C. Supervisor is responsible for notifying the team for the following circumstances:
   a. Prior to the depletion of funds
   b. Prior to accrual of account balance that may affect eligibility for benefits
   c. Prior to purchases exceeding $100

MONITORING (Rev. 4/19)

A supervisor must complete routine monitoring of money and financial transactions.

a. In Therap, a supervisor must use the Audit/Reconciliation option; document in 'Comments' section that review was completed

Supervisor should complete a cash count weekly

If the account has online monitoring, the supervisor should also periodically check the online account, especially for those accounts with check cards.

Supervisor should check for the following:

b. Accurate amounts entered
c. Necessary receipts present
d. Proper notification for expenditures exceeding $100
e. Accurate balances/cash on hand amounts
f. Expenditures are appropriate for the person
g. All required fields completed
h. All money and financial information stored per person in a secure location

Bank statements are mandatory. If a bank statement is missing the supervisor is to contact the bank for a current balance and request a copy of the bank statement. If online banking is enabled the supervisor should print current bank statement.

When the Manager and Coordinator has completed review of all finances in Therap, the Agency Auditor must be notified via email to complete their review.

Coordinators will use Audit/Reconciliation option in Therap and document in 'Comments' section that review was completed

Coordinators must ensure Managers are completing reviews and follow up with any needed issues.

If a location does not have a Manager, the Coordinator will assume all Manager responsibilities.

INTERNAL AUDITING (Rev. 3/2020)

A. The Individual Funds Auditor will be notified by the coordinator when a financial review has been completed for the caseload. If there is paper documentation, financial records will be submitted by the Coordinator to the Individual Funds Auditor upon completion each month.

B. The audits will be one additional month in arrears.

C. When the financial records are submitted, they should be organized by area caseload

D. It is important that the bank statements are submitted. In the case of shared expenses, a Shared Expense form must be completed with the receipts attached. The shared expense receipts should be with the form and not with the individual's financial records.

E. Specific audit procedures will be developed and maintained by the Administrative Services Director. The Auditor will prepare a report on each financial record reviewed.

REIMBURSEMENT FOR EMPLOYEE MEALS (Rev. 10/17)

In 24-hour residential settings where supported persons purchase their own food, the Agency will reimburse for employee meals (employees are to provide their own snacks). Each month, a check will be provided to cover the cost of the employee meals for that month. The amount of the check will be based on the number of employee meals for the month times the meal rate. Receipt of these funds will be maintained in the financial system and appear on the shared expense form.

Annually, the Agency will determine the per-meal rate based on a sampling average method. The rate will be determined by dividing the total monthly amount spent on food at the sample locations by the number of meals for a three-month period.

DAMAGED OR MISSING PROPERTY (Rev. 4/12)

Duet will evaluate on a case-by-case basis who is responsible for replacement or compensation when a person's personal items are missing or damaged. When necessary, the ISP team will evaluate whether it is appropriate for a supported person to make restitution. The ISP will serve as the written informed consent by the individual and/or his or her legal representative

FALSE CLAIMS AND THE DEFICIT REDUCTION ACT OF 2005

Policy Effective Date: 8/18
Supersedes Policy Number: (12/11)

To comply with the Deficit Reduction Act of 2005, Duet provides the following information to employees about certain federal and state laws regarding the prevention and detection offraud, waste and abuse in federally funded services.

To comply with the Deficit Reduction Act of 2005, Duet provides the following information to employees about certain federal and state laws regarding the prevention and detection offraud, waste and abuse in federally funded services.

I. **The Federal False Claims Act** imposes liability on any person who:
- Knowingly presents, or causes to be presented, a false or fraudulent claim, record or statement for payment or approval
- Conspires to defraud Medicare, Medicaid or any other federally funded health care service by getting a false or fraudulent claim paid
- Uses a false record or statement to avoid or decrease an obligation to payMedicare, Medicaid or any other federally funded health care service
- Commits other fraudulent acts enumerated in the statute

"Knowingly" means:
- Has actual knowledge that the information on the claim is false;
- Acts in deliberate ignorance of whether the claim is true or false; or
- Acts in reckless disregard of the truth or falsity of the information.

An individual or entity found liable under the False Claims Act is subject to civil money penalties of between $5,500 and $11,000 per claim plus three times the amount of damages that the government sustained because of the illegal act.

II. **The Program Fraud Civil Remedies Act** is a statute that establishes an administrative remedy against any person who presents or causes to be presented a claim or written statement that the person knows or has reason to know is false, fictitious or fraudulent due to an assertion or omission to certain federal agencies. A violation of this section of the Program Fraud Civil Remedies Act is punishable by a $5,000 civil penalty for each wrongfully filed claim, plus an assessment of twice the amount of any unlawful claim that has been paid. In addition, a person or entity violates the Program Fraud Civil Remedies Act if a written statement is submitted that he or she knows or should know:
- Asserts a material fact that is false, fictitious or fraudulent; or
- Omits a material fact that he or she had an obligation to include, the omission caused the statement to be false, fictitious or fraudulent and the statement contained a certification of accuracy.

A violation of this section of the Program Fraud Civil Remedies Act carries a civil penalty of up to $5,000 in addition to any other remedy allowed under other laws.

III. **Nebraska False Medicaid Claims Act** prohibits the knowing submission of false or fraudulent claims for payment of funds specifically by the state's medical assistance programs. The law further prohibits the failure to disclose a benefit received as the result of the submission of a false claim. Specifically, Nebraska law provides that a person who

later discovers that he or she has benefitted inappropriately from the submission of a false claim but does not disclose the false claim to the state within sixty days of that discovery is in violation of Nebraska's False Medicaid Claims Act. Anyone who, acting on behalf of a provider, knowingly charges, solicits, accepts or receives anything of value in addition to the amount legally payable under the medical assistance programs subjects themselves to civil liability under the False Medicaid Claims Act.

IV. **Anti-Retaliation Protections** - An individual within an organization who observes activities or behavior that may violate the law in some manner and who reports the observations either to management or to governmental agencies is protected against retaliation under certain laws.

Duet provides services in a manner that complies with the applicable federal and state laws and that meet the standards of business and professional ethics. Duet is responsible to provide appropriate oversight and monitoring to prevent, deter and detect fraud. If an employee suspects this, they should refer to HR Policy 8.25 for proper reporting procedures.

V. **Annual Review** - False Claims and the Deficit Reduction Act of 2005 must be reviewed Annually

Approved by Duet Director

Duet Director

August 12, 2020

Date

Approved by ENHSA Governing Board

ENHSA Governing Board Chair

August 12, 2020

Date

DEVELOPMENT, TRAINING, OVERSIGHT, AND MONITORING OF SHARED LIVING PROVIDERS POLICY

Policy Effective Date: 3/19
Supersedes Policy Number: 161 (10/16)

Duet provides shared living services through the development, training, oversight, and service monitoring of shared living providers (SLP). Duet ensures that services/supports to individuals under the Shared Living Providers Policy are appropriate to individual needs and choices and approved by the NDHHS as specified in the person's Individual support plan (ISP) and in compliance with the Residential Shared Living Provider Agreement. This will be accomplished by the following:

A. Training
    a. All SLP are required to complete required training
    b. Training is provided to SLP in order to meet state regulations
    c. SLP must demonstrate competency
    d. SLP will not perform certain duties if they have not received either on the job orformal training and demonstrated competency

B. Oversight
    a. Duet is responsible to ensure the SLP maintains records and documentation in enough detail to allow Duet and the NDHHS to verify unites of service
    b. Duet provides staff commensurate with the needs of the service authorization
    c. The SLP remains accountable to Duet for the expenditure of funds received under the contract, including reports, documents or financial disclosure related to audits, attendance records and billing
    d. Duet will ensure the SLP collects date on each habilitation program

C. Service Monitoring
    a. A Duet representative will conduct monitoring activities including:
        i. Reviewing conditions set forth in the contract as needed
        ii. Identifying modification/changes for future agreements
        iii. Evaluating and reviewing services being provided
    b. Provide technical assistance to the SLP
    c. The SLP will remit month to Duet Central Records copies of all relevant information
    d. The SLP will participate in Duet's Quality Assurance activities
    e. The SLP will use Therap for documentation of medication administration and follow up an any nursing concerns
    f. The SLP will use Therap for all applicable individual files as mandated

Approved by Duet Director

Duet Director

August 12, 2020

Date

Approved by ENHSA Governing Board

ENHSA Governing Board Chair

August 12, 2020

Date

PROCEDURES FOR SERVICE PROVISION

Procedure Effective Date: 4/19
Supersedes Procedure Numbers: 211 (3/18)

I. Inquiry/Application

In order to be eligible for Duet services, eligibility must be determined by the state of Nebraska, or the individual must have the ability to private pay. Individuals requesting services/supports must provide the following:

A. Application for Services (which includes social history information) or Therap Referral
B. Service Authorization (if applicable)
C. Specialized Assessments (speech, language, OT, PT, if applicable)
D. Medical History (and current medical information; consult with RN case manager
E. Current Psychological Evaluation (within 3 years)
F. Service History (residential, day, educational)
G. Specialized behavior assessments, including FBA and BSP (if applicable); consult with Duet Behavior Support Consultant.

II. Service Agreement

The individual, parent (if minor child), the legal representative (if applicable) will visit Duet home(s) and day services, and a decision will be made regarding whether they choose Duet as the provider. After a thorough review of documentation about the person's preferences, strengths/outcomes, and an identification of supports needed, a determination will be made regarding whether Duet has the ability to support that person. Factors which may affect Duet's ability to support are:

A. Severe behaviors or other safety issues, which pose a danger to self or others.
B. Medical needs that are beyond staff scope of practice.
C. A request that a person be denied the care necessary to sustain life.
D. Transportation limitations.
E. Authorized funding is insufficient based on an assessment of individual needs.
F. Agency's ability to meet person's preferences and expectations.
G. Geographic barriers

Once all parties agree, the intake process can be initiated.

An individual's day services cannot be provided at the person's home unless there are health concerns documented by a health care professional that requires the individual to remain at home. Exceptions must be approved by DHHS and are time-limited.

III. Intake Requirements

Individuals who are entering Duet services must provide the following in addition to the documents provided during inquiry (application):

A. Intake Information for Residential and Day Services (if applicable):

1. Social History (Duet-26)
2. Psychological Evaluation within past 3 years
3. Dental Examination within past year
4. Physical Examination within past year
5. Behavior Baseline
6. Legal guardianship documents
7. Medical History within past 3 years
8. General Event Reports within past year
9. Past Programs
10. Current ISP Narrative
11. Consent for Medical/Dental Treatment (Duet-155)
12. Emergency Information (including obtaining photo)
13. Photo, Television, Movie, Video Recording, Social Media and Website Consent (Duet-23)
14. Informed Consent for Psychotropic Medication (Duet-16)
15. Health care professional's Orders (Duet-107) or another order for current medication
16. Health care professional's Orders for Psychotropic Medication (Duet-118) for current medication
17. Individual Medication Profile
18. I-9, W-4, PAF, (Day Service only)
19. Authorization for Release of Confidential Information (Duet-9)

B. Intake Information for Respite:
   1. Application for Service or Therap Referral
   2. Service Authorization
   3. Current photo (children within 3 years; adults within 5 years)
   4. Physical Examination with the past year
   5. Dental Examination within the past year
   6. Social History (Duet-26)
   7. Respite Information/Services Plan
   8. Health care professional's Orders (Duet-107) for current medication
   9. Individual Medication Profile
   10. Legal guardianship documents

C. Duet cannot offer day services to an individual until the person has completed requirements of Nebraska Vocational Rehabilitation (VR):

   1. Pre-employment transition services under VR or transition services under IDEA (Individuals with Disabilities Education Act)
   2. Application from VR services that results in determination of eligibility or ineligibility (if eligible, Duet cannot pay subminimum wage)
   3. Career counseling, and information and referral services (CCIR)

IV. Required Notification

A. Upon entering a service (and **annually** thereafter), each person, parent (if a minor), or legal representative will receive:

   1. Notice of Privacy Practices for Protective Health Information (upon entry to

services only).

2. Agreement Regarding Procedures Notification of Cost, Rights, Complaint, and Responsibilities - The person and the legal representative will be given and acknowledge receipt of written notice of the following:
    a. Any associated cost to the individual for the service or items including terms of payment, as applicable. The notice will specify that individuals will not be charged for services or items that are covered through other funding sources, including items necessary to provide habilitation and transportation related to habilitation. The notice will provide information on the process for determining who is responsible for replacement or compensation when an individual's personal items are damaged or missing. It will also provide information regarding the meal reimbursement procedures for situations where staff consume food purchased by the individuals they support.
    b. A description of the individual's rights and responsibilities is provided in a manner that is easily understood, given verbally and in writing, in the native language of the individual or through other modes of communication necessary for understanding.
    c. A review of the complaint process, including the person's right to go to court, and the option to file an anonymous complaint.

B. Documentation that the information described above has been given to the individual/parent/legal representative (if applicable) and attached to the individuals Individual Data Form (IDF) within Therap.

V. Transition Planning

The ISP Team is responsible for ensuring a smooth transition upon entry into services, when moving from one service setting to another, or upon terminating services.

A. Entry Into Services - Prior to entry into a new service**,** an Intake Planning meeting will be held to discuss supports, personal preferences, share information, and identify activities that will help the person transition smoothly into services. The team must also identify the amount of support the individual needs and whether the funding and/or resources available enable those needs to be met.

B. Transfer/Change in Services (within Duet) - If it is desired or necessary to transfer to a different setting, the team meets to evaluate if the current resources are adequate to provide supports that will meet the needs and preferences of the person. In all situations involving transfers within Duet service settings, activities will be coordinated with the team to ensure smooth transition.

C. Termination - When a decision has been made that a person will be leaving service, the ISP team will provide support, upon request, during the transition process. A transition plan will be developed in conjunction with the new provider. The plan must be agreed upon by the ISP team and include:

1. A primary focus on the individual's needs and preferences
2. Timelines

3. Supports and strategies that are needed for the new provider
4. Plans for the current provider to meet needs during prior to termination.

D. In the event of an unplanned change in a subcontracted service, Duet and the ISP team, will provide continuing planning for continuation of services.

E. In addition to the situations noted above, the ISP team will periodically evaluate the adequacy of funding authorized based on the supports the person may need at different life stages and request that a new ICAP or exception funding.

VI. Sufficient Staffing

Staff support is based on the needs and preferences of the person as determined by the ISP team. The funding authorized by the DHHS should correspond to the identified support needs. Sufficient staff will be maintained to provide needed supports and supervision to meet the needs of each individual.

VII. Transportation

A. Transportation is provided in a safe and comfortable manner and will include:

1. Transportation my not be denied due to the lack of adaptation of vehicles
2. Sufficient staffing to ensure safety and meet the needs of each individual
3. Drivers will have a valid driver's license and know traffic laws. They can also assist individuals during transport when needed.
4. Required training for van drivers includes Support/Encourage/Empower, Lifting, Standard First Aid and Verbal Intervention and Personal Safety. In addition, other training will be available based on the special needs of the person being Transported. This may include, and Operating Wheelchair Lifts (including demonstration). In addition, meetings are held with Duet Case Management Nurses and Behavior Support Consultants on an as-needed basis to discuss safety protocols and other person-specific information.

VIII. Termination

Termination may occur at the request of the individual, parent (if minor child), or legal representative. Duet may also decide to terminate services based on the following:

A. Individual moves from the Duet service area
C. Severe behaviors which pose a danger to self or others
D. Medical needs which are beyond staff scope of practice
E. A request that a person be denied the care necessary to sustain life
F. Transportation limitations
G. Authorized funding is insufficient based on assessed level of support
H. Inability to meet the person's preferences and expectations

Duet terminates services, sixty (60) calendar days written notice will be provided unless services are funded through a contract addendum with enhanced rates in which case ninety (90) day notice is required. When the person, parent (for minor child), or legal representative terminates, thirty (30) day notice to Duet is required.

In the instance where Duet has provided notice of termination, Duet will abide by the Uniform Residential Landlord and Tenant Act provision that addresses evictions and appeals, per Nebraska Revised Statute 76-1440 and 76-1447. Also, in the event where a person and/or family gives thirty (30) day notice, the individual is required to fulfill any housing lease agreement they may hold.

IX. Closing a Service Setting

The Director will provide a written notice to the Department and the individual at least 60 days prior to closing a service setting.

Room and Board Billing Policy

Policy Effective: 4/19
Supersedes Procedure Number: 8/18

Duet will bill individuals who live in Agency homes for room and board. Room and Board will be charged according to State approved rates and according to the type of setting in which the individual lives. Financial information will be requested annually or as needed to determine the room and board billing rates.

Duet may apply for payeeship of benefit funds for any individual over 60 days past due on payment for room and board. When any individual or financial representative fails to pay the amounts determined to be due under these rules and regulations, Duet/ENHSA may proceed against such person in any manner authorized by law for the recovery of money owed to a creditor.

Any individual/financial representative aggrieved by billing rate determination may appeal the decision by filling a request in writing to the Duet Director. The cause or causes for the grievances plus supportive data should be included with the request for redetermination. The decision of the Director shall be final.

Duet is paid by the state of Nebraska based on the supports that Duet provides. Each service has an assigned rate and will be billed for each service separately. Most services are billed according to current state practice. The total hours or days of claim payment for any person cannot exceed the maximum amount of the person's individual budget amount (IBA) in their service authorization(s). Services billed are provided in compliance with all statutory, regulatory, and contract requirements and in accordance with the approved Home and Community Based Services (HCBS) Medicaid Waivers.

Approved by Duet Director

Duet Director

August 12, 2020
Date

Approved by ENHSA Governing Board

ENHSA Governing Board Chair

August 12, 2020
Date

PROCEDURES FOR CHARGES FOR ROOM AND BOARD

Procedure Effective: 8/02
Supersedes Procedure
Number: 281

1. Persons living in Duet owned or leased homes will be charged a room and board fee. The room and board fees will follow the standard rates set by NHHS for a CDD (Center for Developmentally Disabled), and a non-licensed agency or shared living home. The amount of the actual charge will be contingent on benefits received after factoring the individual's personal needs allowance.

2. Persons living in Duet homes not receiving any of the benefits, or receiving reduced benefits, will be charged the same established rates for the type of service setting in which they live (CDD, non-licensed group home or shared living setting). Reasons for reduced or no benefits include high work income, deduction of an overpayment and having excessive resources.

3. Each year, revised room and board billing rates will be established. The person, or their parent/legal representative, will be required to submit the necessary financial information in order to determine the proper billing rate. If the person does not submit the requested information, then the standard rate will be charged.

4. Duet will bill monthly. The current bill will reflect charges for the previous month and any past due balance.

5. For accounts that are past due and where no payment has been received for 60 days, a notice will be sent indicating either full payment or specific arrangements for full payment must be made and the Agency may initiate payeeship proceedings.

6. The Agency will pursue all reasonable means to collect on past due accounts. If, after failing to respond to Agency efforts, outside efforts to collect on the account will be pursued.

SERVICE BILLING

Policy Effective Date: 8/18
Supersedes Policy Number: 282 (3/18)

Duet is paid by the state of Nebraska based on the supports that Duet provides. Each service has an assigned rate and will be billed for each service separately. Most services are billed according to current state practice. The total hours or days of claim payment for any person cannot exceed the maximum amount of the person's individual budget amount (IBA) in their service authorization(s). Services billed are provided in compliance with all statutory, regulatory, and contract requirements and in accordance with the approved Home and Community Based Services (HCBS) Medicaid Waivers.

DDD utilizes a web-based electronic case management system called Therap Services, LLC (Therap). Service authorizations are generated by Service Coordination in Therap, then entered NFOCUS. The DD Coordinator electronically sends the approved service authorization to the provider agency, who is responsible to review the service authorization for accuracy before acknowledging. Attendance is recorded on Therap and will be approved by a Duet representative prior to submitting claims for payment.

Individuals may be assessed a share of cost by the state of Nebraska for services based on income. Benefits are considered income. State funding will be provided to the individual less the person's share of cost. The individual, parent, or legal representative will be responsible for paying the person's share of cost.

I. Duet can only bill for times when the individual is present and receiving habilitative supports, unless otherwise specified in service definition.

A. Billable Activities. The following are a list of billable activities:

- Habilitation training and direct support of needs as specified in the person's ISP, including documentation.
- Individualized job development and support on behalf of the individual as specified in their ISP.
- Attendance and participation at the participant's team meetings.
- For days when an individual might be hospitalized but also received services prior to admission or after discharge, the services must be claimed at the hourly rate. Daily rates do not apply on days when an individual is either admitted to or discharged from the hospital and a maximum of seven hours is allowable. For hospital stays where staff provide support, the provider can request exception funding.
- Transportation

B. Unallowable or unbillable activities include the following:

- Staff meetings, staff training, habilitation plan training, program research and development, supervisory or administrative activities, staff paid leave time, ancillary support activities not involving the person (such as shopping for supplies, building cleaning, or maintenance).

- Any time periods where other paid services are provided concurrently in a provider owned and controlled location. Examples of other paid services include, but are not limited to, Personal Assistance Services (PAS), speech therapy, physical therapy, or counseling sessions.
- For an individual under 21 years of age, time periods the person is to be attending school - generally 8:00 a.m. to 3:00 p.m. or the operational hours of the school.
- Paid staff time providing only general care and supervision not specified in the ISP.
- If an ISP identifies a provider as being responsible for assisting the individual to schedule and attend an annual physical examination and the person loses or has a gap in their waiver eligibility due to an expired annual physical examination, the federal matching funds that are unable to be acquired by DDD will be deducted from the provider payment while the match is unavailable.

Transportation Safety and Security Policy

Policy Effective: 3/1/18
Supersedes Policy
Number: N/A

All passengers must wear an approved safety device while riding on any ENHSA/Duet provided transportation.

Passengers using mobility devices are required to have their mobility device properly secured.

A passenger is required to sign a Transportation Program Waiver releasing ENHSA/Duet from liability for personal injury or damage to a mobility device in the following circumstances:

- If driver is unable to properly secure the mobility device and the passenger makes the decision to stay on the vehicle without the mobility device being properly secured.
- If driver recommends that a passenger transfer from his or her mobility device into a vehicle seat and the passenger chooses not to transfer and to remain in the improperly secured mobility device.

Any passenger who cannot enter the vehicle using the stairs or ramp, but who does not use a wheelchair, will be allowed to enter the vehicle using the lift.

Drivers have the discretion to assign seats and determine wheelchair placement when necessary for the efficiency and/or safety of the passengers.

State laws apply toward child passengers. Car and booster seats are not provided. The parent/legal representative will be responsible for securing these seats into the van, drivers are not allowed to do so.

Passengers shall at no time exit the vehicle until they have arrived at their destination and vehicle has come to a complete stop.

Reasonable modifications/accommodations shall be made to ensure accessibility to individuals with disabilities. A Reasonable Modification complaint process and form are available upon request.

Approved by Duet Director

Duet Director

August 12, 2020
Date

Approved by ENHSA Governing Board

ENHSA Governing Board Chair

August 12, 2020
Date

Service Animals

Procedure Effective: 3/1/18 Supersedes Procedure Number: N/A

ENHSA/Duet allows service animals to accompany passengers under the Department of Transportation (DOT) Americans with Disabilities Act (ADA, 49 C.F.R Section 37.3). Revised regulations define a ‘service animal’ as any guide dog, signal dog, or other animal individually trained to work or perform tasks for an individual with a disability including, but not limited to, guiding individuals with impaired vision, alerting individuals with impaired hearing to intruders, or sounds, providing minimal protection or rescue work, pulling a wheelchair, or fetching dropped items. The task(s) performed by the service animal must be directly related to the passenger’s disability. Under the ADA, ‘comfort,’ ‘therapy’ or ‘emotional support animals’ do not meet the definition of a service animals. Animals other than service animals can ride in the transit vehicle only in a secured pet travel carrier. Reasonable modifications/accommodations shall be made to ensure accessibility to individuals with disabilities. A Reasonable Modification complaint process and forms are available upon request. More information regarding rules and regulations regarding service animals is available at www.ada.gov.

INDIVIDUAL SUPPORT PLAN POLICY

Policy Effective Date 8/18
Supersedes Policy Number: 310 (5/16)

Duet shall participate in the development and implementation of an Individual Support Plan (ISP) for each person supported by Duet. The plan encourages and supports individuality, integrity, self-determination, well-being and community inclusion that enhances and enriches the lives of people with developmental disabilities.

The ISP is the documentation of a person-centered planning process. It documents the risks; action plans and supports that align with the individual's wants and desires and responsibilities assigned to members of the team.

PROCEDURES FOR THE INDIVIDUAL SUPPORT PLAN (ISP)

Procedures Effective Date: 2/19
Supersedes Procedure Number: 311 (8/18)

Everyone supported by Duet must receive habilitation services to acquire, retain and improve the skills necessary so the individual is able to live as independently as possible; enhance choice and self-management; and participate in the rights and responsibilities of community membership. Habilitation must be observable in daily practice and identifiable in the Individual Support Plan (ISP) and supporting documentation. Habilitation should be an ongoing planned process that includes comprehensive assessments, an individualized plan, training and supports, service delivery, documentation of service delivery, measuring progress of the plan and monitoring the service to determine if the services continue to meet the needs of the individual.

Duet values each person as a unique individual filled with gifts and possibilities that align with the agency's core values of Individuality, Integrity, Self-determination, Well-being and Community. The ISP is a person centered-plan that specifies agreed-upon supports to be delivered to the individual to meet identified needs, wants, and desires.

Person-centered planning should be driven by personal preferences, choice, and desired outcomes. The team supports the person to balance what is important to the person, with what is important for the person to promote overall development, health and well-being. A plan is developed with the person to achieve the desired outcomes.

A. Team Roles: The team consists of the person, legal representative (if applicable), service coordinator, provider representative(s) and other individuals chosen by the person. The team works toward consensus development of a meaningful outcome driven plan that assists the person to move toward a desirable future by discovering a personal vision and creating opportunities to participate in the life of their community. Team members will:
    a. Listen, observe and ask questions to discover and understand the person's desired outcomes
    b. Develop individualized plans and supports from information gathered that challenges the person to overcome barriers and achieve the highest level of independence
    c. Learn and apply what the person expects from the services and support
    d. Provide supports that will facilitate the accomplishment of desired outcomes
    e. Support eh person in making informed choices considering both risks and responsibilities
    f. Support the person in exercising his/her rights
    g. Encourage and support valued relationships with family members

B. Individual Assessment: Person centered planning begins with discovering the person's gifts, talents and desired outcomes. The information gathered during the assessment process comes from the perspective of the individual as well as those that know and care about the person. Assessments are completed with the individual to obtain accurate.and complete information related to history, preferences, abilities and needed services and supports. The assessments will be the bases for the development of the ISP and must be completed within 30 calendar days of entry to services. Assessments will be completed at least annually and updated accordingly. The tools and methods used will be identified by the team based on the person's

individual support needs. Information gathered through (but not limited to) the following:

a. Personal Outcome Evaluations including Duet Personal Priorities and Preferences Assessment (PPPA) or other outcome-based evaluation
b. Skill Assessments including the TSMI or Adaptive Behavior Scale (ABS)
c. Behavior Support Evaluations including the Duet-99 Problem Behavior Inventory, Functional Behavior Assessment or other behavior assessments
d. Health/Medical assessments including health history, dental, physical, Health Support Plans, care plans, medical protocols, seating/positioning recommendations, nutritional guidelines, assessments/recommendations from Physical, Occupational and Speech Therapy
e. Safety/Financial assessments such as fall risk, aspiration/choking and financial plans
f. Behavioral/Mental Health
g. Other assessments for determination of DD Waiver Eligibility
h. A summary of all assessments will be completed on a Duet-30

C. Initial Planning Process/Change of Service: once the person or legal representative has determined Duet will provide supports, an intake process will be implemented
    a. Prior to the intake meeting, staff gather and/or complete requested information as specified on the Pre-Intake/Intake Packet Checklist Duet-4 (refer to Duet Procedure 211)
    b. Pre-assessments completed by Vocational Rehabilitation to determine the person's eligibility for day services
    c. The initial planning meeting is held prior to the projected start date to discuss ways the person will become familiar with his/her new home or workplace
    d. The person and team will identify any assessments that will provide information about ways to support the person in achieving outcomes
    e. Employees meet with the person to discuss his/her preferences and what he/she expects from the services and supports
    f. Using the identified outcomes and personal preferences the team will determine how to facilitate the achievement of the outcomes and supports
    g. Once the person moves into the new home or workplace, employees should ensure the person is comfortable and welcome

D. ISP Process: the process for organizing services is determined through a meeting called an Individual Support Plan (ISP) Meeting. Team meeting discussion is recorded electronically on an ISP narrative by the Service Coordinator and is updated as needed to remain current.

The DD Service Coordinator may start with gathering information for the upcoming ISP meeting. A Personal Focus Worksheet (PFW) may be used. This information gathered prior to the meeting will be documented and shared with team members.
Team members will be asked to identify risk and align supports. Discussions will need to include:

- Plans to mitigate risk
- Plan for other services in the event they are unable to be provided
- Supervision needs, including alone time
- Restrictions that include interventions, strategies and progress on eliminating the restriction
- Psychotropic Medications
- Review of General Event Reports since last meeting
- Review of emergency safety interventions
- Any legal needs

Once this is accomplished, support documents generated electronically will be developed by the staff and implemented to prevent and/or minimize risks

The information gathered from the team members will be the basis for the ISP meeting.

The Annual ISP meeting will be held prior to the implementation of the ISP (or the new budget year) and will be considered a one-year plan. The team will review the previous years' ISP as well as information gathered for the new ISP year. Team members will agree to action plans and supports that align with the individual's wants and desires. At the end of the meeting team members sign the signature page that indicates their attendance and participation. Team members must ensure individual programs, data collection and support documents are kept current electronically throughout the year.

Team meetings should be held semi-annually, unless otherwise determined by the SC, parents and or legal representatives, to review not only the support documentation, but progress made since the annual meeting. This is also an opportunity to begin planning for the next annual year. If the support documentation continues to meet the needs of the individual and addresses the identified risks, the plan will continue as written.

Team members will need to be contacted to obtain verbal approval for all changes to the ISP or support documents. Exceptions where an actual team meeting may need to be held include but are not limited to a change of service, changes in restrictions or changes in psychotropic medication.

The ISP will include outcomes, supports and specific measurable steps based on the person.

- Outcomes: the person decides his/her plans. These are outcomes that can be supported through formal habilitation or information supports. The team discusses the outcomes and determines how to support the person to achieve his/her plan

- Supports: summarize assessment information that relates to the outcome and identify what needs to be come to move toward achievement

- Measurable Steps: the team discusses strategies that are both formal and informal, measurable steps and supports are based on prioritized needs, relevant to the ISP, functional, tailored to the person's needs, respectful of choice and documented in the ISP

The team will look realistically at the person's strengths and abilities to determine how much and what type of support is needed. Discussions may include:

- Goals and Celebrations: achievements from the past year, things the person would like to work on, strengths
- Medical Information: changes in health, ongoing medical conditions, current medications and effectiveness, nutritional considerations, risk, need to medical assessments such as Occupational or Physical Therapy, assistive devices
- Financial & Benefit Planning: the extent to which the person can participate in the management of their finances, any upcoming expenditures, Medicaid and SNAP benefit information
- Employment: goals and strategies, current employment, involvement in Vocational Rehabilitation
- Formal Supports: programs, positive behavior supports
- Informal Supports: identification of support, needs, objectives
- Right protections/restrictions: strategies to reduce or eliminate restrictions, environmental restrictions designed for others and how the person will gain access, funding source and individual budget

E. Implementation of ISP: the plan developed at the ISP meeting includes a variety of activities that facilitate the achievement of personal outcomes. The team will be responsible to ensure implementation of the plan and attainment of personal goals Implementation of supports is consistent across all environments and must be flexible and subject to change when supports are no longer needed or effective. Incidental learning and appropriate skills are encouraged, reinforced and aligned with information included in ISP. Implementation includes the following:
    - Specific measurable steps and supports that are relevant to the ISP, functional, person centered and respectful of choice
    - Activities and environments facilitate acquisition of skills, greater independence and personal choice

F. Programs: Programs and data collections methods are developed based on the person's expressed interest and desire to learn/attain new skills and must be based on the goals or action plans identified in the ISP. Each program is written with enough detail to consistently implement and document. Implementation dates for all new programs will be decided at the ISP meeting. Documentation will take place in Therap.

G. Monitoring Programs: Progress is accurately measured and consistently monitored. The programs will be modified when needed based on data and changes in the person's

circumstances. Data collection reports will document the review as well as any changes or recommendations made to the programs.

H. Goal Completion Prior to Annual ISP Meeting: When the completion goal is close to being met between meetings the person and the team must decide on changes to be made. If there are no other programs in place, there should not be a break in the teaching, therefore a new program must be developed and ready to implement. Continuation of data collection on the completed program will not be acceptable. All team members including Service Coordination must be notified as soon as possible to discuss the need for new programs.
    a. Programs may be continued into the ISP year if:
        i. The goal was established a short time prior to the annual ISP
        ii. The goal is consistent with the person' vision
        iii. The person is making significant progress

I. Support Documents: Persons responsible for support documents will plan and organize activities to carry out assignments as identified in the ISP. These may be one-time supports or on-going supports. Progress and/or completion of supports are documented electronically such as Health Related, Support Documents Checklists or other monitoring form as applicable.

J. Community Resources and Natural Supports: Staff are responsible for facilitating activities and supports to enable a person to maintain relationships, enjoy community activities, pursue interests and exercise rights. The ISP may identify people and activities in the community which are important to the person. Some activities/responsibilities may be carried out by people who are friends, co-workers, family members and other interested persons. Staff are responsible for implementing community activities as assigned in the ISP and encouraged to facilitate activities that involve people not paid to provide support.

K. Communication: Staff will maintain open and ongoing communication with the person in order to identify any new or changing interests/desires. They must be responsive to the person and facilitate activities designed to help the person pursue those interests and desires. New or changing information will be shared with the team.

    There will be an ongoing review of the adequacy of the person's authorized individual service budget based on the support the person requires at different points in his/her life. If it is determined that the person's individual service budget is no longer enough to responsibly support the individual, a request for an increase in his/her budget will need to be made. If this is denied, Duet will evaluate the continued ability to serve the individual.

HEALTH AND SAFETY POLICY

Policy Effective Date: 8/18
Supersedes Policy Number: 410 (2/05)

Every person receiving support from Duet shall receive attention to his/her health and safety needs as prescribed by supervising health care professionals and in accordance with the plan developed by the ISP team. This involves activities related to prevention, early detection and remediation of health problems and meeting nutritional needs. Ongoing attention to health and safety may include but is not limited to monitoring health and wellness, recording observations, providing medications, seeking emergency treatment, follow-up appointments and referrals to specialists.

The following statements address a variety of issues pertaining to the health and safety of persons receiving support and the staff providing that support:

- Staff who provide medication must be on the state registry as a Medication Aide as specified in the Medication Aide Act, Neb. Rev. Stat. Section 71-6739. Staff will only perform special care procedures after being trained by a licensed health care professional. (Refer to Medication Policy #440.)

- In emergency and potentially life-threatening situations, Duet staff are responsible for taking all actions necessary to sustain life and will never comply with a request for a "no-code", except under the auspices of a certified hospice program.

- For some individuals, it may be necessary to obtain approval to use mechanical restraints or medications to protect the person from harm during a medical/dental intervention or to promote healing following a medical procedure or injury.

- Duet's Exposure Control Plan, in accordance with OSHA regulations, identifies procedures and delineates responsibilities for the detection, prevention and control of infections from bloodborne pathogens and other potentially infectious materials. The plan identifies **work practice controls** intended to reduce the likelihood of exposure. These include specific procedures for handwashing, general hygiene practices, disposal of sharps and infectious waste and handling of specimens as well as the use of personal protective equipment (PPE).

- In the event of an emergency involving a missing person, severe weather, fire or natural disaster, Duet staff will act to protect and ensure the safety of persons supported in accordance with applicable established procedures. Emergency preparedness activities include maintaining current personal information that may be needed in an emergency and conducting fire/tornado drills at regular intervals.

- In 24-hour settings, menus are to be planned in accordance with the recommended dietary allowance (RDA) of the National Research Council and reviewed by a registered dietician/

nutritionist. Foods must meet the nutritional needs and preferences of the individuals, be of good quality and enough quantity, and be prepared and stored in a safe and sanitary manner at proper temperatures. A modified diet requires a written order from a health care professional.

- Vacations and day trips are an important part of the lives of persons whom DUET supports. Careful planning is required, and special arrangements may be needed based on individual needs. ISP teams are responsible for assessing individual needs and planning for meeting those needs. Staff are to consider the resources and arrangements necessary to address all the person's health and safety concerns throughout the course of a vacation or a day trip.

- Safety committees in each area meet on a regular basis to discuss and resolve safety issues.

While the statements above and the procedures that follow do not and cannot explicitly address every specific health and safety issue possible, Duet's general intention is to provide individualized supports to help individuals live safe and healthy lives in accordance with their wishes and available resources.

Approved by Duet Director

Duet Director

August 12, 2020

Date

Approved by ENHSA Governing Board

ENHSA Governing Board Chair

August 12, 2020

Date

PROCEDURES FOR HEALTH AND SAFETY

Procedure Effective Date: 2/19
Supersedes Procedure Number: 411(8/18)

Duet is committed to providing supports to individuals so that they are safe, secure, and experience the best possible health. The individual, legal representative, and Duet staff will evaluate and determine the level of support necessary to achieve good health and promote safety. Listed below are general safety and supervision considerations that require monitoring.

Support/Supervision

Staff will provide the level of support necessary to meet the needs of the person as determined by the ISP team. Types of supports may include supervision at home, in vehicles, in the community, and while eating unless the person's ability and age allow that they may be left alone safely. Everyone should be encouraged to participate in community activities and be part of the community. Staff should also respect privacy and dignity of the person.

Supervision in bathroom: A high number of accidents occur in the bathroom. Monitoring should be provided for the individual who has uncontrolled seizures, orthopedic needs, who requires assistance to adjust water temperature, or other needs which require staff supervision.

Bath/Shower Water Temperature Safety: There are two components of water temperature safety: 1) hot water temperature at the fixture, and 2) water temperature during baths or showers.

Water Temperatures: Hot water temperatures in areas accessible to the individual must range between 110º-115ºF at the fixture with 112ºF as the desired setting. Burns can occur at even lower temperatures for children or persons with conditions. Restriction on the water temperature is not needed if the ISP's for all the people supported at this location document that they can independently adjust the hot water temperature. Aside from routine water temperature checks, if staff notice during normal use that the water temperature is excessive, they must immediately physically take the water temperature following the established protocol. Should the water temperature exceed 115ºF they must notify their supervisor and the Maintenance Director so that immediate action can be taken. The temperature reading and any actions taken must be documented in the Water Temperature Log (Duet-235).

Bath/Shower Water Temperature Safety: If the individual has not demonstrated the ability to independently adjust water temperature, staff will assist/supervise regulation of water temperature during baths, shower, or hygiene. Further supports may be necessary if the person requires constant supervision during the bathing process.

Supporting mobility: Support should be provided when the walking surface is hazardous for the

person served, or when the individual needs support with ambulation. Some instances in which support may be necessary are getting in and out of vehicles, maneuvering wet surfaces, and ascending or descending stairs.

Support while eating: For some individuals who have specific problems with choking or swallowing, it may be necessary to provide support during meals. Staff may need to avoid serving certain foods (e.g., hotdogs, peanut butter, pizza, popcorn), cut foods as needed, supervise the amount of food per mouthful, or encourage the individual to chew and swallow before taking another bite.

Level of Support: Staff must be aware of the level of supervision needed for each individual. The team will identify if and for how long the individual can be left alone safely.

Nursing Support: Persons with health/medical needs are monitored on an ongoing basis by nursing staff. The RN delegates special care procedures through the development of a Nursing Assessment and Health Support Plan.

Therapeutic Heating Devices: Therapeutic heating devices should be used only under the direction of a heath care professional. Staff supervision may be required for the use of heating devices. Orders from a health care professional should be adhered to regarding controlled setting and length of application. Prior to use, check with a Duet nurse for individual procedures.

Portable Heating Units: If portable heaters must be used, use “ceramic” heaters that are safe, programmable and energy efficient. These can only be used with management approval. Use of portable heating units with radiant heat is prohibited.

Safety

Individuals should feel safe and free from threats of danger. People should live, work and pursue leisure activities in an environment that is safe. Staff should be aware of safety risks/concerns and take actions to remedy or minimize the risk. Furthermore, staff should be familiar with individual protocols to ensure safety.

Unauthorized Visitors: Staff should be aware of any visitors and request proper identification, if applicable. Staff should not have overnight guests, friends, spouse or children in the home during scheduled work hours. There are safety and liability considerations related to having visitors as well as the potential for staff to be distracted from normal duties. Therefore, unauthorized visitors are not allowed.

Common Hazards: Staff should ensure that environments are free of hazards.

Tobacco-Free Workplace: Duet has a tobacco-free policy that prohibits the use of tobacco-derived or tobacco containing products including, but not limited to: cigarettes, electronic cigarettes, cigars and cigarillos, hookah smoked products, pipes, and oral tobacco (e.g., spit

and spitless, smokeless, chew, snuff) and nasal tobacco (e.g. snus). It also includes any product intended to mimic tobacco products or the smoking of any other substance, including vaping. Smoking is prohibited in all agency owned and leased homes and in vehicles, and in personal vehicles when transporting people on Agency authorized business. Smoking is not permitted anywhere on the Central Office campus; this includes inside your vehicle. Any smoking receptacle must be kept 10 feet from any Agency owned and operated properties.

Vehicle Safety: Seatbelts must be worn while riding in motor vehicles. Seating in vehicles with airbags should be considered based on the age/size of the individual. Child safety/booster seats must be used for children up to the age of six (6) or 4'9" tall. If the individual is under 100 lbs., they should be seated in the back for safety.

Potential Safety Risks: include natural or man-made disasters. For any catastrophic event, follow the protocol for each area/division regarding notification procedure and designated essential personnel. Refer to the Duet Disaster/Emergency Preparation Plan.

Power Equipment Safety Operations/Occupational Health Hazards: Service settings will conduct activities with safety as a primary concern. Accordingly, all individuals will follow established safety procedures related to Power Equipment Safety Operations and Occupational Health Hazards.

Meeting General and Special Health Needs

A. Each person will have a primary health care professional and dentist who will oversee the person's healthcare needs.

B. Responsibility for routine attention to a person's health needs shall be assigned by the ISP team and under the direction of a licensed Health Care Professional.

Obtaining Physical/Dental Exams and Other Evaluations

A. Persons entering services must have a current physical and dental exam.

B. For persons in CDD homes exams must be conducted within the last three months or within 15 days after entering services.

C. For persons entering Waiver funded services, physical and dental examinations must be current within one-year preceding admission.

D. The need for physical and dental examinations and other evaluations for all persons is reviewed by the team at the Intake and the Annual ISP and documented in the ISP narrative.

Absence from Day Program

Common sense should dictate whether the person should be sent to the day program or retained home for bed rest and/or proper medical care. Some examples of common illnesses

which may necessitate the person staying home are: common cold, constipation, diarrhea, drowsiness or excessive lethargy, earache, swelling, drainage or matting in the eyes, fever, nosebleed that has not stopped, atypical seizures, skin irritation that appears infected, and vomiting. The decision for the person to remain at home should always be person-centered and include the desires of the individual.

If the person is home ill for several days, residential staff should maintain communication with the day program. Also, when the individual returns to the day program, staff should provide the day program with any information which may be beneficial to the individual returning to work.

Common Illnesses

Listed below are common illnesses that require staff monitoring. If symptoms persist or become worse, seek medical advice. If there are questions or concerns, contact the Duet nurse or the person's health care professional for assistance or clarification. **If the person is ill for more than 3 days, Duet Administrative staff, the health care professional (if supported 24-hours by the agency), parent/legal representative, service coordinator and the RN Case Manager (if applicable) must be notified.** Unless otherwise specified, the person should be kept home from the day program for the following conditions:

Common Cold: associated with fever, sore throat, runny nose, chills, headache, persistent cough or chest congestion

Constipation:

a. If constipation is accompanied by nausea, vomiting, severe abdominal pain, signs and symptoms of dehydration, and/or a fever, **contact the health care professional immediately.** Keep the individual home from the day program.

b. If a person has not had a bowel movement for 3 days, **the health care professional and the RN Case Manager must be contacted.**

c. If a person has a standing order for problems with constipation, the order must be followed. Administer the PRN order for constipation after **contacting the Duet nurse.**

d. As a rule, if after an additional 24 hours the person has not eliminated, the **health care professional and the RN Case Manger must be contacted** unless otherwise specified by the Physician.

e. Incidents of bowel movements shall be documented for persons on medication to control constipation unless the person refuses to cooperate with monitoring or report information to staff. In such cases, staff should make every effort to obtain as much information as possible and document the refusal to allow monitoring.

Diarrhea: a loose stool that occurs more often than every 2 hours, the **health care professional is to be contacted** if:

a. Diarrhea is persistent and there is no improvement within 24 hours

b. The person is experiencing cramping, fever, or vomiting

c. Person refuses fluid

d. Person does not urinate, or stool contains blood

Drowsiness or excessive lethargy: The person should be kept home when there is no known explanation and there is a possible medical reason (fever, cough, diarrhea, etc.). Contact the health care professional.

Ears: For any aches or related symptoms, keep the individual home and contact the health care professional.

Eyes: If there is any redness accompanied by swelling, drainage, or mattering, contact the health care professional.

Fever: There is a normal range in which a person's body temperature may vary and still be considered normal. However, if temperature exceeds the normal range, **notify the Duet nurse or health care professional** following the guidelines below. **Notify the health care professional** if there are accompanying symptoms such as chills, stiff neck, marked pain (especially abdominal pain) or vomiting and temperature exceeds 98.6° axillary, 99.6° orally, or 100.6° rectally.

Temperature Type	Normal Temperature Range	Notify Physician or RN for temperature without accompanying symptoms	Notify physician with temperature and accompanying symptoms
Rectal	98.6°-100°	102°	100.6°
Oral	97.6°-99°	101°	99.6°
Axillary	96.6°-98°	100°	98.6°

Nosebleed: If a nosebleed has occurred, communicate with corresponding program. Keep home until the bleeding has stopped.

Seizures: **Notify the health care professional** if there is a variance in seizure activity (e.g., duration, frequency, severity, increased respiratory distress). Follow Seizure Protocol; if there is no seizure protocol, call 911.

Skin irritation: If the person has any skin irritation that would include redness, raised areas, blisters, and possible boils or open areas should have an accompanying note sent to the day

program as to possible cause and **nurse should be notified.** Also watch for signs of infection that would include area warm to touch, redness, swelling, and tenderness. Only exceptions would be dry skin, redness around mouth caused by drooling or mouthing, and any irritation caused by scratching or pinching that shows no signs of infection. The person can go to day program except when irritation is from a known contagious factor or doctor's order to stay home.

Vomiting: If vomiting is due to illness (e.g., flu symptoms, upset stomach, bowel problems), the individual should be kept at home. If vomiting is continuous, severe, accompanied by blood, or the temperature is elevated, **notify the health care professional.**
NOTE: If person often vomits without illness (e.g., gags self, self-induced from burping or emotional upset), do not keep home unless there are other
signs of illness such as fever or drowsiness.

Medical Restraints/Support and Protective Devices

When physical restraints or behavior control medications are used to control the behaviors of an individual during a necessary medical or dental procedure, a health care professional must document that the behavior could not otherwise be controlled. The order must be signed and dated by the health care professional.

When mechanical restraints are used to promote healing following a medical procedure or an injury, an order must document the medical condition or injury need for restraint; the provision of medical treatment or observation; the order must be signed and dated by the health care professional and renewed every 24 hours.

Support and Protective Devices

Support and protective devices include mechanical devices used to provide support to achieve functional body position or a device for medical or post-surgery care. These devices include dentures, hearing aids, wheelchair belts, AFO’s (Ankle Foot Orthosis), hand splints, body jackets, side-lyers, and side rails.

Use and rationale for support and protective devices is documented in the ISP.

A health care professional’s order or PT evaluation should document the purpose for the device, the duration and frequency of use, and provisions for monitoring and checking proper application.

Employees will be trained in the proper application of devices.

Assistive support devices require approval of HLRC.

Hospitalization

In the event of hospitalization, staff must notify the Service Coordinator, the parent/legal representative, and the chain of command up to the Area Director. The RN case manager should also be contacted upon admission and prior to dismissal. Staff will complete the Therap General Event Report.

If the individual has an RN Case Manager, they should be contacted as soon as possible after admission and prior to dismissal.

If possible, staff support should be provided during the individual's hospital stay.

A GER should be completed on Therap within 24 hours.

PROCEDURES FOR RESPONDING TO LIFE THREATENING SITUATIONS

Procedure Effective Date: 2/19
Supersedes Procedure Number: 412 (8/18)

Examples of Emergency and Life-Threatening Situations

This list is not expected to be inclusive of all situations which may be life threatening or potentially life threatening.

-Attempted suicide
-Burns involving blistering or broken skin, difficulty breathing, or covering a large surface area
-Chemical burns to any location of the body
-Constipation (with accompanying symptoms, such as distention, nausea, vomiting, pain)
-Diabetic emergencies: insulin shock/diabetic coma
-Electrical shock or burns
-Eye injuries: penetrating objects and chemicals burning the eye
-Falls greater than the individual's standing height
-Falls associated with tingling in the hands or feet, pain in the back or neck, or muscle weakness or lack of feeling in torso or arms
-Fractures, dislocations
-Head, neck, and back injury
-Heart attack (chest pain or pressure)
-Heat burns of the face, neck, genitals, hands, or feet
-Heat stroke
-Impaled object in any area of the body
-Individual is unconscious (or unusually confused/severely disoriented)
-Inhalation of smoke or chemicals
-Inhalation or swallowing poisons
-Large bone fractures or any dislocation (except in the hand or finger)
-Obstructed airway/choking (breathing difficulty)
-Respiratory (breathing ceases) or Cardiac (absent pulse) arrest
-Seizure
    Activity noted per Seizure Protocol
    First seizure noted for individual
    Following seizure, victim remains unconscious
    Victim goes into respiratory arrest
    Severe injury during seizure
    Pregnant or diabetic
-Severe abdominal distention (intense abdominal pain)
-Severe allergic reactions
-Severe bleeding

-Severe cold emergencies: hypothermia and frostbite
-Shock
-Stroke
-Sudden illness (feeling ill, dizzy, confused or weak, skin color changes, sweating, nausea and vomiting
-Vomiting or passing blood

Action to Sustain Life and Notification/Documentation Procedures

In the event of an apparent life-threatening situation the employee shall take immediate action:

1. **Contact 911** to activate the Emergency Medical System.

2. Provide care, attending to life-threatening conditions first.

3. Continue providing care and/or monitoring the individual until emergency personnel arrive.

4. Notify the parent or legal representative, chain of command through the Duet Director, and service coordinator.

5. If staff cannot accompany the individual to the hospital, plan for someone to meet that person at the hospital. Communicate pertinent information to the emergency personnel.

6. Accompany the person to the hospital, taking all pertinent medical records. Hospital personnel may make copies of the records.

7. Update parent or legal representative, service coordinator, and chain of command on the person's condition. Complete an event report on the Therap.

8. Complete medical charting.

9. When the person is released, obtain dismissal orders (signed by licensed health care professional, not dismissing nurse) and Update GER the Therap.

For some persons living at the Medical Support Unit (MSU), there may be standing health care professional's orders designating that the health care professional be contacted in lieu of 911. In such a case, the following procedures apply:

1. The RN will begin resuscitation procedures while **contacting the health care professional** for further direction.

2. Once the health care professional is contacted, the RN will follow their directives

Response to a Request for Advanced Directive

It is the policy of Duet to take immediate action to sustain life for individuals living in Duet settings. If, at any point, an Advanced Directive is requested, the chain of command shall be notified of the request. If the individual, parent, or legal representative is not in agreement with the policy, he/she can contact the service coordinator in pursuing alternative placement.

Hospice Support

Under certain conditions, hospice support may be made available so that the person may remain at home if it is medically feasible. An agreement is made between the hospice program and the individual or legal representative to provide medical supports to individuals who have a terminal diagnosis.

PROCEDURES FOR INFECTION CONTROL

Procedure Effective Date: 8/18
Supersedes Procedure Number: 413 (10/11)

Responding to Incidents of Communicable Disease or Potential Infection

Any person who is afflicted with a disease in a communicable stage, or who is a carrier of a communicable disease, or who has an open wound or sore, is not permitted to work in a capacity where there is a likelihood of transmitting the disease or infection.

Any individual with skin lesions, boils, purulent discharge, or any other symptoms that could indicate the presence of a communicable disease, should seek immediate medical attention.

If the individual is diagnosed with a communicable disease, the health care professional will determine what treatment and precautions are needed.

Duet will take whatever measures are reasonable and necessary to protect the health and safety of all persons.

- Necessary precautions will be taken per doctor recommendations to control the disease and prevent it from spreading.
- Health care professional's recommendations will be followed regarding the individual returning to work/school.
- A specific school/work release from the individual's health care professional may be necessary for medical conditions which are contagious or infectious.
- The agency may contact the health department and/or a medical consultant for follow-up and recommendations.

Reporting Communicable or Infectious Diseases

If the individual has been diagnosed with a communicable disease, notification must be made to the following: Duet nursing services; the chain of command up to the Agency Director who will determine the most appropriate way to handle any notifications to others who may be affected; the individual's ISP team, including the legal representative.

Staff who have been diagnosed with a communicable or infectious disease will notify the chain of command to the Agency Director and ENHSA Human Resources.

Training

All new employees will complete Medication Aide training. Employees will also receive training on the transmission, prevention, and control of infection, including bloodborne pathogens.

Additional training will be done when new tasks or modifications occur which may potentially increase the likelihood of exposure to infection.

If applicable, the ISP team will determine how and when training will occur to teach prevention, recognition and control of communicable diseases.

DUET BLOODBORNE PATHOGENS EXPOSURE CONTROL PLAN

Procedure Effective Date: 4/19
Supersedes Procedure Number: 413.1 (1/18)

EXPOSURE DETERMINATION

All employees in the following job classifications are expected to incur at some time during their employment an occupational exposure to blood or other potentially infectious materials. The exposure determination is made without regard to the use of personal protective equipment (i.e., employees are exposed even if they wear protective equipment). Within Duet, the following job classifications are in this category:

Job Classification

Nurse (all positions), Manager, Direct Support Professionals (all positions), Shared Living Provider, Production Manager, Psychologist, Behavior Consultants, Workstation Supervisor, Job Coach

Tasks/Procedures

Direct support

Employees in the following job classifications under unusual circumstances could have an occupational exposure to blood or other potentially infectious materials, tasks or procedures. The job classifications that represent this category of exposure are listed below as well as the occupational tasks or procedures that could cause exposure.

Job Classification

Director, Coordinator and Administrative Support Personnel

Tasks/Procedures

Assisting an accident victim and visible blood is present; in emergency situations where these employees may work in direct support positions.

IMPLEMENTATION SCHEDULE AND METHODOLOGY

In keeping with good safety practice, Duet requires a schedule and method of implementation for the Bloodborne Pathogen Exposure Control Plan, as follows:
Compliance Methods

All employees of Duet will be trained on the topic of "Universal Precautions." Universal precautions will be observed at all facilities in order to prevent contact with blood or other potentially infectious material. All human blood and certain human body fluids will be considered infectious regardless of the perceived status of the source individual.

WORK PRACTICE CONTROLS

Work practice controls will be utilized to eliminate or minimize exposure to employees and persons served. At all facilities, the following controls, as applicable, will be utilized:

- Staff will be required to use **personal protective equipment (PPE)** including gloves, face shields, gowns, and other protective equipment as necessary.
- **Needles and disposable sharp instruments** are to be disposed of in containers specifically designed for this purpose.
- **Specimens** are placed in a leak-proof container, then in a leak-proof outer container for transport.
- Staff will practice **good hygiene** using frequent **handwashing**, and the use of universal precautions when coming in contact with blood and/or other potentially infectious materials.
- Staff will utilize effective **sanitation procedures** to ensure a clean environment for all settings in which a service is provided.
- All **contaminated waste** will be placed in biohazard bags and disposed properly.
- **Contaminated laundry** will be washed with a bleach or virucidal solution.
- **Garbage/trash** will be stored in containers that are leak-proof with tight fitting lids.
- All settings are to be kept clean and free of insects and rodents **through routine inspection.** Staff will seek measures to control insects and rodents when they are detected.

The above controls will be monitored and maintained on a regular basis and implemented immediately following an exposure incident, as applicable. The manager is responsible for the implementation of work practice controls in residential settings. The Coordinator is responsible for the implementation of work practice controls in day service settings.

Personal Protective Equipment

The use of personal protective equipment (PPE) is required to reduce the possibility of contamination by contact with bloodborne pathogens or other potentially infectious materials. The equipment used will be provided without cost to employees. Personal protective equipment

will be made available at each setting based on the anticipated exposure to blood or other potentially infectious materials (e.g., Standard First Aid, special care procedures) and may include gloves, face shield, gown, protective eyewear. The equipment will be of good quality to prevent or reduce risk of exposure to blood or other potentially infectious materials through contact with skin or mucous membranes. Individuals are responsible for inspecting PPE before use. Damaged or defective PPE should be replaced immediately. Personal protective equipment must be removed before leaving the work area. Disposable PPE should be disposed of properly. Any reusable PPE (if applicable) should be decontaminated and stored. Supervisors will check monthly to confirm that PPE is available. The Evacuation Report will document the availability of equipment.

The following are examples of commonly used PPE:

Gloves

1. Gloves must be worn whenever hands may encounter blood or body fluids
2. Gloves must be worn whenever medication is administered directly to the skin, open sores or mucous area (eye drops, ear drops, brushing teeth etc)
3. Disposable latex/vinyl single-use gloves will be used
4. Gloves will be changed and disposed of after direct contact with each person, and/or when care is completed
5. Hands will be washed immediately after the removal of gloves
6. Any cuts or abrasions must be covered with a bandage and gloves worn when working with a supported person
7. Gloves must be worn when cleaning toilets or other areas that may be contaminated with body fluids
8. Utility gloves may be used for non-personal care cleaning tasks and may be disinfected and reused if the integrity of the glove is not compromised

Face Shields

Disposable face shields must be available in the facility and should be used when possible by staff during CPR.

Disposable Gowns

Disposable gowns will be worn during procedures that are likely to soil clothing (e.g., laundering items that are excessively soiled with blood or other body fluids, situations where there is a large amount of body fluids present, cleaning household areas when there is likely to be spattering of infectious waste products).

<u>Sharps Disposal</u>

Re-capping, re-sheathing, or cutting of used needles, or dismantling of syringes and needle are prohibited.
Contaminated needles and disposable sharp instruments are to be disposed of in containers provided by an authorized environmental disposal company. These containers must be conveniently available in all areas where blood and/or body fluids are handled.

Specimen Handling

Specimens are placed in a leak-proof container, then in a leak-proof outer container for transport.

General Hygiene Practice

Hand washing is the single most important means of preventing the spread of infection. Hands must be washed immediately after providing direct care to an individual (even when gloves are used), after handling food, and where there has been contact with any chemical substance. Hand washing facilities are available in all Duet locations.

The use of antiseptic towelette, germicidal hand soap, or an antiseptic hand gel is acceptable where hand washing facilities are not readily available. When used, hand washing with and running water must follow as soon as possible.

Eating, drinking, applying cosmetics, and handling contact lenses are prohibited in work areas where there is a potential for exposure to blood and/or body fluids.

Personal care items such as nail clippers, hair care items, make-up, razors and toothbrushes shall **never be shared.** Items shall be individually identified and stored separately. Equipment which has become contaminated with blood or other potentially infectious materials shall be decontaminated with a veridical agent or 10% bleach solution.

Blood spills are cleaned immediately, and the area disinfected with a 1:10 solution of bleach or another effective disinfectant solution.

Staff should use **universal precautions** (body fluids could be infectious, and precautions should be taken) when encountering blood and/or other potentially infectious materials.

Procedures for Sanitation

General Sanitation

It is the responsibility of staff to ensure a clean environment for all settings. However, the degree of monitoring will vary depending on the type of setting. For each 24-hour residential home and each assisted day setting, a **setting-specific written household/sanitation chore list** must be followed. Staff will monitor off-site, shared living providers, and in-home settings to

ensure cleanliness of these settings using the QA Checklist.

Procedures for Accidents Involving Body Fluids

Staff should take the necessary actions (e.g., wearing gloves, washing hands, etc.) to ensure that they are not exposed to communicable diseases during an accident or spill involving body fluids (e.g., blood, urine, feces, etc.). When an accident or spill occurs, staff must immediately contain and clean up the situation in accordance with procedures provided through the Medication Aide Training. Hands and any other skin should be washed with soap and water immediately or as soon as possible following contact with potentially infectious body fluids. Mucous membranes should be flushed with water immediately on contact with such materials.

- Decontamination will be accomplished by utilizing the following materials: 10% bleach solution or another disinfectant solution, or EPA listed germicides.

- All contaminated work surfaces will be decontaminated immediately or as soon as possible after any spill of blood or other potentially infectious materials.

- All bins, pails, cans and similar receptacles that are used shall be decontaminated immediately.

Regulated Waste Disposal

All contaminated waste will be placed in biohazard plastic bags, i.e., sanitary pads, bandages from open wound, gauze pads used for cleaning wounds, used disposable rubber gloves and other used protective equipment/clothing, or any item (other than sharps). All contaminated waste in biohazard bags will be disposed of properly.

Laundry Procedures

Laundry contaminated with blood or other potentially infectious materials will be handled as little as possible, washed separately and immediately. Such laundry will be placed in appropriately marked bags in the area where the contamination occurs and will not be sorted or rinsed in that area. If there is visible blood or evidence of other potentially infectious materials, a 10% bleach solution or a virucidal detergent will be used to presoak. If clothing that cannot be bleached is contaminated, a virucidal detergent will be used. All employees who handle contaminated laundry will utilize **personal protective equipment** (e.g., gloves) to prevent contact with blood or other potentially infectious materials. Contaminated laundry will be washed separately and immediately.

Garbage/Trash Disposal

Indoor trash containers containing non-infectious waste shall be lined with leak-proof disposable bags and be covered with tight-fitting lids. Trash must be taken out as needed. **Outdoor** containers must have tight-fitting, waterproof lids. There shall be enough containers large enough to hold all garbage until scheduled pick-ups. All containers shall be kept clean. If applicable, recyclables should be rinsed clean and stored properly.

Any broken glassware **will not be picked up directly with bare hands.** The following procedures will be used:

1. A broom and a dustpan can be used after first putting on heavy utility gloves.

2. Tongs or metal clamps may be used so that you do not touch the glass direct

3. All equipment used (broom, dustpan, gloves, metal clamps or tongs) must then be decontaminated using a 10% bleach solution or a virucidal agent.

4. Wash hands after completion.

Insect/Rodent Control

All settings are to be kept clean and free of insects and rodents. Each setting shall be checked routinely by the supervisor or other assigned person for signs of insects and rodents. Staff seeing any such indications between inspections shall report to the supervisor immediately. It shall be the supervisor's responsibility to seek measures to control insects and rodents. These methods may include cleaning, renovation, or extermination by licensed pest control companies.

HEPATITIS B VACCINE

All employees in job classifications identified as having the potential for exposure to blood or other infectious materials will be offered the Hepatitis B vaccine at no cost to the employee. Training will be conducted, and the vaccine will be offered within 10 working days of their initial work assignment unless the employee has previously had the vaccine or unless the employee wishes to submit to antibody testing which shows the employee to have sufficient immunity. Employees who decline the Hepatitis B vaccine will sign a declination form. Employees who initially decline the vaccine but who later wish to have it may then have the vaccine provided at no cost.

Post-Exposure Evaluation and Follow-Up to Hepatitis B/HIV

An exposure incident is defined as direct needle penetration of skin, a break in the skin from a bite or abrasion, direct contact of body fluids with mucous membranes (splash in eyes, mouth, or through non-intact skin). Any employee who has an occupational exposure, or suspects an exposure to blood or body fluids, should immediately report this to their supervisor. At that time, Duet will make available a confidential medical evaluation and follow-up which will include

the following elements:

- Documentation of the route(s) of exposure and the circumstances under which the exposure occurred,

- Identification of the source individual,

- Testing of the source individual's blood as soon as feasible to determine Hepatitis B and HIV infectivity:

    - Consent to test for Hepatitis B and HIV will be obtained from the source individual or legal representative.

    - If the Hepatitis B and HIV status of the source individual is known, the status will be documented, and repeat testing is not necessary.

    - The results of the source individual's testing will be made available to the exposed employee. The employee will also be informed of applicable law, regulations and policies concerning disclosure of the identity, and infectious status of the source individual.

- Collection and testing of the exposed employee's blood for Hepatitis B and HIV serological status:

    - The exposed employee's blood shall be collected as soon as is feasible and tested after consent is obtained for Hepatitis B and HIV antibody status. The results of the testing will be provided to the ENHSA HR Director.

    - If the employee consents to baseline blood collection but does not give consent at that time for HIV serologic testing, the blood sample shall be preserved for at least 90 days. If, within 90 days of the exposure incident, the employee elects to have the baseline sample tested, such testing shall be done as soon as possible.

- Post-exposure prophylaxis, when medically indicated, will be given as recommended by the U.S. Public Health Service. In addition, when the source individual is known to be HIV positive or a high risk for HIV infectivity, additional treatment will be offered.

- Counseling will be offered to every employee who has an exposure incident. Such counseling will include, when appropriate, recommendations for treatment, follow-up care and testing, reporting of illness, safe sex guidelines, and any other information necessary and relevant to their exposure. The employee will be given an opportunity to ask questions.

Additional counseling will be provided as necessary and requested in the post-exposure period.

Training

Training for employees from day service settings on the OSHA standard for Bloodborne Pathogens will include the following:

- The OSHA standard for Bloodborne Pathogens
- Epidemiology and symptomotology of bloodborne diseases
- Modes of transmission of bloodborne pathogens
- Exposure Control Plan (i.e., points of the plan, lines of responsibility, how the plan will be implemented).
- Situations which might cause exposure to blood or other potentially infectious materials
- Control methods which will be used to control exposure to blood or other potentially infectious materials
- Personal protective equipment available at the setting and contact person
- Post-exposure evaluation and follow-up
- Signs and labels used at the setting
- Hepatitis B vaccine program.

All employees from day service settings will receive annual refresher training and include new material or updated information from OSHA.

Record Keeping

All medical records required by the OSHA standard will be maintained by ENHSA personnel as designated. A written curriculum that covers all topics required by OSHA will be on file in the Duet Area Office.

Appendix A
Definitions (Rev. 8/04)

Bloodborne Pathogens: Pathogenic microorganisms that are present in human blood and can cause disease in humans. These pathogens include, but are not limited to, Hepatitis B Virus (HBV) and Human Immunodeficiency Virus (HIV).

Centers for Disease Control (CDC): The U.S. agency that tracks the spread of diseases. It developed Universal Precautions for controlling HBV and HIV in the workplace. It is a part of the U.S. Department of Health and Human Services.

Contaminated: The presence or reasonably anticipated presence of blood or other potentially infectious materials on an item or surface.

Contaminated Laundry: Laundry which has been soiled with blood or other potentially infectious materials or may contain sharps.

Contaminated Sharps: Any contaminated object that can penetrate the skin including, but not limited to, needles, scalpels, broken glass, broken capillary tubes, and exposed ends of dental wires.

Decontamination: The use of physical or chemical means to remove, inactivate or destroy bloodborne pathogens to the point where they are no longer capable of transmitting infectious particles and the surface or item is rendered safe for handling, use or disposal.

Engineering Controls: Controls (e.g., sharps disposal containers, self-sheathing needles) that isolate or remove the bloodborne pathogens hazard from the workplace.

Exposure Incident: A specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials that results from the performance of an employee's duties.

Infectious Diseases. Conditions which are communicable in nature and capable of producing infectious diseases in others.

Occupational Exposure: Reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials that may result from the performance of an employee's duties.

Other Potentially Infectious Materials: (1) The following human body fluids: semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, any bodily fluid that is visibly contaminated with blood, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids; (2) Any unfixed tissue or organ (other than intact skin) from a human (living or dead); and (3) HIV-containing cell or tissue cultures, organ cultures, and HIV- or HBV-containing culture medium or other solutions; and blood, organs, or other tissues from experimental animals infected with HIV or HBV.

Parenteral: The piercing of mucous membranes or skin barrier though such events as needle sticks, human bites, cuts, and abrasions.

Personal Protective Equipment: Specialized clothing or equipment for protection against a hazard. General work clothes not intended to function as protection against a hazard are not considered to be personal protective equipment.

Regulated Waste: Liquid or semi-liquid blood or other potentially infectious materials; contaminated items that would release blood or other potentially infectious materials in a liquid or semi-liquid state if compressed; items that are caked with dried blood or other potentially infectious materials and are capable of releasing these materials during handling; contaminated sharps; and pathological and microbiological wastes containing blood or other potentially infectious materials.

Universal Precautions: Guidelines for preventing HIV and HBV at work which are based on the concept that body fluids could be infectious, and precautions should be taken.

Work Practice Controls: Controls that reduce the likelihood of exposure by altering the manner in which a task is performed (e.g., prohibiting recapping of needles by a two-handed technique)

PROCEDURES FOR PANDEMIC FLU

Procedure Effective Date: 9/18
Supersedes Procedure Number: 413.2 (8/09)

Each area will have plans in place in the event of a pandemic flu or other emergency. Area management will delegate chain of command authority as needed. The area office will serve as the central focus for distributing information.

In the event of a widespread medical crisis area management will follow current recommendations issued by the CDC and local health departments.

1. Individual sites are responsible to:
   - Have updated emergency medical contact information (refer to Therap Individual Data Form)
   - Have information available for emergency numbers, including management chain of command and other staff.
   - Ensure that adequate cleaning/sanitation supplies are on hand.
   - Utilize protective face masks/respirator masks that are available within the area.
   - Determine areas where an infected person can be isolated from others.
   - Consult with and follow recommendations medical personnel if needed.

2. Area management is responsible to:
   - Determine minimum staffing levels necessary to maintain essential supports.
   - Maintain copies of emergency plans for all agency sponsored sites.
   - Provide information about sanitation guidelines, infection control procedures, and taking care of a sick person in the home (available from CDC website).
   - Consult CDC and local health department web sites for up to date information and recommendations and communicate that with staff.
   - Close day centers (if conditions warrant and CDC recommendations support that) and reassign day staff to other duties.
   - Provide support to homes that may be quarantined (determine who is responsible for staffing, deliver food, meds, supplies, etc.).
   - Monitor absenteeism and deploy staff as needed.
   - Maintain area staff and substitute contact information.
   - Ensure that staff are trained in Agency's Disaster/Emergency Preparation plan and that procedures for specific sites are reviewed with staff working there

PROCEDURES FOR MISSING PERSONS

Procedure Effective Date: 9/18
Supersedes Procedure Number: 414 (3.05)

ISP teams shall determine the status of each person with respect to self-sufficiency. This should be determined in the Intake meeting or ISP and updated as necessary at ISP or team meetings.

1. If a person is missing who cannot be unsupervised in the community, **contact law enforcement immediately.** Any of the following protected health information may be provided to the police (per HIPAA regulations):

   a. Name and address
   b. Date of birth
   c. Social Security number
   d. Type of disability/injury
   e. Physical characteristics, including photo
   f. Individual's current mental status (i.e., depressed, upset, etc.)
   g. Inform the police of the person's last known location and identify with whom the person was last seen

   Notify chain of command, parent/legal representative, and service coordinator. Attempt to locate the missing person by coordinating a local search, contacting family or friends, or checking frequently visited places. A Therap General Event Report should be written.

2. If a person can be unsupervised in the community per ISP team decision, refer to the Therap IDF to identify how much time the individual can be in the community before police notification is required.

   Notify chain of command, parent/legal representative, and service coordinator. Attempt to locate the missing person by coordinating a local neighborhood search, contacting family or friends, or checking frequently visited places. If the person is not found or has not returned by the identified time limit, **the police should be notified.** HHS should be notified that a Critical Incident has occurred. A Therap General Event Report must be completed

DUET DISASTER/EMERGENCY PREPARATION PLAN

Procedure Effective Date: 7/19
Supersedes Procedure Number: 416 (3/08), 831 (3/05), 415 (10/11)

In the event of a disaster or emergency, Duet has the responsibility to establish and implement disaster preparedness plans and procedures to ensure that the individual's care, safety, and well-being are provided and maintained to the greatest degree possible. This includes anticipating disruption of utilities, and inability to access medications, groceries, and finances in day/residential service settings. These plans should include planning for disruptions, which may last multiple days. Examples of disaster are flash flood, biological or chemical attack, earthquake, tornado, winter storm, heat emergencies and fire. The focus of the Disaster/Emergency Preparation Plan is on **awareness** (through shared knowledge), **readiness** and **responsiveness** when emergency situations arise.

Disaster Plan Preparedness

Communication

The Duet administration building, and area offices will serve as the first choice to be utilized as the command center for communications in the event of a disaster. The area office will serve as the central focus for distributing information and resources to staff at different sites. Staff will utilize chain of command to maintain communication and to implement evacuation and sheltering plan, if needed. The chain of command will delegate authority as needed.

The purpose of the disaster plan is, through systematic communication, to maintain a high level of awareness regarding potential disaster and safety issues so that all individuals are prepared to respond. Furthermore, problems are identified and addressed promptly, and preventative measures are identified and implemented to the greatest degree possible.

Meeting Place

All persons may need to be evacuated in the event of certain types of disaster. In the event of a disaster that affects the safe occupation of the home or day service, the designated meeting place will be right outside of the building unless a safer alternative has been identified. In the event of severe weather or other natural disaster all persons will move to a safe area within the building. In case individuals cannot return to the building or the area is evacuated, the area office will serve as the first option for a meeting place for individuals if it is safe.

Utilities

In the event of an emergency, the first priority is always the safety of individuals. However, if everyone is evacuated safely, and there is a safe opportunity, utilities should be turned off if lines are damaged or if utility personnel have instructed that the lines be shut off. Staff will have been trained where the fuse box, water, electric and gas shut offs are.

Community Resources

If you are instructed to evacuate or the setting is deemed uninhabitable, specific community-based emergency response agencies (American Red Cross, Salvation Army) may provide alternative housing, such as emergency public shelter or hotel/motel lodging.

Emergency Action Plan

- Remain calm and be patient.

- Report the emergency. Notify all occupants of the building using alarm system or voice, call 911.
- Depending on the disaster/emergency determine whether people need to **evacuate the building or shelter in place** (seek shelter inside the building).
    - Evacuate the building – move people to safety using the setting-specific escape route.
        - Emergencies that require evacuation include gas leaks, flash floods, ingestion, absorption or inhalation of hazardous substances or materials inside the building, and fires.

    - Shelter in place - move people to a safe setting inside the building
        - Examples include tornado, ingestion, absorption or inhalation of hazardous substances or materials outside the building, winter storm.

- Account for all persons**.**
- Provide first aid or call 911 for medical attention, if needed.
- Contact Supervisor.
- Utilize media to obtain updates, news, and instructions.
- Follow the advice of local emergency officials regarding evacuation.
- Evacuate, if advised to do so. If possible, take Disaster Binder as evacuation occurs.
- If time permits and safety allows shut off gas and/or water.
- In the day service settings, remove the forklift and propane tanks (if applicable) if time permits and safety allows.
- If time permits and safety allows, remove computer EPHI (Emergency Protected Health Information) files, back up files data, and any other records.

Types of Disasters
In the event of a disaster, the Federal Emergency Management Agency (FEMA), the American Red Cross, and the Salvation Army recommend the following:

Chemical Threat
A chemical threat is the release of a toxic gas, liquid, or solid that can poison people and the environment.

In the event of a chemical threat:
- Move to an above ground location, if outdoors move upwind from the source and seek shelter immediately.
- Close all vents in the room. Seal all cracks around the door and vents into the room using duct tape. Use plastic sheeting over windows, sealing with duct tape.
- Close and lock all windows and exterior doors.
- Turn off all fans, heating and air conditioning systems.
- Close the fireplace damper.
- Utilize media to obtain further instructions from authorities.

Biological Threat
Biological agents are organisms or toxins that can kill or incapacitate people, livestock, and crops. The three basic groups of biological agents that would likely be used as weapons are bacteria, viruses, and toxins. Biological agents can be dispersed by spraying them into the air, infected animals that carry the disease to humans, and by contaminating food or water. Delivery methods include aerosols (biological agents dispersed by spraying them into the air. Inhalation of the agent may cause disease in people or animals), animals (disease is spread by insects and animals, such as fleas, mice, flies, mosquitoes, and livestock), food and water contamination, or person to

person contact (such as the spread of the plague, small pox, and the Lassa viruses).
- Move away from the area quickly.
- Wash infected area with soap and water.
- Contact authorities.
- Listen to the media for official instructions and information on signs or symptoms.
- Seek medical attention if someone becomes ill after the attack.
- Remove and bag your clothes and personal items. Follow official instructions regarding the disposal of contaminated items.
- Use common sense and practice good hygiene.

Tornado
- Go to a pre-designated shelter area such as a safe room, basement, storm cellar, or the lowest building level. Take Disaster Binder.
- If there is no basement, go to the center of an interior room on the lowest level (closet, interior hallway, bathroom) away from corners, windows, doors, and outside walls.
- Put as many walls as possible between you and the outside.
- Get under a sturdy table and use your arms to protect your head and neck.
- **DO NOT OPEN WINDOWS.**
- Utilize media to obtain further instructions from authorities and to be aware of when the tornado warning is complete.

Fire
- Activate the alarm system or verbally alert individuals in the location.
- If possible, use the fire extinguisher to extinguish the fire.
- Call 911.
- Begin evacuating the facility, meeting at the prearranged place away from the location.
- If possible, retrieve the disaster preparedness binder from the location.
- Complete a head count to ensure everyone is evacuated from the location.
- Contact supervisor.
- In the day settings, remove the forklifts and propane tanks (if possible) if time permits and safety allows.
- If time permits and safety allows, remove computers EPHI files, back up data files, and any other records.

Flash Flood
- If advised to evacuate, do so immediately. If possible, take disaster binder.
- Move to a safe area before access is cut off by floodwater.
- Go to the predetermined meeting place or to the nearest emergency shelter.
- Contact the supervisor.
- Do not attempt to drive over a flooded road. The depth of the road is not always obvious.
- If time permits and safety allows, remove computers EPHI files, back up data files, and any other records.

Water Pipe/Water Main Break
- Turn off water from main water shut off valve within the location.
- Assist individuals away from the area where the break occurred.
- Assess the damage to the area and call your supervisor.
- If possible, begin to clean up area where water leak occurred. Place buckets or other receptacles under leaks coming from ceilings
- If available, use water supplies for drinking, cooking, and hygiene until water service is restored. If not available, access community emergency resources to obtain.

- If staff suspects that there is a water main break located outside the location, they should call the local utilities emergency line and report their observations. Staff should follow the directions provided to them by the utilities company.

Sewer Main Break or Back Up

- Evacuate the affected area; in extreme cases, it may be necessary to evacuate the entire location. If possible when leaving location, take disaster binder.
- Turn off water at the main water shut off valve.
- Ventilate the area if possible.
- Call your supervisor.
- If the problem is an outside sewer line, call the utilities emergency line to report.
- When cleaning area affected by sewage, use protective covering on hand and face. Dispose of all soiled materials appropriately. Practice common sense and good hygiene skills.

Gas Leak

A gas leak can be extremely dangerous because the smallest spark or flame can ignite gas fumes, causing an explosion. Natural gas has a garlic like odor. In the event of a gas leak:

- **DO NOT LIGHT A MATCH OR LIGHTER**
- **DO NOT OPERATE ANY ELECTRICAL SWITCHES** (they could ignite an explosion)
- Call 911
- Ventilate the house/location by opening doors and windows. If the smell of gas is strong, move everyone outdoors at once.
- Turn off the gas supply valve located in the location.
- Notify supervisor.
- Follow any directions given to you by emergency workers about returning to or evacuating the location. If you must evacuate, take the disaster preparedness binder.

Carbon Monoxide Leak

Carbon monoxide is a deadly gas, which has no color, odor, or taste. Carbon monoxide fumes can be emitted from furnaces, carbon-based materials, fuels, car exhausts, and refrigerators. Prolonged exposure to carbon monoxide can cause serious illness, brain damage, or even death. Symptoms of carbon monoxide poisoning are shortness of breath, mild nausea, mild headaches, and light-headedness. The easiest way to detect a carbon monoxide leak is through a properly installed and rated carbon monoxide detector. A CO detector is designed to go off if abnormal levels of carbon monoxide are present in the air. In the event of a carbon monoxide leak:

- Evacuate the location immediately.
- Take the disaster preparedness binder.
- If possible open windows and doors on your way out of the location.
- Once the location is evacuated, call 911.
- Do not return to the location for any reason. Use a cell phone or neighbors' phone to contact your supervisor.
- Contact the medical professional for each individual and for extreme cases go directly to the emergency room for treatment.
- You should only return to the location once the appropriate authorities have indicated it is okay.

Winter Storm

In the event of a winter storm:

- Stay indoors during the storm.
- Utilize media to obtain weather reports and emergency information

- Wear several layers of loose fitting, lightweight, warm clothing rather than one layer of heavy clothing.
- To keep pipes from freezing, let faucets drip a little. Know where the main water shut off valve is located, in case of water pipe rupture.
- Avoid any unnecessary travel.
- Eat regularly. Food provides the body with energy for producing its own heat.
- Keep hydrated; avoid drinks with caffeine as it can cause dehydration and accelerates symptoms of hypothermia.

<u>If you must go outside during a winter storm:</u>
- Wear layered clothing, mittens, or gloves, and a hat.
- Cover your mouth to protect lungs from extremely cold air.
- Watch for signs of hypothermia, this occurs when the body's core temperature drops to less than 95°F:
  - Uncontrollable shivering
  - Slow speech
  - Memory lapses
  - Frequent stumbling
  - Drowsiness
  - Exhaustion
- Watch for signs of frost bite, which is a severe reaction to cold exposure which can cause permanent harm to people:
  - Loss of feeling in the fingers, toes, nose, or earlobes
  - White or pale appearance in the fingers, toes, nose, or earlobes
- If hypothermia or frostbite is suspected seek immediate medical assistance.
- Keep dry. Change wet clothes to prevent a loss of body heat.
- Avoid overexertion and stretch before shoveling snow.

<u>Power Outages</u>
In the event of a power outage
- Check neighboring houses to ensure if outage is just at the location or neighborhood wide.
- Check the fuse/breaker box to ensure power loss is not due to a tripped circuit.
- Call the power company to report the outage.
- Use battery powered lanterns or flashlights. Candles should not be used as an emergency lighting source.
- Do not open the refrigerator or freezer. An unopened refrigerator will keep food cold for at least a few hours and an unopened freezer will keep food cold for up to 2 days.
- Turn off appliances that were being used when the power went off. By doing this you reduce the risk of overloading their circuitry when the power is restored.
- Use the phone for emergencies only.
- Utilize media or radio to obtain the latest information.
- When the power is off for more than one hour, contact chain of command.

<u>If power is lost during a winter storm:</u>
- Temporarily close off other areas of your home and remain in one area of the residence.
- Hang blankets over windows and place rolled up rugs or towels at the base of the doorjam.
- Eat regularly and drink ample fluids.

<u>Extreme Heat</u>
In the event of prolonged periods of extreme heat:
- Stay inside as much as possible and limit exposure to the sun.

- Stay on the lowest floor out of the sunshine if air conditioning is not available.
- Eat well-balanced, light, and regular meals.
- Drink plenty of water.
- Dress in loose fitting, lightweight and light-colored clothes.
- Monitor for the following heat related conditions and provide appropriate first aid or seek medical attention, when applicable:

Sunburn:
- Skin redness and pain
- Possible sweating
- Blisters
- Fever
- Headache

Heat Cramps
- Painful spasms, usually in the leg and abdominal muscles
- Heavy sweating

Heat Exhaustion
- Heavy sweating
- Skin may be cool, pale, flushed
- Weak Pulse
- Normal Body temperature is possible, but most likely it will rise
- Fainting or dizziness
- Nausea
- Vomiting
- Exhaustion
- Headaches

Heat Stroke (A severe medical emergency)
- High body temperature (105+)
- Hot, red, dry skin
- Weak pulse
- Rapid shallow breathing
- Possible unconsciousness

<u>Earthquake</u>
In the event of an earthquake:

<u>If Indoors</u>
- Drop to the ground, take cover by getting under a sturdy piece of furniture, and hold on until the shaking stops. If there isn't a table or desk near you, cover your face and head with your arms and crouch in an inside corner of a building.
- Stay away from glass, windows, outside doors, and walls, and anything that could fall, such as lighting fixtures or furniture.
- Use a doorway for shelter only if it is in proximity and it is a strongly supported, load-bearing doorway.
- Stay inside till the shaking stops and it is safe to go outside.
- Assess individuals for any injuries and provide first aid as needed or call 911 for emergency medical assistance.
- Utilize media to obtain news and instructions.
- If location is uninhabitable and must be evacuated go to the site specified by your

supervisor or a community-based emergency shelter. Take disaster preparedness binder.
- Electricity may go out and sprinkler systems or fire alarms may turn on.

If Outdoors
- Stay there. Do not attempt to go inside.
- Move away from buildings, streetlights, and utility wires.
- Once in an open area, stay there until the shaking stops. The greatest danger exists directly outside buildings, at exits and alongside exterior walls.

If in a Moving Vehicle
- Stop as quickly as safety permits and stay inside the vehicle.
- Avoid stopping near or under buildings, trees, overpasses, and utility wires.
- Proceed cautiously once the earthquake has stopped.
- Avoid travel on roads, bridges, or ramps that might have been damaged by the earthquake.

Emergency Supplies

Disaster Preparedness Identification Information

This Disaster Preparedness Binder will be in a central and accessible location in each setting.

Disaster Preparedness Binder

- Identification information and photo for each individual (can retrieve from Therap)
- List of current prescription medications and PRN medications
- Copy of most current nursing care plan (if applicable)
- Site specific evacuation information
- Floor Plans of the setting
- List of Chain of Command Names and Contact Information
- List of community emergency response providers (Salvation Army, Red Cross, etc.)

Disaster Preparedness Supplies

In the event of an emergency, it is important to have some basic supplies. If those supplies are not accessible, utilize community emergency resources.

Some examples could include:

- Special needs items (formula, nebulizer, inhaler, syringes, tubing)
- First aid supplies
- Medication
- Change of clothing
- Sleeping bag, blankets, pillows

Food - The following is a suggested list of foods to have on hand for emergencies:
- Ready to eat canned meats, chicken, tuna, spam, ham
- Canned fruits
- Canned vegetables

- Canned juices
- Powdered milk
- Staples – sugar, cereal, salt, pepper
- High energy foods – jelly, crackers, granola bars, trail mix
- Comfort foods, if diet permits – cookies, hard candies, instant coffee, tea, sweetened cereals.
- Disposable paper products – plates, utensils, paper towels, paper plates, toilet paper
- Non-electric can opener

Bottled water - Drinking water (pre-sealed and replenished every 6 months)

- Store one gallon of water per person per day (two quarts for drinking, two quarts for food preparation/sanitation)
- Keep at least a three-day supply of water for each person in the household.

Emergency tools

- Battery powered radio
- Flashlight
- Extra batteries
- Pliers
- Shut-off wrench
- Duct tape
- Paper and Pencil
- Plastic Sheeting
- Permanent Marker

Maintaining your Disaster Preparedness Supplies

Just as important as putting supplies together is maintaining them so they are safe to use when they are needed.

- Keep canned foods in a dry place where the temperature is cool.
- Store boxed food in tightly closed containers to protect from pests and to extend shelf life.
- Throw out any canned goods that become swollen, dented, corroded, or expired.
- Update the supply kit as individual needs change~~s~~.
- Keep items in airtight plastic bags and place supplies in portable containers.

Review Process

The Disaster/Emergency Preparation Plan should be reviewed annually. The review should be documented on the Duet-236. Staff should also sign and date the back of the form to acknowledge the review. The review form is submitted to the Coordinator/Division Director. Original form to be filed on site, copy routed to Quality Assurance Coordinator.

PROCEDURES FOR EVACUATION AND WATER TEMPERATURE SAFETY REPORTS

Procedure Effective Date: 2/19
Supersedes Procedure Number: 416 (9/11)

Emergency Escape Exit Routes

A floor plan indicating the route of evacuation from any given point and the final destination (the route and destination will vary, depending on the type of emergency; e.g., basement or interior room away from outside glass for tornadoes, out-of-doors for fire) must be posted on each floor in each setting.

Evacuation/Water Temperature Safety Report

Conduct emergency evacuation drills using the Evacuation/Water Temperature Safety Report.

1. All settings must conduct fire drills monthly, and tornado drills **monthly** during tornado season (March through September).

2. Evacuation time should be appropriate to the number of people in the home and abilities.

3. Fire and tornado drills should not be run on the same day, and drill times should be varied.

Monitor quality and quantity of materials and products for emergency use.

1. Fire extinguishers are readily accessible and properly placed for immediate use, the correct type of fire extinguisher is available, the extinguisher is fully charged, the safety pin is in place, properly maintained, and there is documentation of monthly inspections on the tag located on the extinguisher.

2. Smoke alarms and smoke detectors are properly maintained and placed, batteries charged, emergency lighting, electrical wiring (if applicable).

3. Evacuation routes are well marked, lit, kept free from obstruction, travel distance to exit is within 200 feet of a person in the setting, and exit doors are adequate for the number of persons to evacuate the setting.

Document practice operations on the Evacuation/Water Temperature Safety Report form and submit to the appropriate supervisor who will review the report, conduct the water temperature check, submit promptly to the Coordinator. A copy of the form should be retained on site.

Water Temperature Safety Checks

Water temperature safety checks will be completed monthly by the supervisor and or appropriate designee.

For all settings, the temperature range must be between 110ºF and 115ºF. With 112ºF as the desired setting. If the temperature is greater than 115ºF, immediate action should be taken to

lower the temperature.

Aside from routine water temperature checks, if staff notice during normal use that the water temperature is excessive, they must immediately physically take the water temperature following the established protocol. Should the water temperature exceed 115ºF they must notify their supervisor and the Maintenance Director so that immediate action can be taken. The temperature reading and any actions taken must be documented in the Water Temperature Log (Duet-235W).

Limitation on the water temperature is not needed if the ISPs for all individuals at the location document that they can independently adjust water temperature or if the individual lives with their family.

Training

Staff will receive Fire Safety training within 30 days or prior to assignment.

Staff will receive a setting-specific new-employee orientation/on-the-job training which reviews specific emergency procedures, including location of first aid supplies, evacuation drills, gas and water shut-off, location of circuit breakers and fuses.

1. All new day service staff will receive training on fire prevention including work area fire hazards, proper storage and handling of flammable materials, general housekeeping practices of combustible/ flammable materials.

2. The fire prevention training for day service supervisors and other designated staff will annually receive training on the following topics: types of fires, types of fire extinguishers, fire extinguisher inspection and service requirements, live extinguisher training, fire detection and alarm systems and emergency evacuation/exit. This training is documented on the staff training record for fire prevention.

All Duet Employees will receive training on water temperature safety checks in OJT and First Aid training.

PROCEDURES FOR MENU PLANNING, FOOD PREPARATION AND STORAGE

Procedure Effective Date: 9/04
Supersedes Procedure
Number: 417

Menu Planning

Preferences of individuals served will be considered in the planning, purchasing and preparing of food based on the individual's abilities. In 24-hour settings, menus are to be planned in accordance with the recommended dietary allowances (RDA) of the Food and Nutrition Board of the National Research Council and reviewed by a dietitian/nutritionist.

Persons requiring a modified diet must have a diet prescription signed by his/her health care professional and reviewed and modified periodically. This prescription will be kept on file and available to any person responsible for preparing food. A health care professional's written recommendation for any vitamin and mineral supplements for those persons must also be kept on file.

Food Preparation and Storage

Foods are prepared using methods that conserve nutritive value and enhance flavor and appearance. Food shall be prepared on a clean, dry surface. Persons who prepare food shall first wash their hands with soap and warm water and dry them using a clean, dry towel. Clean dishes, pans, and utensils shall be used.

Food is served in appropriate quantities and at appropriate temperatures. Food which has been **served on the plate but not eaten** shall be disposed of either using a properly working garbage disposal or in garbage containers which have tight fitting, lids and are lined with leak proof disposable bags.

Any prepared foods that are not served must be labeled, dated, and promptly refrigerated. Plan to use leftovers quickly, either in another meal or in snacks. Spoilage cannot always be determined by sight or smell. **The safest guide to follow is when in doubt, throw it out.**

Frozen and refrigerated foods must be stored as quickly as possible. Perishable foods shall be stored in a clean, working refrigerator at temperatures between 33 °F and 45° F. Frozen foods should be stored at 0°F or below and all refrigerated foods at 45°F and below. Agency-paid settings must have thermostats in refrigerators and freezers.

Dry foods should be stored in enclosed cupboards or in clean, well-ventilated areas on shelving at least 12" off the floor in a well-ventilated area free of water, rodents, and insects. Use canisters, cans, or jars with tight fitting lids to keep items, such as rice, flour, sugar, etc., dry and free from insects after opening

PROCEDURES FOR VACATIONS AND OUTINGS

Procedure Effective Date: 9/18 Supersedes Procedure Number: 418 (1/07

Planned vacations are defined as any trip in which Agency staff actively participate in the planning and/or supervision of the vacation. These vacations must be developed within the following criteria:

All vacations in which Agency staff participate must be approved by the Area Director and Duet Director at least two weeks in advance. The Duet Vacations and Outings Request form must be submitted for approval.

Social Security should be contacted if the individual's SSI or SSA funds will be used to pay for the vacation.

Individuals shall be responsible for paying their own expenses on vacations/outings trips.

Certain staff vacation expenses may be covered under the following guidelines:

1. The person's needs, as identified by the ISP team, require that there be staff supervision on the vacation trip.

2. With documentation of ISP team approval and identification of the person's ability to pay, the person's funds may be used to cover a proportionate share of staff expenses related to travel, lodging, and/or supervision (e.g., gate admissions, park entrance fees).

3. When an ISP team has determined that a person does not have an ability to pay, the ISP team may request that the Agency reimburse that person's proportionate share of allowable staff expenses.

4. Staff expenses related to meals, beverages, personal phone calls, souvenirs, or any other purchase not related to supervision will be the individual staff person's responsibility and will not be included when figuring proportionate shares of allowable staff expenses.

5. All vacation plans must include detailed estimates of all expenses and must be submitted for prior approval of any staff expenses involved.

Staff will be expected to keep and turn into their supervisors a detailed statement of all relevant expenses, with verifying receipts.

Supervisors must verify that all drivers have a valid driver's license and, if applicable, the car owner have proof of insurance. This is not applicable if the individual has a pre-paid vacation package through a vacation organization.

The ISP team will review all vacation proposals for an individual to evaluate how that person's identified needs will be met during the vacation trip. Health and safety issues, level of required supervision, ongoing staff objectives, ability to pay and other specific

individual needs are to be considered and planned for by the ISP team prior to submitting a request for approval.

Staff proposing to take persons on activities which include swimming or boating, must develop a **safety plan.** Persons who are not independent swimmers must have 1:1 supervision and water floatation devices where appropriate. Provision for persons who have demonstrated they are competent in swimming will be decided on a case-by-case basis.

Day trips are same-day trips outside the Duet five county region (Region VI), in which Agency staff actively participate in the planning and supervising. Day trips must have prior approval of the chain of command. If expenses are incurred by the individual exceeding $100, information must be provided on the Duet Vacations and Day Trips Request form. In addition, consent must be obtained by the legal representative, and the team must be notified. Social Security should be contacted if the individual's SSI or SSA funds will be used to pay for staff portion of the vacation, and the Vacation and Day Trip form will be completed.

ADMINISTRATION AND PROVISION OF MEDICATIONS POLICY

Policy Effective Date: 1/19
Supersedes Procedure Number: 440 (7/14)

The administration of medication is an activity regulated by the Nebraska Department of Health and Human Services Division of Public Health Licensure Unit, Office of Nursing and Nursing Support. Provision of medication by medication aides is governed by regulations (172 NAC 95, Provision of Medication by Medication Aides and Medication Staff, and 172 NAC 96 Medication Aide Registry). Administration of medication includes three components: the physical act of taking/providing/applying a medication, documentation of the physical act, and awareness of the therapeutic effects of the medication.

Individuals should be actively involved in discussions with their healthcare practitioners regarding medication and the medication administration process, with appropriate staff supports. Individuals maintain their autonomy about taking medication. An individual that has the capability and capacity to make informed decisions about medications and perform all the components of administration are self-medicating. Additionally, there are circumstances under which it is appropriate and desirable for persons to receive support with the administration of medication. Support with taking medication should be provided as needed for those who are not able to independently self-administer.

Duet Registered Nurses accept responsibility for the **direction and monitoring** for activities related to the provision of medication by medication aides. Duet Registered Nurses include the following positions: staff RN, Case Management Nurse, Charge RN, MSU RN/Supervisor, Director of Nursing and contracted RN. Medication aides help with the physical act and documentation of provision of medication; and, under specific conditions may also assist with observing for identified responses and reporting those responses to a Duet RN or physician.
Staff who provide medication or who monitor individuals taking medication will be trained by a Duet nurse and must be registered by the State of Nebraska as a Medication Aide.

Duet documents medication administration for all individuals, except persons who self- administer, through a HIPAA-secure electronic system of medication administration called Therap. With the Medication Administration Record (MAR), staff can record and track when a medication has been provided to an individual, along with any other corresponding documentation.

The State of Nebraska places employees on the Medication Aide registry if they have completed training and have been deemed competent to provide medication. It is the responsibility of Medication Aides to maintain their license and to renew their Medication Aide registration. In addition, it is also the responsibility of the Medication Aide to notify the State of Nebraska of any address change by completing the **Nurse Aide/Medication Aide Registry Address Change form**. If a Medication Aide has provided services as a Medication Aide without proper authority, staff are responsible for all consequences for such action.

ADMINISTRATION AND PROVISION OF MEDICATIONS PROCEDURE

Procedure Effective Date: 1/19 Supersedes
Procedure Number: 441 (8/18)

Responsibilities/Activities of Medication Aides

A medication aide provides medication under the direction and monitoring of a Duet Registered Nurse. Duet Registered Nurses include the following positions: MSU RN, Case Management Nurse, Charge RN, MSU Supervisor, RN Supervisor and contracted RN. A Duet RN retains the authority regarding competency of medication aides to provide medication. Duet RNs also accept responsibility for the direction and monitoring of all activities related to the provision of medication by medication aides.

Medication aides, as directed by a current physician's order and monitored by the prescribing care professional, may perform the following activities after completing Duet Medication Aide Training with an exam score of 80% or higher, a classroom skills validation, and individual competency demonstration. Responsibilities of the Medication Aide include:

Routine Medications - Provide routine medications. Routine medication means that the frequency, amount, strength, and method of provision are specifically fixed. Medication aides will provide **routine** medication according to the five rights:

1. Right **Person**
2. Right **Medication**
3. Right **Dose**
4. Right **Time**
5. Right **Route**
    - **Oral**, which includes any medication given by mouth including sublingual (placing under the tongue) and buccal (placing between the cheek and gum) routes and oral sprays
    - **Inhalation** that includes inhalers
    - **Topical** application of sprays, creams, ointments, and lotions and transdermal patches to the skin
    - **Instillation** by drops, ointments, and sprays into the eyes, ears and nose

A. PRN Medications - Provide prescribed **PRN** (as needed) medications if the individual requests medication for a specific reason and/or if staff observe a specific medication condition for which a physician's order directs the individual and or staff to provide medication. PRN Medications are given under the following conditions:

    1. Medication aides are provided training on the PRN medication procedure and conditions by which they observe, and report identified responses to a Duet RN.

        a. Following the completion of Medication Aide Training and demonstration of classroom and on-site competencies, the medication aide is determined to be competent to provide PRN medications.

        b. The medication aide follows the protocol for PRN medications to ensure safety.

    2. A current physician's order is obtained that provides written direction and includes the name of person, name of medication, specific reason, amount, frequency of administration, and under what conditions to give the medication.

a. As with routine medication, a new physician's order does not have to be obtained each time an individual requires a PRN medication. The order is current for one year plus 30 days from the date prescribed unless the physician has indicated an applicable stop date.

3. The licensed health care professional with prescriptive capability included in their scope of practice must document that it is safe for the individual to take PRN medications.

4. The individual providing the prescribed PRN medication must:
    a. Receive approval from a Duet RN for each individual, each medication, and each dosage prior to giving the medication.
    b. The medication aide documents approval in the PRN section of Therap including the date and time of administration, the specific reason why the medication was given, name of the RN contacted, direction of RN, the person's response to the medication, including effectiveness (follow-up) to medication.
    c. If the PRN medication is not effective, the medication aide will contact a Duet RN for additional instructions.

5. A Duet RN will also document the direction given to the medication aide.

6. Medication prescribed for behavioral support (including sleep medication) is not given on a PRN basis. One time or stat orders are not considered PRN (e.g. Ativan prior to medical/dental procedure).

B. When a medication is prescribed PRN for a medical condition that is likely to recur, keep the medication for no longer than one year unless the expiration date reads otherwise or there is a change in color or consistency of medication. Return medication to pharmacy if the medical condition is not likely to recur (e.g., surgery, dental procedures).

C. Provide medication by **additional routes** (e.g. g-tube, rectal, vaginal). Before a medication aide may provide medication by additional routes the following conditions must be met:
    1. A Duet RN completes a nursing assessment and determines any individual needs related to additional route.
    2. The medication aide is trained, and competency tested by a Duet RN. The RN or medical professional documents the date that the training is completed, and competency demonstrated on the Duet-206.
    3. A Duet RN retains responsibility and accountability for the additional route by providing nursing assessments, planning, evaluation, and assuring documentation.
    4. There is written direction (e.g., physician's orders, health support plan, and/or training protocol) for each person and every additional route. A licensed health care professional must sign, and date documentation related to written direction.

5. The licensed healthcare professional with prescriptive capability included in their scope of practice documents that it is safe for the individual to receive medication by an additional route.

6. The medication aide participates in observing for identified responses and reports responses to a Duet RN.

7. A Duet RN provides on-going supervision of the additional route.

Supervisor Responsibilities

The supervisor must attend training before participating in observing and reporting.

In 24-hour and day service settings (including Shared Living Provider homes) the supervisor reviews medication records, Medication Administration Problem Error Log (Duet -203) or a Self-Administration Problem Error Log (Duet-204), and medical documentation at least weekly and contacts an Duet RN if further direction is needed.

If a medication error is made the supervisor reviews the Medication Administration Problem Error Log (Duet-203) or the Self-Administration Problem Error Log (Duet-204), provides follow-up actions to prevent future errors, and ensures that the Duet RN has been notified. The report is routed to the Case Management Nurse within 72 hours.

Monthly, the supervisor audits the Self Administration Medication Records and the Self-Administration Problem Error Log (Duet-204). The Supervisor also reviews the Therap MAR and the Medication Administration Problem Error Log (Duet-203) and routes to the Duet RN for audit.

The supervisor will monitor medications to assure adequate accountability measures are taken when medications are ordered, received on-site, and counted as required.

The supervisor reviews the written care plan (including special care procedures and/or additional route), observation/Nursing Assessment as needed with the medication aides.

Medication Aide training and competency will include the following:

- Completing classroom instruction
- Passing a written exam with a minimum score of 80%
- Passing a classroom skills validation with 100% accuracy
- Completing an individual-specific competency skill assessment

The medication aide cannot independently provide medication without supervision until successfully completing individual specific competency skills checks. If the medication aide cannot demonstrate competency after five (5) attempts, the Medication Aide RN trainer will be notified.

Competency will also be reassessed every two (2) years prior to the expiration of the medication aide. The current MA must successfully pass the Duet Medication Aide Renewal training with a minimum score of 80%. The skill checks will be completed by the supervisor or coordinator and the medication aide will successfully complete one (1) individual specific competency. If the MA cannot demonstrate competency after 3 attempts the MA trainer will be notified.

Following the initial training the supervisor will be required to provide periodic observation of competency of the medication aide and report concerns to a Duet RN.

The supervisor reviews the accuracy of transcribed orders including changes in doses and/or frequency, or if medication is discontinued.

If the medication aide has problems with demonstrating competency, following the 5 rights, the supervisor will contact a Duet RN.

Health care professional's order will be attached in Therap within 1 business day.

Coordinator Responsibilities

The coordinator will compile the Medication Administration Problem Error Logs (Duet-203) and the Self-Administration Problem Error Log (Duet-204) track submission and return of medication records and MAPEL/SMAPEL logs monthly.
The coordinator will perform periodic audits of medication records for each caseload.

The coordinator will ensure that medication records and related documentation are submitted to the ESS Division for review.

Prior to accepting a new person into services, the RN will be provided medical information about the individual so that a determination can be made regarding ability to serve.

The coordinator must have Medication Aide certification before participating in observing and reporting.

The coordinator is responsible for completing competency skills checks for supervisors that report directly to them. After the supervisor has successfully completed Medication Aide training, the supervisor will be required to complete a competency skill check before they can give medications. The coordinator is responsible for insuring competency standards are met. Documentation is submitted to a Duet RN. Competency will also be reassessed every two (2) years and within 6 months prior to expiration of their Medication Aide Registration. For renewals, the Coordinator must observe the supervisor complete one (1) successful medication pass for each route.

The coordinator will review with the supervisor medical issues and related documentation for individuals on their caseloads.

Nursing Responsibilities

A Duet RN accepts responsibility for the direction and monitoring of activities related to the provision of routine medications, PRN medications, and medication by additional routes by medication aides. This responsibility is outlined in nursing job descriptions.

A Duet nurse provides Medication Aide training and on-going training to Duet staff regarding medication provision.

A Duet nurse reviews medication competency following training and determines that the medication aide can safely provide medication.

A Duet RN trains and directs medication aides to provide medication by an additional route.

A Duet RN provides ongoing supervision and monitoring for the safe provision of medication to individuals.

1. Medication aides are monitored on a regular basis through reviews of medication records and related documentation.

2. A Duet RN will follow-up on any medication problems, including requesting additional documentation and/or completion of reports as needed.

3. A Duet RN reviews all MAPELs, Self-Medication Problem/Error Logs, and Therap General Event reports for issues related to medication provision and ensures that corrective action is taken as a result of non-compliance with Duet Medication policy and procedures.

4. A Duet RN will review medication error documentation and follow up and, if needed, will make further recommendations for preventative measures to avoid or reduce medication errors.

5. For individuals with complex medical needs, special care procedures, or additional routes, a Duet RN will develop, and update written care plans annually and, as needed, if there are any significant changes in health.

A Duet RN is readily accessible to the medication aide by contacting a Duet RN on duty at the medical support units (MSU – North/MSU – South) or the Jerry Graesser Center.

PROCEDURES FOR ACCOUNTABILITY

Procedure Effective Date: 1/19
supersedes Procedure Number: 441 (7/14)

All medications are reviewed by the licensed health care professional with prescriptive authority at least annually. The review may occur up to 30 days beyond the one-year expiration date in cases where insurance coverage is a consideration.

A physician's order is obtained for all prescription and over-the-counter medication prior to provision and upon termination of the medication. The following professionals have prescriptive authority in the state of Nebraska: physicians, dentists, physician assistants, and advanced practice registered RNs (APRN).

Medication Count for 24-Hour and Day Service Settings:

1. Medication is counted and recorded daily on MAR'S. Staff have the responsibility to monitor the count, to identify if the count is correct, and to notify their supervisor and a Duet RN if there is an error.

2. To count liquid medication (except topical medications, drops and sprays), figure the amount on hand in mls., then subtract each dose in count column verifying the estimated count with amount remaining in bottle.

3. Topical medication, drops, and sprays are to be recorded at the beginning of the month with an estimate of amount on hand and amount remaining. On a nightly basis, staff will check that the medication is on hand, and indicate with a "+" on the count line. Refills must be recorded on date received.

4. PRN medications are counted with routine medications at the beginning and the end of each month. If the count is incorrect, staff will record the problem on the Medication Administration Problem/Error Log (Duet-203) and Self Medication Problem/Error Log (Duet-204).

    a. If a PRN dose of medication **is provided** during the month, then it must be counted, and the count recorded on the PRN Medication Record at the end of every day that it was given.
    b. PRN controlled substances must be counted, and the count documented daily.

Medication Counts for individuals living in less than 24-hour settings are determined by the living arrangement, self-administration status, and frequency of staff contact, but is counted at least weekly.

Information and/or questions about medication are referred to a Duet nurse.

Medication ordered and dispensed for one individual is never given to another.

When a medication error has occurred, a Duet nurse is notified immediately. The supervisor is contacted within 24 hours (one business day).

Approved by Duet Director

Duet Director

August 12, 2020

Date

Approved by ENHSA Governing Board

ENHSA Governing Board Chair

August 12, 2020

Date

PROCEDURES FOR PROVIDING MEDICATION

Procedure Effective Date: 1/19
Supersedes Procedure Number: 441 (7/14)

All medications are provided by a medication aide under the written direction of a licensed healthcare provider with prescriptive authority. This includes over-the counter medication.

1. Verbal orders (telephone orders) are only used in the event that a written order cannot be obtained, and the physician determines that the medication should begin without delay. Telephone orders are only taken by an RN, and only in exceptional circumstances.

2. The most current physician's orders for any prescribed medication or treatment are kept on-site.

3. The medication is given from the original pharmacy container with the prescribing professional's instructions clearly indicated on the label. The label must include dosage, frequency, date of refill, date of prescription, name of medication, name of the person, and prescribing professional.

Once medical orders are obtained, they must be implemented within 12 hours. If there is a problem with implementing the order on a timely basis, notify a Duet nurse.

Medications must be in containers that have been labeled by the pharmacist.

There should be a pharmacy-specific time for the medication to be provided. When giving medication, there is a 1-hour leeway on either side of set time of provision.

Staff cannot set up medication for a later time.

When giving medications and the medication becomes contaminated (e.g. person spits out the medication, or drops pill), staff will complete a Medication Administration Problem Error Log (Duet-203) and follow procedures for return of prescribed medication

An entry is made on the medication record immediately after the medication is taken. Staff giving medication will document on the MAR that the medication was given by recording their initials for each dose given. Their initials correspond to the signature/initials in the legend box.

If paper MAR is used, (ex: Internet down) staff will record their initials on the corresponding date/time and sign signature page.

Non-Medicated Topical: Listed below are examples of non-medicated topicals that do not require documentation on a Physician's Order or a medication record unless it is is prescribed as a treatment for a specific condition.

- Sunscreen
- Non-medicated moisturizing lotions (Vaseline Intensive Care lotion, KeriLotion, Eucerin Cream, Lubriderm, etc.)
- Non-medicated moisturizing oils (i.e., Alpha Keri Bath Oil, baby oil)

- Non-medicated dandruff shampoos (Selsun Blue, etc.)
- Lip care (Vaseline to lips, Carmex, Blistex, etc.)
- Over-the-counter skin cleansers (Sea Breeze, Basis Soap, etc.)

Drug information sheets for self-medication individuals from the pharmacist for each medication will be included in the Individual Record Book (IRB) with a list of side effects and reasons for medications. Drug information can be located on Therap for individuals who are not-self medicating.

PROCEDURES FOR RETURN OF PRESCRIBED MEDICATION

Procedure Effective Date: 1/19
Supersedes Procedure Number: 441 (12/14)

When any prescription medication is discontinued permanently, the prescription has expired, or the medication becomes contaminated (medication dropped, spit out or otherwise rendered unusable), the medication is disposed of by a registered pharmacist.

Medication aides never dispose of medications; instead they complete the Medication Return Record and provide it to the pharmacist with the returned medication.

In extraordinary situations two Duet RNs may destroy medications to the point where they are rendered unusable.

Medications may be surrendered to a family member when the individual terminates from services. This is documented on the Duet Medication Administration Record.

Once the pharmacist completes the Medication Return Record, it is submitted with the MAPEL/SMAPEL and other documentation to a Duet RN.

Any problems with the medication return process are documented on the Medication Administration Problem Error Log and the supervisor is notified.

Any medication held for destruction must be stored in a secure location.

When medication is stored in the home, nightly counts will continue.

When medication is brought to a secure location, chain of custody is established.

When medication is stored away from home medications will be counted weekly.

Upon destruction, a final count will be completed by the pharmacist or a Duet RN.

MEDICATION ERRORS AND PROBLEMS

Procedure Effective Date: 1/19
Supersedes Procedure Number: 441(12/14)

Types of Problems/Errors

A medication error is defined as any incorrect provision of medication that violates the five rights and has the potential to adversely affect the individual. These types of errors require immediate notification of a Duet RN. These include:

1. Wrong person
2. Wrong medication
3. Wrong dose
4. Wrong time
5. Wrong route
6. Missed dose

A medication error is also defined as any other issue that may or may not have the potential to adversely impact the individual. Types of errors that require immediate RN notification include:

1. Count incorrect with potential to impact the individual
2. Newly Prescribed Order not initiated within 12 hours
3. If medication was provided: Expired orders, expired medications, improper storage of medication

Note: although not considered an error, contact an RN for refusal to take medication.

Other medication problems that have no potential to adversely impact the individual and do not require immediate Duet RN notification include:

1. Illegible count/entry (medication count accurate)
2. Missing initials (medication count accurate)
3. Missing Medication Return Record
4. Medication becomes contaminated (dropped, spit out, rendered unusable)
5. No documentation for follow up/use of PRN medication
6. No documentation Duet RN instructions/directions for use of PRN
7. Count inaccurate – no impact to individual
8. Problems with Medical Charting
9. Problems with Seizure Record
10. Problems with Health-Related Services

Reporting Medication Problems/Errors

Any medication error that has the potential to have an adverse impact on the individual as defined in sections A & B must be reported as follows:

- The error must be reported immediately to a Duet RN and further direction will be given to the Medication Aide.
- The error must be reported to the immediate supervisor within 1 business day.

- The person who discovers the error completes the error section on the Medication Administration Problem Error Log (Duet-203) or a Self-Administration Problem Error Log (Duet-204). The supervisor reviews the report and provides follow up actions to prevent future errors. The report is routed to the Case Management Nurse within 72 hours.
- Should the impact on the individual require medical attention, the supervisor will complete a Therap GER.

Other medication problems that have no potential to adversely impact the individual as defined in section C above and do not require immediate Duet RN notification must be reported as follows:

- The person who discovers the problem completes the problem section on the Medication Administration Problem Error Log (Duet-203) or a Self-Administration Problem Error Log (Duet-204). The form is routed to the Case Management Nurse.

The supervisor will review and evaluate medication errors or problems. Follow up actions on how to prevent future problems and errors will be documented on the Medication Administration Problem Error Log (Duet -203) or a Self-Administration Problem Error Log (Duet-204). This plan may include Duet RN recommendations and may involve additional training, performance coaching, increased supervision, and/or disciplinary action.

A Duet RN will review medication error documentation and appropriate actions to be implemented. A Duet RN, if needed will make further recommendations for preventative measures to avoid or reduce medication errors.

Medication errors/problems will be tracked, reviewed, and analyzed for trends and quality improvement.

STORAGE OF MEDICATION

Procedure Effective Date: 1/19
Supersedes Procedure Number: 441 (7/14)

All medication is stored in a secured area to maintain proper potency, temperature, light, and packaging. The dispensing pharmacist will label the container with special instructions for proper storage if it differs from standard storage procedures. If staff are uncertain about proper storage, they should contact the dispensing pharmacist. Only staff responsible for provision of medications shall have access to medication.

All medication is stored in locked compartments and only individuals who are Medication Aides will have a key. If a key lock secures a medication cabinet, the keys to the cabinet must be kept on the person of the Medication Aide. If medications are secured by padlock, the combination must be secured.

Schedule II controlled substances (narcotics such as Morphine, Codeine, Demeral, Ritalin, Percodan, Dexedrine) must be kept under a double lock (e.g., a locked cabinet in a locked closet, a locked container within a locked cabinet if located inside an unlocked room). If staff are unsure whether the medication is a Scheduled II drug, they should contact the pharmacist.

An individual’s medication will not be accessible to any other persons living in the same setting.

If medication requires refrigeration, a locked container is provided in the refrigerator.

If the individual lives alone and is self-medicating, then medications are stored according to the preference of the person.

Medication is always stored in the original pharmacy container. Only the pharmacist can transfer medication between medication containers.

Medications that are discontinued or outdated or medication containers with illegible, incomplete, makeshift, damaged, worn, soiled, or missing labels are to be returned to the dispensing pharmacist for proper identification and labeling. Only the pharmacist can make label changes. A Medication Return Record is completed and provided to the pharmacist along with the medication.

Medication for external (e.g., topical medications, eye/ear drops) use is stored separately

TRANSPORTATION OF MEDICATION

Procedure Effective Date: 1/19
Supersedes Procedure Number: 441 (7/14)

Prescribed medication must be in the original prescription containers.

Residential staff, parents or the pharmacy deliver medication (in the original prescription container) to corresponding settings for individuals who are not self-administering.

When medication is sent (in the original container) from one location to another (e.g., parents' home, camp, day service), record the amount sent and returned on the medication record form.

If the person is self-medicating, he/she may transport the medication as he/she wishes.

REFUSAL OF MEDICATION

Procedure Effective Date: 1/19
Supersedes Procedure Number: 441 (7/14)

Staff should recognize and honor the rights of individuals to refuse medication, and at no time should the individual be forced to take medication.

Persuasive methods are used to encourage compliance but should not include anything that is threatening, deceptive, restrictive, and exploitative or causes injury to the person.

If the individual refuses to take medication beyond the 1-hour leeway, contact a Duet RN for further direction.

Refusal of medication is documented on the Medication Administration Problem Error Log (Duet-203). Document refusal in Therap or on the MAR.

PROCEDURES FOR SELF-ADMINISTRATION OF MEDICATIONS

Procedure Effective Date: 4/08
Supersedes Procedure Number: 441

A. For everyone to attain the highest possible level of independence, all individuals shall be encouraged to participate in activities that promote wellness and good health. Self-administration of medication is an important skill for independent living. As discussed by the ISP team, the Assessment for Self-Administration (Duet-48) will be used to determine a person's capabilities regarding self-administration of medication. When the results of the assessment indicate an individual is not independently capable to self-administer his or her own medications, the ISP team may develop a plan to support the individual with medication administration. The plan may include staff objectives, natural supports, or a formal program.

B. An individual with a support plan for self-administration will need to demonstrate competence related to the five rights as specified in the Assessment for Self-Administration of Medication.

C. Documentation of medication administration/self-administration will occur using the following records:

- When an individual has been rated *"**independent**"* or ***"able with support"*** on all of the five rights on the Assessment for Self-Administration of Medication, use the **Self-Administration Medication Record, Duet-114.**

- When an individual has been rated ***"unable"*** on any one of the five rights on the Administration for Self-Administration of Medication, use the Therap eMAR.

D. Training of individuals to self-administer medication shall include instruction, for each medication prescribed, in the following areas:

1. Name of medication or identification of medication (size, shape, color and reason for medication)

2. Dosage or quantity to be taken

3. Route of administration

4. Frequency or times of administration

5. Purpose of medication, special instructions, common side-effects and potential consequences of not taking the medication or of not taking the medication properly

6. When to seek medical assistance and any action to be taken in the event of a missed dose, medication error, or adverse drug reaction

E. The ISP team determines what supports may be necessary for the individual to safely and effectively self-administer. Supports may include physical assistance,

adaptive devices, or verbal and physical prompts.

F. The ISP team determines the degree of staff monitoring, including how often staff will check on progress, frequency of counting meds, and follow-up necessary to achieve accuracy.

G. The Duet Self-Administration Medication Record will be reviewed by a Duet nurse monthly. If the nurse has concerns regarding the situation, the nurse will notify the supervisor to determine what action, if any, is needed.

DUET ASSESSMENT FOR SELF-ADMINISTRATION OF MEDICATION

Procedure Effective Date: 4/08
Supersedes Procedure Number: 441

The Duet Assessment for Self-Administration of Medication is to be completed in order to determine the individual's self-medication status.

Criterion for Self-Administration

If an individual is unable to perform the five rights at an "able with support" level, the MAR, will be used. When a self-medicating program is initiated; a Medication Aide must be present to monitor and document on the Duet-11 each dose. If an individual can perform the five rights at an "able with support" level, the Duet-114 Self Administration Medication Record is to be used.

The Self-Administration program will be started based on the required supports as documented in the Assessment. The goal is to move toward independence in self-administration by capitalizing on the individual's strengths and providing training and support in areas that require support. For some individuals, adaptations and supports may be in place depending on their needs. The ISP must reflect that the individual needs these supports, and that the individual can self-administer as long as these supports are in place. The ISP team will evaluate the need for supports annually.

Right Person

Person answers question, "Who can take your medication?"

- Person gives correct response - mark as independent.
- Person gives incorrect response - mark unable.

Person must be able to answer this question correctly to begin self-medication program.

Right Medication

Person identifies name of medication.

Show individual each medication he/she takes and ask, "What is this medication?"

- Person identifies name of medication - mark as independent.
- Person identifies medication by color - mark with support.
- Person identifies medication by shape - mark with support.
- Person identifies medication by size - mark with support.
- Person identifies medication by reason (e.g., my seizure pill) - mark with support.
- Person is unable to identify medication - mark as unable.

Person identifies purpose of medication.

Show individual each medication he/she takes and ask, "Why do you take this medication?"

- Person identifies diagnosis or purpose for which the medication has been prescribed - mark as independent.
- Person identifies a symptom or other need for their medication (e.g., leg cramps, heart pill, eye medication) - mark with support.
- Person does not know why he/she takes the medication - mark as unable.

Right Dose

Person identifies proper dose of each medication.

A. Show individual each medication he/she takes and ask, “How much of this medication do you take each time you take it?”
   - Person identifies correct measurement (e.g., 5 mg) - mark as independent.
   - Person identifies number of medications to be taken (e.g., 2 tabs) - mark as with support.
   - Person does not know amount of medication he/she takes - mark as unable.

B. Ask person to remove and/or measure out the dose of each medication he/she takes.
   - Person removes/measures out exact amount of medication - mark as independent.
   - Person pours out liquid medication into a pre-measured cup - mark as independent.
   - Person cannot successfully do the above, however person correctly removes from pre-measured/prepackaged pharmacy pack the correct amount - mark with support.
   - Person is unable to do any of the above - mark as unable.

Right Time

Person identifies correct time for each medication.

Show individual each medication he/she takes and ask, “What time do you take this medication?”

- Person identifies correct times for each medication - mark as independent.
- Person is unable to identify the specific time he/she takes each medication, however, does identify a setting cue (e.g., when staff call me on phone, at breakfast, television show, when my alarm goes off) - mark with support.
- Person is unable to do any of the above - mark as unable.

Right Route

Person knows appropriate route of medication.

Show individual each medication he/she takes and ask, “How do you take your medication?”

- Identifies correct route to take medication - mark as independent.
- Person is unable to identify correct route to take medication - mark as unable.

Knows Side Effects of Medication

Person knows common side effects of his/her medications.

- Person identifies possible common side effects - mark as independent.
- Person identifies changes in body and seeks assistance - mark with support.
- Person is unable to identify side effects (staff must observe and monitor) - mark as unable.

Self-Administers Without Reminders

- If individual takes medication consistently without reminders - mark as independent.
- If individual can take medication with reminder cue (e.g., phone call, etc.) - mark with support.
- If individual is unable to do the above, person shall not self-medicate - mark as unable.

Knows What to Do if Misses Dose

Ask individual, “If you forgot to take your medication at (fill in time) and it is now (fill in time), what would you do?”

- If the individual identifies the appropriate answer - mark independent.
- If the individual is unable to answer appropriately - mark unable.

Knows What to Do if He/She Takes the Wrong Dose

Ask the individual, "If you took (e.g., 2 tabs instead of 1 tab), what would you do?"

- If the individual identifies the appropriate answer - mark independent.
- If the individual is unable to answer appropriately - mark unable.

Gets Prescriptions Filled

- If the individual fills prescriptions independently - mark independent.
- If the individual needs prompts/transportation support/other supports - mark with support.
- If the person is unable to order/refill/pick-up meds - mark unable.

PRN Medications

For each PRN medication, staff must determine the individual's ability to self-administer by assessing the five rights.

Monitoring Supports

The ISP team determines monitoring supports for the individual. This includes determining the frequency of counts, support with filling the med container and the accessibility of remaining medication (how much of the remaining medications are available to the individual at any given time). Documentation of types of supports needed must be included on the Assessment for Self-Administration of Medication and the Self-Administration Medication Record using the examples below:

Self-medicating with support

- Medication Aide observes filling of daily medication container
- Medication Aide observes filling weekly medication container, medication counts done by Medication Aide as determined by the ISP team, at least weekly
- Pharmacy delivers monthly pill back, medication counts as determined by ISP team, at least weekly

Independent - Health care professional monitors clinical response to medication. Medication counts are completed by Medication Aide as determined by team.

DEATH OF A PERSON SERVED POLICY

Policy Effective: 7/19 Supersedes
Policy Number: 490 (3/95) (9/18)

Duet shall define procedures for death of a person in services which include notification of family members or legal representative, internal chain of command, legal authorities, and the Nebraska Department of Health and Human Services.

Approved by Duet Director

Duet Director

August 12, 2020

Date

Approved by ENHSA Governing Board

ENHSA Governing Board Chair

August 12, 2020

Date

PROCEDURES FOR DEATH OF PERSON SERVED

Procedure Effective: 9/18
Supersedes Procedure Number: 491 (10/11)

A. Notification

1. Agency staff is to immediately notify the supervisor, the legal representative, next of kin and the service coordinator. If the supervisor is not available, staff will follow the area/division chain of command.

2. Supervisory personnel will contact the legal authority

   a. In Douglas County, the Douglas County Coroner is to be contacted at 444-7000. The operator can contact the coroner 24/7 and will obtain a phone number for a return call, if necessary. The coroner will need the following information:

      -Full name of deceased
      -Date of birth
      -Home address of deceased
      -Date and time of death
      -Attending health care professional
      -Primary illness or apparent cause of death (general terms)
      -Name and relationship of a family member who has been notified of the death
      -Funeral home or mortuary to be used
      -If there were any suspicious circumstances concerning the death. Staff will follow the instructions of the County Coroner.

   b. For all other counties, contact the law enforcement and follow the above.

   c. Upon release from the County Coroner, notify the funeral home of the family's choice.

   If the person dies in a medical facility (hospital or nursing home), this section does not apply.

3. The supervisor will immediately ensure that all other supervisors in the chain of command are notified, including the Area/Division Director and Duet Director.

4. Contact Department of Health and Human Services and complete a Therap General Event Report.

5. When warranted as determined by Agency Executive Director or their

designee, the Agency Executive Director or their designee will notify the ENHSA Governing Board of the individual's death.

6. Within 10 days, the Agency Executive Director or their designee must complete a Notification of Death form and submit to the Department of Health and Human Services.

B. Autopsy

1. At the discretion of the County Coroner, an autopsy may be ordered.

2. Staff will cooperate with any legal authorities during the investigation of a death.

C. Funeral Arrangements

1. Duet staff, upon request, will aid the family with funeral arrangements and an obituary notice.

2. When there is no family and/or the burial is to be paid by the county, Duet staff shall plan in conjunction with the appropriate county.

3. A designated employee will arrange for a floral memorial from the Agency.

D. Attendance at Funeral

1. Bereavement leave will be granted to staff in conjunction with Personnel Policy #5.40. The Area Director will make the final determination on attendance based on coverage needed for each service setting.

E. Disposition of Belongings, Funds, Etc.

1. All personal belongings of the deceased will be returned to the family, documented on the Clothing/Possessions Inventory, and sent to Central Records.

2. All accounts for which the Agency is responsible will be closed, with the funds going to the deceased's legal representative (if applicable). If no legal representative, the remaining funds are sent to Medicaid, after all bills are paid. Disposition of funds is recorded on the final ledger sheet/Therap financial account. In the event there is no estate or next of kin, contact the County Attorney for disposition of assets and personal belongings.

3. When the Agency is payee for benefits, designated personnel will notify Social Security.

3. If the legal representative wishes to donate items to the Agency or another designated entity, donation should be documented on the Clothing/Possession Inventory with the signature of the legal representative.

F. Reports

If needed, the Agency will request that the legal representative obtain copies of legal reports including death certificate, autopsy report, and police report (if applicable). These reports will be filed in the person's Central Record file.

G. Follow-Up

1. If determined necessary, the supervisor will immediately seek to obtain any necessary training/counseling for support staff affected by the death.

2. Duet staff will complete a Change of Status.

3. If determined necessary, an Internal Investigation will be conducted in accordance with established Agency guidelines.

4. The Agency's Human and Legal Rights Committee will review the Therap General Event Report and any reports submitted to or received from the Nebraska Department of Health and Human Services regarding the death of an individual.

RIGHTS OF PERSONS RECEIVING SERVICES (Rev. 9/18)

Each individual is considered to be capable of exercising their rights as allowed by law. These rights should be provided in a manner understood by person and include:

1. the right to life
2. the right to receive services without regard to race, color, religion, disability, sex, marital status, national origin or age
3. the right to receive due process in the handling of complaints or the modification or denial of rights
4. the right to be free from harm in safe and sanitary settings; and be free from cruel and unusual punishment
5. the right to the least restrictive setting or environment necessary for treatment or habilitation
6. the right to practice the religion of one's choice
7. the right to be paid for one's work, other than for personal housekeeping chores or therapeutic work tasks, in accordance with state and federal wage and hour labor laws
8. the right to regular, nourishing meals providing an adequate and appropriate diet
9. the right to adequate medical and dental care in a timely manner
10. the right to eat or be fed in a comfortable, usually upright position
11. the right not to have one's personal possessions confiscated or removed (abuse of personal possessions may result in temporary removal, if severe)
12. the right to a clean, comfortable bed
13. the right to an individual support plan to learn appropriate behaviors and skills, along with adequate staff to carry it out
14. the right to access legal advocacy services and legal representation
15. the right to receive sealed mail
16. the right to freedom of speech (excludes abusive speech and speech intended to incite others to illegal action)
17. the right to be treated with dignity and respect
18. the right to receive reasonable accommodation as required by the Americans with Disabilities Act, including Title II

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19. the right to liberty, including safely moving about on and off the premises of his/her residence

20. the right to vote, enter into a contract, marry, and exercise other citizenship rights available to American citizens

21. the right to refuse treatment and participate in all decision-making processes

22. the right not to be subjected to experimental research (this includes new, unproved behavioral techniques or medications)

23. the right to keep and use personal possessions, including money

24. the right to make and receive telephone calls or other forms of communication devices, if they are made in reasonable numbers and at reasonable times

25. the right to have visitors

26. the right to have opportunities to interact with persons of the opposite sex

27. the right to privacy

28. the right to have regular (daily) outdoor exercise or recreational outlets

29. the right to open and read one's own mail

30. the right to receive treatment, including services and assistance which present opportunities to increase independence, interdependence, productivity, and integration into the community

31. the right to develop and maintain personal relationships, choose friends and select living companions

32 the right to receive age appropriate services in an environment designed to foster social and physical integration with the community

33. the right to receive instruction to learn appropriate behaviors, skills and supports to ultimately live, work and recreate with people who do not have disabilities

The agency prohibits any form of retaliation against individuals supported. A copy of the Rights of Persons Receiving Services is reviewed annually. Agreement Regarding Procedures Notification of Cost, Rights, Complaint, and Responsibilities form provides evidence that the person or legal representative received a copy.

Some rights can be denied or modified, but only through a legal action or through voluntary, informed consent as a restrictive agency procedure (requiring participation in a review/approval process).

Individual Rights Under HIPAA

(Health Insurance Portability and Accountability Act)

1. the right to request restrictions on certain uses and disclosures of their Protected Health Information (PHI);
2. the right to receive confidential communications of his or her PHI;
3. the right to inspect and copy his/her PHI (some exceptions may apply);
4. the right to request an amendment to his/her PHI;
5. the right to an accounting of disclosures of his/her PHI;
6. the right to a paper copy of Duet's NPP (Notice of Privacy Practices).

POLICY REGARDING COMPLAINTS

Policy Effective Date: 2/19
Supersedes Policy Number 520 (9/18)

Duet recognizes the responsibility to provide a process for a fair, consistent, and timely means of resolving disputes within the agency related to meeting needs and interpreting agency and person-centered policies. The complaint and grievance process, including the right to go to court, must be reviewed annually. Therefore, the procedures for complaint shall be followed to ensure an orderly and responsive appeals process.

Whenever they are contacted about a disagreement with a decision or a complaint, it shall be the responsibility of all Duet employees to assist, explain, and to model ways of resolving problems (including problem-solving and compromise).

The filing of a complaint shall operate to stay the decision or action, and the person shall remain in their current placement unless, as determined by the Agency Director, one or more of the following conditions exist:

- The current placement is a temporary placement of a duration and made pursuant to a medical or other emergency and said emergency ceases to exist.
- A medical or other emergency arises necessitating a change in service or placement.
- The health or safety of the person would be endangered by the continued placement.
- The health or safety of other persons would be endangered by the continued placement.

A copy of the complaint procedure is provided to the individual/legal representative upon admission to services and annually thereafter. The Agreement Regarding Procedures Notification of Cost, Rights, Complaint, and Responsibilities form provides documentation that the individual and legal representative has received or been sent the complaint procedure. The agency prohibits any form of retaliation.

Approved by Duet Director

Duet Director

August 12, 2020
Date

Approved by ENHSA Governing Board

ENHSA Governing Board Chair

August 12, 2020
Date

PROCEDURES FOR COMPLAINT

Procedure Effective Date: 8/18
Supersedes Procedure Number 521 (12/06)

Problems or concerns may arise regarding the supports provided. The focus of these procedures is to establish a fair and orderly process for responding to concerns. The goal of these procedures is for all complaints to have resolution that is agreeable to all parties. These procedures are available to the person, parents, legal representative, and the other ISP team members.

It is Duet's desire to see that all concerns are handled in a timely fashion. The parties involved are encouraged to present the issues in a fair and non-confrontational manner. It is the expectation of the agency for staff members, in responding to the concerns, to act in a professional manner that is conducive to the understanding and potential resolution of the concerns. Complaints can also be anonymous. There are three steps available to the concerned parties:

Verbal (Informal) - For most concerns, the person is encouraged to contact the program supervisor. It is the expectation of the agency that the supervisor will resolve these concerns, if it is possible, and will do so in a timely fashion. If the response is not satisfactory, the concerned party is encouraged to contact the next level of supervision in the chain of command.

Verbal/Written (Formal) - When the informal process does not resolve the concern, a written or verbal option is available. The concerned party should **identify the nature of the problem, the efforts that have been put forth to resolve the problems, and a statement as to what they see as the satisfactory resolution to the concerns identified.** This written or verbal statement should then be presented to the responsible administrative staff. The Area/Division Director will solicit the documentation and information necessary to fairly consider the issues and will provide a written response to the concerned party within a reasonable period. A copy of the response will be forwarded to the Duet Director. In extenuating circumstances, the Area Director may extend the time frame to allow for further fact finding. If the concerned party is still dissatisfied with the response, they may submit their concerns to the Duet Director who will follow the same timelines and guidelines as set forth for the Area/Division Directors.

Legal - In according to Nebraska state statute, these procedures are not intended to take the place of complaint and review procedures the State 404 NAC 3-004 Informal Dispute Resolutions and Hearings for Issues Related to DD Services Funded by State General Funds. The individual, legal representative, and or parent (if minor child), also have the right to due process, including going to court to resolve issues.

Anonymous Complaints – If desired, an anonymous complaint can be filed using the Duet Complaint form located on program site and/or on the Duet website (Duet-dd.org) or by contacting the Administrative Services Director.

Complaints will be reviewed and investigated, if applicable, within 10 business days. The complainant will be notified, if requested, of the disposition of the complaint. The outcome will be documented on the Complaint Form which is kept in every Duet setting. The Complaint Form must be kept in a location that is easily accessible.

HIPAA COMPLAINT

The Health Insurance Portability and Accountability Act (HIPAA) requires that persons, parents or legal representatives are informed as to how to file a complaint if they think Duet is not protecting their privacy or rights. This is outlined in the Notice of Privacy Practices.

Individuals or legal representatives must submit their complaint to the agency's Privacy Officer or may file a complaint with Health and Human Services. Complaint procedures are provided at each annual ISP and is documented in the Agreement Regarding Procedures Notification of Cost, Complaint, and Responsibilities.

ABUSE AND NEGLECT REPORTING POLICY

Policy Effective Date: 7/19
Supersedes Policy Number: 530 (10/11) (6/18)

Any employee who has reasonable cause to believe that a person has been subjected to abuse or neglect or observes conditions or circumstances which reasonably could result in abuse or neglect, according to the legal or agency definition, is required to report such situations. The reporting of suspected abuse or neglect does not assume guilt of the parties involved. The agency will seek to intervene in any situation that it views as abuse or neglect of a person.

Failure to report situations that meet the legal definition is a misdemeanor. Any person making a report according to State Statute shall be immune from any liability, civil or criminal, thatmight be incurred or imposed, except for maliciously false statements. In the case of physical abuse (i.e., injury resulting in damage to bodily tissue), protective services will be notified (through age 17, Child Protective Services; 18 and over, Adult Protective Services) and a General Event Report will be completed. If necessary, a supervisory follow-up will be conducted.

The Agency will cooperate fully with legal authorities conducting investigations of possible abuse or neglect. Further, the Agency will follow up with employees involved in abuse or neglect including appropriate disciplinary action and, when warranted, legal action. Within Duet, employees may be dismissed for neglect or abuse of persons served or knowledge thereof with failure to report (see ENHSA Human Resources Policy and Procedures Manual). An internal investigation process will be completed using certified investigators in cases where an employee is suspected of violating Duet policy on abuse or neglect or where there is abuse between persons and additional information is needed.

The Human and Legal Rights Committee will review all cases involving suspected abuse and neglect. The committee will ensure rights are protected and that all matters are thoroughly reviewed. The committee will provide feedback to the Duet Director on any areas from a follow-up, which may need to be investigated further or suggest additional recommendations. The committee will monitor the completion of any recommendations.

Employees and members of the Human and Legal Rights Committee, other than the Duet Director, will not disseminate information about an allegation to the public or news media. All questions concerning the incident are to be referred to the Duet Director.

Legal Definition (Nebraska State Statutes (§28-351 - 361.01):
According to Nebraska State Statutes, child abuse means "knowingly, intentionally, or negligently causing or permitting a minor child to be: a) placed in a situation that endangers his/her life or health; b) cruelly confined or cruelly punished; c) deprived of necessary food, clothing, shelter, or care, d) left unattended in a motor vehicle if such minor child is six years of age or younger; e) sexually abused; or f) sexually exploited by allowing, encouraging, or forcing such person to solicit for or engage in prostitution, debauchery, public indecency, or obscene or pornographic photography, films or depictions."

According to Nebraska State Statutes, adult abuse means “any knowing intentional or negligent act or omission on the part of a caregiver, a vulnerable adult, or any other person which results in physical injury, unreasonable confinement, cruel punishment, sexual abuse, exploitation, or denial of essential services to a vulnerable adult."

Physical abuse - means damage to bodily tissue caused by non-therapeutic conduct, including, but not limited to, fractures, bruises, lacerations, internal injuries, or dislocations, and shall include, but not be limited to, physical pain, illness, or impairment of physical function.

Emotional abuse – means a pattern of acts, threats of acts, or coercive tactics, including, but not limited to, threatening or intimidating to gain compliance, destruction of the victim's personal property or threats to do so, violence to an animal or object in the presence of the victim as a way to instill fear, yelling, screaming, name calling, shaming, mocking, or criticizing the victim, possessiveness or isolation from friends and family. Emotional abuse can be verbal or nonverbal.

● **Unreasonable confinement** - means confinement which intentionally causes physical injury.

● **Cruel punishment** - means punishment which intentionally causes physical injury.

● **Exploitation** - means the taking of property of a vulnerable adult by means of undue influence, breach of a fiduciary relationship, deception, or extortion or by any unlawful means.

● **Sexual abuse** - sexual assault and incest.

● **Essential services** - means services necessary to safeguard person or property. Such services shall include, but not be limited to, sufficient and appropriate food and clothing, temperature and sanitary shelter, treatment for physical needs, and proper supervision.

Neglect, according to State Statute refers to "any knowing or intentional act or omission on the part of a caregiver to provide essential services or the failure of a vulnerable adult, due to physical or mental impairments, to perform self-care or obtain essential services to such an extent that there is actual physical injury to a vulnerable adult or imminent danger of the vulnerable adult suffering physical injury or death".

Duet Definition

As it relates to Duet employees, the agency's definition of abuse or neglect is more stringent than the legal definition and includes violations of a person's human or legal rights. For example: a) the use of corporal punishment (spanking, slapping, pinching); b) providing illegal drugs to persons served, alcohol to minors, or alcohol when contraindicated by ISP team; c) dehumanization of a person (teasing, calling the person by a non-preferred nickname); d) verbal/emotional abuse; e) withholding meals; f) use of other prohibited practices as listed in procedures for behavior management; g) violation of human or legal rights.

Since Duet's definition is broader than the legal definition, this will be referred to herein as violation of agency policy. Agency policies can only be applied to agency employee.

Approved by Duet Director

Duet Director

August 12, 2020

Date

Approved by ENHSA Governing Board

ENHSA Governing Board Chair

August 12, 2020

Date

PROCEDURES FOR REPORTING ABUSE/NEGLECT AND SUPERVISORY FOLLOW-UP REPORT/ACTION PLAN

Procedure Effective Date: 2/19
Supersedes Procedure Number: 531 (2/19)

If any employee has reason to suspect or believe that a person is being or has been abused or neglected by any party under the agency or State definition of abuse and neglect, the steps listed below should be followed. Every employee has the responsibility under the law to report situations, when, in his/her judgment, there is reason to suspect abuse or neglect. This responsibility cannot be negated by a supervisor's instruction.

Action Required	Person Responsible	Time Frame
1. Take necessary action to protect physical welfare or procure necessary medical care for the person. The supervisor shall remove that person from danger by:	Employee	Immediate
a. Regardless of the situation, staff will be relieved from duty pending follow up. This assumes that specific staff have been identified, there is reason to believe the staff poses a potential danger to the well-being of the person and the alleged act, if substantiated, could result in termination	Supervisor/Area Chain of Command/ Investigative Team	Immediate
b. If the person lives in a non-Duet supervised setting and there is reason to believe the person in danger, contact the police to remove the person from the home.	Supervisor/Area Chain of Command/ Investigative Team	Immediate
2. Notify/discuss situation with supervisor.	Employee	Immediate
3. The person is examined by a health care professional in the event of the following: a. If the person has sustained an injury requiring medical attention. b. If the medical examination may help determine what happened. c. If a sexual assault may have occurred where penetration, physical injury, or bodily fluid may be present or	Employee	Immediate

suspected. DO NOT clean the person or change clothes even if torn or dirty as this might destroy evidence.		
4. Discuss the situation with the Area Chain of Command to determine whether the incident meets either the legal or Duet definition of Abuse or Neglect.	Employee/Chain of Command	Immediately upon becoming aware of the event
5. Notify the Service Coordinator	Supervisor	Immediately upon becoming aware of the event
6. Notify the family members/legal representative (if applicable) and/or persons involved	Supervisor	Immediately upon becoming aware of the event
7. In all cases of suspected abuse/neglect that meet the legal definition (included suspected abuse between individuals), contact the 24-hr hotline (1-800-652-1999)	Employee and/or Chain of Command	Immediately upon becoming aware of the event
8. Employee documents observations in detail on the Therap in all cases that appear to meet the legal or Duet definition of abuse or neglect. a. In the case of abuse between individuals, the Therap report may serve as the follow-up report when the facts are known and clearly documented. Separate report must be completed for the aggressor and the injured party. b. In the case where it is suspected or known a staff is involved, the supervisor notes on the Therap report that an Internal Investigation is being conducted.	Employee Employee Supervisor	Within 24 hours Employee Within 24 hours
9. The investigative team will be identified, and the investigation process will commence a. Written Internal Investigation with follow-up recommendations	Investigative Team Investigative Team Deputy Director	Immediately Within 7 days of the completion of the investigation Within 7 days

b. Written follow up and action plan		
10. Contact the individual, family member/legal representative about the results of the Internal Investigation. Confidentiality of other persons involved will always be respected.	Area Director/ Coordinator	Immediately upon concluding the investigation
11. Monitor implementation of all recommendations	Internal Chain of Command	Ongoing
12. Review Internal Investigation, and monitor for implementation of recommendations.	HLRC and the Investigative Process Committee	At the next scheduled meeting

EMPLOYEES OF DUET AND SPOUSES SERVING AS LEGAL REPRESENTATIVES POLICY

Policy Effective Date: 9/18
Supersedes Policy Number: 560 (3/95)

Nebraska State Statutes Probate Code, Section 245, indicates that Duet employees are prohibited from being legal representatives of persons who are directly supported by Duet. In addition, it is Duet's policy that persons closely related to or associated with a Duet employee are prohibited from being the legal representative of a person with whom the employee is directly involved on the job. This is to comply with the intent of the law and to avoid the potential for and/or the appearance of a conflict of interest. The Duet Director will, when necessary, evaluate cases to determine if the policy pertains to that situation.

Approved by Duet Director

Duet Director

August 12, 2020
Date

Approved by ENHSA Governing Board

ENHSA Governing Board Chair

August 12, 2020
Date

CONFIDENTIALITY POLICY

Policy Effective Date: 9/18
Supersedes Policy Number: 580 (5/16)

All information that pertains to the identity, diagnosis, or habilitation of a person receiving Duet supports shall be considered confidential. All records are the property of ENHSA/Duet. All disclosures will be in accordance with the HIPAA Privacy Policy. In some circumstances, the Agency must allow access to individual records and information without prior authorization of the person. Such circumstances are contained in these policies and procedures and in the Release of PHI policy and Notice of Privacy Practices. To provide a means to ensure that information regarding the person and their record are kept in a confidential manner.

Appropriate Agency personnel shall have access to the information necessary for the provision of services and to carry out Agency business. Only those staff responsible for supporting the individual or who are conducting Agency business may access a record.

Requests for the release of information for anyone outside the Agency, including the person, or his/her parent or legal representative, must be referral to Central Records. Records are not to be viewed at the houses, day services, or other program settings.

Only the Area/Division Director, Duet Director, the HIPAA Privacy Officer/Administrative Services Director, or their designee may make or distribute copies of information in the record to those outside the Agency

Representatives from Duet funding and licensing agencies with proper authorization may view records for the purpose of oversight, and/or to determine eligibility for funding or licensure.

In emergency situations threatening the health or safety of the person, verbal information may be given to medical professional, hospital, or emergency personnel.

Information regarding one person receiving support shall be kept secure from other persons and the general public. Information should also not be shared or discussed with another person receiving support or in the presence of others who are not involved with that individual. Staff members will ensure the person's right to privacy.

Staff participating in ISPs, school conferences, disability hearings, or other conferences relating to the person shall participate in a manner to ensure the person's right to privacy.

Subpoenas, court orders, and court summons must be obeyed.

Secondary information such as computer printouts, indexes, logbooks, program checklists, daily logs, and other related forms that contain identifiable information shall be considered confidential. Destruction of such information must be accomplished by thorough shredding before disposal.

Request for information from Duet and Duet's request for information from other providers, agencies, or institutions do not require an authorization for ongoing treatment/service needs.

For any purpose other than treatment or placement in this or another program, a written authorization is required. Contact the Privacy Officer if an authorization is needed.

Copies of information will be provided on written request and payment rendered of a reasonable fee for the retrieval, compilation, preparation, and copying. Contracted providers, transferring agencies and providers, hospitals, and health care professionals shall not be charged for release of information necessary to maintain continuity in the provision of service.

Approved by Duet Director

Duet Director

August 12, 2020

Date

Approved by ENHSA Governing Board

ENHSA Governing Board Chair

August 12, 2020

Date

HUMAN & LEGAL RIGHTS COMMITTEE (HLRC) POLICY

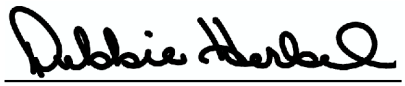
Policy Effective Date: 2/19
Supersedes Policy Number: 590 (9/18)

The responsibilities of the Human & Legal Rights Committee are to:

- Review all high notification general events reports.
- Review all Safety Plans
- Review all Prescribed Psychotropic Medications.
- Review all Internal Investigations.
- Provide feedback and recommendations to the agency on each investigation.
- Provide input to the agency on policies and procedures which involve human/legal rights issues.
- Discuss any other issue which may involve the violation of rights.

At least half of the committee will be comprised of individuals, family, legal representatives, or other interested persons who are not provider staff. At least one member of the committee shall be a person who has an intellectual disability or a close relative. Persons selected for the committee shall have a demonstrated interest in the rights of persons with intellectual disabilities, the ability to be objective, and the ability to maintain confidentiality. The Executive Assistant to the Duet Director will maintain an updated membership list. Due to the sensitive nature of the issues facing the committee, it is always imperative that confidentiality be maintained. Confidentiality requirements will be reviewed periodically with committee members.

Approved by Duet Director



Duet Director

August 12, 2020

Date

Approved by ENHSA Governing Board

ENHSA Governing Board Chair

August 12, 2020

Date

PROCEDURES FOR HUMAN & LEGAL RIGHTS COMMITTEE

Procedure Effective Date: 2/19
Supersedes Procedure Number: 591 (9/18)

Orientation

Each member shall receive a copy of the applicable agency policy and procedures, the State Law which defines abuse/neglect, and applicable state and federal regulations which cover the committee's operation. In addition, the committee members will be encouraged to attend the same training agency staff members receive on abuse/neglect issues.

Meeting Frequency

The HLRC shall meet at least quarterly or more often if determined necessary by the committee. Formal minutes of the committee's actions will be maintained.

Agency Liaison

The Duet Director or designee shall be the agency staff member designated as liaison to the committee. This person will be a non-voting member and is not included in membership count. The Duet Director or designee will ensure that the committee has free and full access to the information necessary to properly fulfill its obligations.

Order of Business

The committee will have no formal officers. A designee will be charged with the responsibility of conducting the committee's meetings, setting agendas, and scheduling the meetings. All matters requiring a decision will be determined by a simple majority vote of the members present. All members are responsible to identify situations that may be perceived as a conflict of interest. Any member with a conflict of interest on an issue will be excused from discussion and voting on that issue.

Review of Process

Prior to the next scheduled meeting, each committee member shall receive an agenda, copies of any relevant general event reports, new investigations, follow-up reports from previously reviewed matters, and any other information as determined relevant. Each document will be reviewed. Any issue needing further follow-up from the agency will be identified. The committee designee will be responsible for obtaining the necessary follow-up and presenting the information at the next meeting. Most follow-ups will be in written memorandum format. When no further follow-up is needed, the case will be closed and will no longer be monitored by the HLRC.

RECORDS POLICY

Policy Effective Date: 3/19
Supersedes Policy Number: 610 (9/18)

For everyone receiving supports, a record specific to that person will be assembled and maintained in one central record unit. The unit record will be stored according to Schedule 48– Duet Record Retention in the Central Records Department. In addition, certain records will be maintained on Therap. A working copy of the Individual Record Book will be maintained at the site(s) where the individual receives supports. Duet staff may request copies of the original unit record, as needed, by calling, emailing, or faxing their request to Central Records. All records are the property of Duet. Each individual/legal representative has the right to access and receive copies of their Protected Health Information as outlined in the HIPAA policy and the Release of Protected Health Information procedures.

Confidentiality

All information, either in oral, written or electronic format, is considered protected health information and, therefore, is strictly confidential. This includes any individually identifiable data such as an address, Social Security number, gender, diagnoses, etc. Refer to the Confidentiality Policy and the HIPAA policy for details. No information will be released without an authorization unless permitted or required by the HIPAA rule, federal and/or state regulations. Protected Health Information may be disclosed to other healthcare providers as needed for treatment purposes without an authorization. Other healthcare providers will not be charged for copies so that continuity of care is assured. The agency may impose a reasonable fee for copies for disclosures outlined in the Release of Protected Information procedures. When appropriate, only the Privacy Officer or Agency Director may defer the copying fee.

Purpose of the Record

In either the electronic or paper form, the record contains essential data and documentation regarding the “Who, What, Where, When, Why and How” of all the supports received. The record should answer the following:

- Who is the individual and who at Duet is supporting that person?
- What supports are provided, including supports provided outside of Duet?
- When and where are the supports provided?
- Why does the individual want support?
- How effective are the supports provided (or what is the desired outcome)?

The record shall also serve to promote and/or provide the following:

- Development, evaluation and implementation of the Individual Support Plan (ISP)
- Documentation of the individual’s response to teaching and progress toward the goals specified in the ISP
- Documentation of medical or health related conditions
- To protect the legal rights of the individual, the agency and agency personnel.
- Meeting certification and licensure requirements.
- Serve as a resource to the individual for their medical history, legal documentation, evaluations, benefits and the services received.

Record Format

The format in Central Records will be uniform for each record. The Individual Record Book format in the areas will allow for the ease of location of record documents. Standardized forms, either electronic or paper, will be used agency-wide and must be approved before use. Requests for any new or revised forms must be submitted to the Policy Committee for approval.

Content

The information in the record will be complete, accurate and legible. The documentation should be objective while fully describing the person's condition, medical events, progress, and abilities. The information will be recorded in a manner that complies with the agency policies and all state/federal regulations. Record copies from other providers that are used for provision of services and/or treatment will be considered a part of the record.

Documentation

The staff person(s) providing support to the individual has the responsibility for documenting the supports provided. All entries in the record must be authenticated by full signature, job title and date of the entry. The documentation will be in accordance with regulatory mandates, legal standards and documentation requirements outlined in this policy. Initialed entries will not be allowed unless the signature log or similar key legend is completed. In the case of electronic records, signatures may be replaced by an approved uniquely identifiable electronic equivalent.

Record Completion

All records maintained in Central Records are reviewed for accuracy and completeness. All record documents will be thoroughly completed before routing to Central Records.

Retention, Storage & Security

All Duet unit and ancillary records for individuals will be retained in accordance with the Duet Schedule-48 and applicable legal and regulatory requirements. Record documents that have reached their retention limit may be disposed of. Destruction shall be accomplished by controlled shredding or other acceptable means of document destruction.

All records must be stored in a secure place, to ensure confidentiality. The records will be maintained in such a manner that protects the record from loss, destruction, tampering or use by unauthorized persons.

Changes in Ownership/Dissolution of Agency

In the event there are changes in Agency ownership or the Agency dissolves, the Duet Director will notify the Department of Health and Human Services in writing of the location and storage of individual records. If changes in ownership occurs, all individual records will be transferred to the current owner.

Approved by Duet Director

Duet Director

August 12, 2020

Date

Approved by ENHSA Governing Board

ENHSA Governing Board Chair

August 12, 2020

Date

PROCEDURES FOR RECORDS

Procedure Effective Date: 8/19
Supersedes Procedure Number: 611 (9/18)

Content

The content of the record may be developed according to the information available and service provided, but it must contain the following entries and completed forms at the following levels of support:

A. At the time of **intake**, the record must include:

1. Application for Service signed by the person and/or their legal representative. The application for service includes social history information.
2. Legal representative or custody documents (when a civil court hearing has taken place regarding the legal representative or custody of the individual).
3. ISP/IEP's from previous providers and any other pertinent information which may include medical, dental, psychiatric, and psychological examinations/evaluations.
4. Acknowledgment of the receipt of the Agreement Regarding Procedures. Notification of Cost, Rights, Complaint, and Responsibilities as well as the Notice of Privacy Practice (NPP), which is included in the Consent for Medical/Dental Treatment (Duet-155).

B. On **admission**:

1. Residential and/or day program records must include:

    a. Emergency information: name and phone number of the person's health care professional and the name and phone number of the legal representative and/or person to be notified in the event of an emergency.

    b. Photograph, current (children within 3 years, adults within 5 years).

    c. Consent for Medical/Dental Treatment (Duet-155). Other consent forms as applicable.

    d. Change of Status form for admission to the program and date of admission.

2. Admission records must include information specific to certain services:

    a. Regarding admission to **CDD licensed homes**, the records must include:
        1) A dated physical examination completed by a physician within the past 3 months, or within 15 days following admittance.

2) A dated dental examination.

3) Records of previous services.

4) Consent for Medical/Dental Treatment (Duet-155). Other consent forms as applicable.

b. Regarding admission to **Title XIX Waiver** services, records must include:

1) A dated physical examination completed by a health care professional within 1 year of admittance.

2) A dated dental examination within 1 year of admittance.

3. On admission to respite only and persons who are private pay, records must include:

a. Emergency information: name and phone number of the person's health care professional and the name and phone number of the legal representative and/or person to be notified in the event of an emergency.

b. Photograph, current (children within 3 years, adults within 5 years).

c. Consent for Medical/Dental Treatment (Duet-155). Other consent forms as applicable.

Note: Persons who begin active status services but who do not continue with services for the first 30 days will not be required to have the full complement of paperwork completed. However, intake documents, consents, and a Change of Status must be completed at time of admission.

d. Medical information, diagnosis, exams and evaluations as applicable.

e. Allergies.

C. During the time supports are being provided, all records will be kept updated for changes occurring in the circumstances of the person, upon receipt of written notification of Duet staff, DD Service Coordinator, or from other applicable documents.

1. Residential/day service entries must include:

a. Change of Status form placing the person in supports with all demographic information.

b. Photograph updated every 3 years for children, every 5 years for adults.

c. Individual Support Plan (ISP), including assessments, programs, and data for the ISP period.

d. Behavior Support documents as determined necessary by the team and

developed according to the Positive Behavior Support Policy and Procedures, including the FBA, BSP, and Safety Plan, if applicable.

e. Legal Forms.

1) Consent forms.

a) Photo, Television, Movie, Video Recording, Social Media and Newsletter Consent (Duet-23) annually.
b) Consent for Medical/Dental Treatment (Duet-155).
c) Informed Consent for Psychotropic Medications (Duet-16).
d) Other consents as applicable.

2) Most current legal guardianship or custody documents as hearings occur.

f. Medical Information

1) Allergies.
2) Immunization records.
3) Diagnosis.
4) Health care professional's orders for medications administered and treatments given.
5) Dental Orders as needed.
6) Health care professional's consultation reports.
7) Therap Medication Administration Record for medications administered (as applicable).
8) Medical Documentation/Health Related Service Needs as appropriate.
9) Therap Health Tracking as appropriate
   a) Seizure Tracking
   b) Blood Glucose Monitoring
   c) Height and Weight
   d) Intake/Elimination
   e) Menses
   f) Appointments

g. Evaluations and Examinations.

1) Physical and dental examinations are required annually for each person in Title XIX waiver services.

2) The need for the following evaluations and examinations must be reviewed annually by the team for all persons and completed as determined necessary:

a) Audiology
b) Behavior Support
c) Dental
d) Dietary

e) Occupational Therapy
f) Physical
g) Physical Therapy
h) Psychological evaluation completed by a licensed psychologist
I) Speech
j) Vision

h. Pertinent correspondence, including information from Social Security, Nebraska Department of Health and Human Services System, or any other benefit agency.
i. Other support/service information.

Quality

To assure that the record is maintained according to policy:

A. All proposed forms and revisions to existing record forms will be reviewed by Policy Committee for appropriateness of content and uniformity of format.

B. Staff participating in quality improvement activities will review the records according to the Quality Assurance Plan. Information which is obtained in performing quality reviews shall not be included in the record.

Correction of Information

A. Record documentation should never be erased or totally obliterated. If an error is made in recording, the author may correct the error at the time it occurs or as soon as it is discovered by completing the following steps:

1. Draw a single line through the incorrect entry.
2. Enter the correct information.
3. Sign first and last initial.
4. Date the correction is made.

If the error is within electronic documentation, a comment will be added to indicate reason for correction.

B. Requests by individuals, parents, or legal representatives to correct or amend records must be referred to the Privacy Officer immediately. All amendment requests will be processed in accordance with the HIPAA rules.

Routing of Forms

Original forms from the Individual Record will be routed to the Central Records Department for maintenance in the Central Record file. Documentation originating within Therap will also be stored within Therap. Routing must be done upon completion of the form and in

accordance with Duet policies and procedures. Upon termination, all permanent forms should be forwarded to Central Records with the Change of Status.

Guidelines for Record Entries

A. Each event requiring entry in a written record shall be characterized by the following:

1. Written in blue or black ink
2. Name of person served on each page, both sides if 2-sided paper
3. Clearly noted date (month, day and year)
4. Original document in record
5. Factual and objective information without negative or subjective comments
6. Accuracy with legible handwriting
7. Entries made on approved form
8. Documented as close to the time of the actual event as possible
9. Late entries and addendums so noted; reason for late entry or addendum given
10. Error corrections made consistent with Section III A&B of this procedure
11. Signature (first name and last name) on each entry, title and date of entry
12. When initialed entries are utilized, they shall be accompanied by the full signature, title and initials of the person making the entry on either a legend on the page or on the signature log

C. Each event requiring entry in an electronic record shall be characterized by the following:

1. Staff shall be logged into Therap as themselves.
2. Factual and objective information without negative or subjective comments
3. Documented as close to the time of the actual event as possible
4. Late entries and addendums so noted; reason for late entry or addendum given in comments
5. Electronic signature, title, and date of entry automatically recorded by Therap.
6. Staff shall log out after completing Therap documentation.

RECORDS RETENTION POLICY

Policy Effective Date: 11/19
Supersedes Procedure Number: 620 (8/19)

Retention Schedule:

Retain records for seven years after the final service termination.

All records are to be kept for six years from the date of final payment for services. Records will be maintained electronically in Therap.

Financial information must be kept for seven years. If kept in Therap, records are not required to be kept elsewhere.

Disposal:

Destruction of records shall be carried out according to the approved record retention schedule.

Destruction shall be accomplished by shredding or other acceptable means of document disintegration. The confidentiality of the information shall be maintained throughout all stages of the destruction process.

Approved by Duet Director

Duet Director

August 12, 2020
Date

Approved by ENHSA Governing Board

ENHSA Governing Board Chair

August 12, 2020
Date

HIPAA PRIVACY POLICY

Policy Effective Date: 6/04
Supersedes Procedure Number: n/a

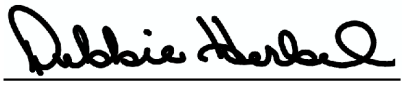
HIPAA stands for the federal law entitled the Health Insurance Portability and Accountability Act, which was passed in 1996. Regulations issued under HIPAA protect the privacy of health information and establish patient rights for all Americans.

Protected health information is defined as individually identifiable health information that is created or received by Duet that relates to an individual's past, present or future health or condition or payment for the provision of services. It is protected if it identifies the individual or there is a reasonable basis to believe the information can be used to identify the individual. Any release of information will be carried out in accordance with all applicable state and federal laws. All Protected Health Information is considered confidential and must be safeguarded against inappropriate use or disclosure.

Except as permitted, Duet may not use or disclose protected health information without a valid authorization. All requests outside of treatment, payment, or operations must be routed to the Privacy Officer.

Duet staff are legally responsible for protecting the health information of the individuals served. Special laws mandate the ways in which information is stored and shared.

Approved by Duet Director



Duet Director

August 12, 2020
Date

Approved by ENHSA Governing Board

ENHSA Governing Board Chair

August 12, 2020
Date

HIPAA PRIVACY PROCEDURES

Procedure Effective Date: 3/08
Supersedes Procedure Number:

I. Notice of Privacy Practice (NPP)

HIPAA regulations require that all persons served receive an NPP. The HIPAA regulations require that the notice be posted in public areas of the Agency, for example, administrative area offices, day service settings, workshops. Individuals and their families will be given a copy at admission and will be asked to sign an acknowledgment indicating they have received it. The notice explains how the medical information will be used and what their rights are.

II. Minimum Necessary Rule

When using, disclosing or requesting protected health information (PHI), you must make reasonable efforts to restrict PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure or request. Depending on the circumstances, disclosure may or may not require authorization, accounting or an opportunity to object.

Exception: For purposes of treatment, the concept of minimum necessary should not impede the free flow of information necessary to ensure comprehensive treatment. Otherwise, access should be limited to the records based on the need to know. For example, financial auditors do not need medical information, pharmacists need only medication related information, such as drug allergies or interactions. Staff members are restricted from records that are not within their scope of responsibility.

A. Disclosures are allowed without authorization, an accounting or opportunity to object in the following circumstances:

1. For treatment - Activities for the provision, coordination and management of treatment or treatment related service. **The minimum necessary rule does not apply for the disclosures or uses involving treatment.** Examples of allowable releases would be to discuss a person's case with doctors, therapists, service coordination, ISP team members, or hospital personnel.

2. For payment activities to obtain or provide reimbursement for services. **The minimum necessary rule does apply.** Examples: Discussing a case with service coordination, SSI, or Medicaid personnel. In most cases, payment activities within Duet are limited.

3. For operational activities, such as Quality Assurance, behavior medication committees, audits, and training, **the minimum necessary rule does apply.**

B. No authorization or accounting is required for disclosure to family members or close personal friends, however, an opportunity to object is required. The minimum necessary rule does apply.

1. If the individual has the capacity to understand, he or she should be given the opportunity to object to the disclosure. If the individual has a legal representative, she or he should be given the opportunity to object.

2. PHI may be released to family or friends that are involved in the individual's care or payment of services.

3. PHI that is released to family or friends should be directly relevant to their involvement with the individual. The minimum necessary rule does apply.

4. If the legal representative or individual are not present or if there is an emergency, you should use your best judgment about whether or not the disclosure is in the individual's best interest.

III. Protected Health Information (PHI)

PHI is individually identifiable health information in any form. This includes information created or received by Duet that relates to an individual's past, present or future health condition. It can include any information that can identify the individual. This includes but is not limited to:

A. Name, address, and zip code of the individual
B. Any reports that contain the individual's name (such as meeting minutes)
C. The record or copies of the record
D. Financial or billing information
E. Logbooks, calendars
F. Date of birth or Social Security number
G. Oral communications regarding the individual
H. ISP narratives, program documentation
I. Photographs, videos
J. All electronic data or data printouts
K. Diagnosis
L. Provision of service
M. Payment of services (how payment will be made)

IV. Individual Rights Under HIPAA

A. **The right to request restrictions on certain uses and disclosures of his/her PHI.** Individuals may request that Duet restrict sharing, discussing or use of PHI while staff are carrying out habilitation, payment or operations. Duet is not required to grant the request but must justify whatever decision is made. If an individual or legal representative asks about restricting access to their record, contact the Privacy Officer immediately.

B. **The right to receive confidential communications of his or her PHI.** Whenever possible, Duet must honor requests an individual or legal representative may have to receive information about their case by alternative means, methods or location. According to the HIPAA rule, Duet is prohibited from asking why the person is making that request. The request must be made in writing. If Duet cannot accommodate the request, the reason must be documented and retained for a period of six years. Contact the Privacy Officer immediately if anyone asks for confidential communications.

C. **The right to inspect and copy his/her PHI (some exceptions may apply).** While individuals/legal representatives have the right to inspect or receive copies of their record, the individual/parent/legal representative will sign the Request to View Protected Health Information form. However, the staff may discuss the PHI with the individual or legal representative as needed. Duet

staff should not release copies of the record without contacting the Privacy Officer for guidance. Exception: Subsequent to the Annual ISP meetings, copies of the ISP and related documentation may be distributed to the legal representative or person at that time.

D. **The right to request an amendment to his/her PHI.** If an individual or legal representative feels part of their record is incorrect or they disagree with what is written, they have the right to request an "amendment" to their record. Their correction/disagreement would become an addition to the record. All requests for amendments must be made in writing to the Privacy Officer.

E. **The right to an accounting of disclosures of his/her PHI.** The HIPAA rule requires certain disclosures to be documented. The individual then can request an accounting of these disclosures that have been made over the past six years. The Privacy Officer is responsible for accounting the disclosures that occur.

F. **The right to a paper copy of Duet's NPP (Notice of Privacy Practices).** All individuals and/or legal representatives must be given a copy of Duet's notice of privacy practices at the time of admission and must sign an acknowledgment of receipt. Area staff are responsible for distributing the NPP.

V. Uses and Disclosures of PHI

There are four types of disclosures.

A. Disclosures are allowed without authorization, an accounting or opportunity to object in the following circumstances:

1. For treatment
2. For payment activities to obtain or provide reimbursement for services
3. For operational activities, such as Quality Assurance, behavior medication committees, audits, and training

B. Disclosures permitted without authorization or opportunity to object, but which do require accounting:

1. Those made for public health purposes, such as to APS, CPS or reporting communicable disease
2. Those made for health oversight activities or mandated by law, such as DDS surveyors, Department of Health surveyors, state reviewers for licensure, and fraud prevention enforcement agencies
3. Government benefit programs, such as Medicare, SSI, or food stamps, unless Duet is payee.
4. Reporting to coroners or funeral directors
5. For law enforcement, such as reporting a missing person, reporting crime when the individual is the victim or perpetrator, or investigating a suspicious death

C. Disclosures to family members or close personal friends. No authorization or accounting is required but requires an opportunity to object.

1. If the individual has the capacity to understand, he or she should be given the opportunity to object to the disclosure. If the individual has a

legal representative, she or he should be given the opportunity to object.

2. PHI may be released to family or friends that are involved in the individual's care or payment of services.
3. The PHI that is released to family should be directly relevant to their involvement with the individual.
4. If the legal representative or individual are not present or if there is an emergency, you should use your best judgment about whether the disclosure is in the individual's best interest.

D. Disclosures that require an authorization. Any disclosure that is not listed above will require an authorization to release information. HIPAA requires that certain elements be present on the authorization. All authorizations and inquiries should be referred to the Privacy Officer. It is the Privacy Officer's responsibility to ensure all the proper procedures have been followed. Examples: Information for attorneys, court, family not involved in the person's care, Special Olympics, housing, employment, and referrals to non-treatment programs.

VI. Protecting Privacy

A. Treatment - When using or sharing information for treatment purposes, the emphasis must be on the health/wellness of the individual.

B. Oral Communications

1. Don't discuss information about individuals in a public place where others can overhear.
2. Do not leave a message on an answering machine with details of PHI. If you need to leave a message, make it simple and ask the person to return your call.
3. Don't discuss person-centered issues with family/friends.

C. Records

1. Make sure records are not kept where unauthorized people can see them.
2. Lock the records in a desk/filing cabinet if possible or lock them in a room when Duet staff are not present.
3. Do not post private information where the public or other individuals can view it.
4. Shred all documents containing PHI before discarding it.
5. If traveling with records, take the necessary precautions to ensure they are not stolen or lost.
6. Secure records in your vehicle if you leave your vehicle unattended. For example, place records in trunk of car or out of view in trucks/SUV's, etc.

D. Faxing

1. When sending a fax, verify the intended recipient or other authorized person is there to receive it.
2. Place fax machines in a secure location.

3. If faxes with PHI are received and remain unattended for some time, find the intended recipient.
4. All faxes containing PHI going to the Central Office should be sent to a secure fax machine.

E. Computers - All computers containing PHI must be password protected.

1. Ensure computer screen faces away from public viewing.
2. When stepping away from the computer, close all applications. If you are going to be away for a long time, shut the PC down.
3. Do not send PHI by email unless it is encrypted. Send by SCOMM within Therap where applicable.

F. Release of Information - Do not disclose PHI to anyone outside the agency unless it is permitted under the rule. If you are unsure about what to do, ask your supervisor or contact the Privacy Officer.

VII. Complaints

HIPAA requires that individuals, parents or legal representatives are informed as to how to file a complaint if they think Duet is not protecting their privacy or rights. This is outlined in the Notice of Privacy Practices.

Individuals or legal representatives must submit their complaint to the agency's Privacy Officer or may file a complaint with Health and Human Services. Complaint forms are available in Central Records or at the Area/Division Office.

1. If an individual or legal representative wish to file a complaint, provide him/her with the Privacy Complaint Form.
2. Instruct the individual to contact the Privacy Officer using the information provided on the form.

VIII. Employee Responsibility to Report

All Duet employees are required to attend initial and ongoing training on the HIPAA Privacy Rule. As an employee, Duet staff have a responsibility to report any breaches of the HIPAA rule that have been observed. Most breaches are due to either training issues or a breakdown of procedures. Most breaches are not deliberate or malicious. However, disciplinary action can be imposed if it is appropriate to the situation. An example of incidents that can lead to disciplinary action: repeated violations of the HIPAA rule or deliberate improper disclosure of PHI.

1. For any concerns about compliance with HIPAA regulations or feel that PHI was released inappropriately, contact the Privacy Officer.
2. Complaints can be made anonymously by completing an Employee Complaint form.

PROCEDURES TO OBTAIN INFORMED CONSENT

Procedure Effective Date: 3/95
Supersedes Procedure Number: 633

In order to ensure that informed consent is obtained when signatures are requested on agency consent forms, the following conditions must be met.

A. The person served or their legal representative, as previously defined, must be told exactly what their signature on the release form authorizes.

   NOTE: If the authorization is for the release of confidential information, the person must be told exactly to whom the information is being released, why it is being, requested, and how it will be used. They should be offered the opportunity to review the information or receive assistance in reviewing it.

B. The person must understand the consequences of giving permission or denying permission.

C. The person must be told that their consent is time limited, and revocable.

D. The consenting person should be asked questions about the benefits, risks, purposes, and alternatives of the consent. If their responses show that the information is misunderstood or inadequate, then the information should be added to or restated more simply.

E. The person supported must have the ability to understand the information being communicated and be able to make an informed decision.

PROCEDURES FOR REPORTING CHANGE OF STATUS

Procedure Effective Date: 4/96
Supersedes Procedure Number: 643

It is Duet's responsibility to report all changes in information of persons supported to the Central Records Department.

The Duet Change of Status form (Duet-2) is to be completed at each occurrence of change in information of the person supported. If there are several changes, they may be included on one form and reported at the same time.

It is the Area's responsibility to complete and submit the change of status as soon as a change(s) occurs.

The top portion of the form must be completed on all changes.

The Area initiating the change is to run a copy for their own record and route the original to Central Records.

INDIVIDUAL RECORD POLICY

Policy Effective Date: 9/19
Supersedes Policy Number: 660 (8/11)

Individual Record (IR) shall be prepared for each person in each program setting. The Individual Record shall be kept at the program setting and shall be available to all staff working with that person. All information in the Individual Record shall be considered confidential.

Approved by Duet Director

Duet Director

August 12, 2020
Date

Approved by ENHSA Governing Board

Governing Board Chairperson

August 12, 2020
Date

PROCEDURES FOR INDIVIDUAL RECORD

Procedure Effective Date: 8/19 supersedes Procedure Number: 661 (2/15)

Assembling of Individual Record

The Individual Record (IR) is the reference point for all current documentation for each person in services and includes electronic and written records. The IR is the current or working portion of the person's file, as distinct from the total unit record kept in Central Records. The unit file in Central Records contains all documents created from the time of admission. All forms contained in the IR must be completed in their entirety and should be completed promptly.

All required records shall be available and accessible to staff on-site. However, the file format and location of records may vary in each location. Any IR in book format will contain a Table of Contents that includes a listing of the program-specific filing sequence. (See Table of Contents, Duet-77). The Table of Contents shall contain a brief description of where to locate the record, e.g., Therap Module, Program Book, Medication Book, financial records. Additional program/setting-specific records and forms may be added.

Documentation within the IR will be retained according to procedure. Any forms removed from a record (IR, Program Book, Medication Book, or financial records) must be returned at the end of the shift.

Some forms require the individual or their legal representative to sign their consent. If the person has a legal representative and that person changes, new consent forms must be completed and updated with the current legal representative's signature.

Use of Forms

Personal Information:

Therap Individual Data Form (IDF) - The IDF provides information pertaining to the person in case of an emergency and should be updated as information changes. The IDF should contain a recent photo that is updated every three (3) years for children and five (5) years for adults.

Duet-26 Social History - Social History information is obtained from the person's family and other team members upon admission to Duet services. However, it must be updated as significant events transpire. Staff will complete a Social History form, send the original to Central Records, and retain/upload a copy for the Individual Record.

Duet-155 Consent for Medical/Dental Treatment - This form is completed prior to a person entering Duet services. The Duet-155 is valid until the individual's legal status changes, a minor child reaches age of majority, or status of legal representative changes. This form also requires that staff give the person and/or the parent/legal representative a copy of the Notice of Privacy Practices.

Duet-160 Occupational Health Hazard Consent - This consent is completed whenever an individual has the potential to encounter any type of hazardous chemical such as janitorial products or sub-contract work. The consent is updated annually and remains at the setting.

Duet-22 Power Equipment Consent - Team approval is necessary prior to any person beginning training on any type of power equipment, e.g., radial arm saw, table saw or lawn mower. The original approval form is routed to Central Records and a copy is retained/uploaded for the setting/IR.

Duet-23 Photo, Television, Movie, Video Recording, Social Media and Website Consent - This form is completed when any person has been identified in any internal or external publication or media event. This form must be completed for each occurrence. The original is sent to Central Records and a copy retained in the setting. The individual and the legal representative can revoke the consent at any time.

Duet-209 Clothing/Possession Inventory (residential only) - An inventory of clothing/possessions should be completed upon admission to residential services. As new items are purchased or received valued at $75 or more, an entry should be made to the inventory. Any items that are discarded should be approved by the person and/or legal representative prior to discarding. The inventory should be reviewed periodically to ensure accuracy. Original inventories remain in the IR.

Legal Guardianship Document - If Letters of Legal Guardianship for the individual have been issued, the legal representative must be the one to sign all legal and administrative documents on behalf of the individual. Some examples of such documents are consent forms and the authorization to release information. A copy of the legal guardianship papers must be obtained at the Intake process whenever possible, within 30 days of admission or anytime the legal guardianship changes. Send a copy to Central Records and retain one for the Area.

Medication Documentation:

Therap Medication History Report - This report provides a history of medications taken by the person.

Duet-207 Individual Medication Administration Profile Guide - Provides individual specific medical information that includes allergies, diagnoses, baseline vitals, and medication information. In addition, the profile also provides medication-related information related to how does the person respond to requests to take medication, preferences on how the person likes to take the medication, and any special instructions or swallowing considerations. The profile is updated as needed throughout the ISP year, and always at the annual ISP, and staff sign. All staff must review and sign the medication profile indicating that they understand the support needs for the individual prior to providing medication to the individual.

Duet-208 Documentation of Recipient Safety - Completed by the Duet Case Management Nurse for all individuals. This document acknowledges that it is safe and appropriate for the individual to receive medications by medication aide following the Duet Medication Policy. This authorization includes provision of all routine and PRN medications as prescribed as well as medications provided by additional routes as trained by a licensed health care professional and documented on the Documentation of Training in Additional Routes/Special Care Procedures (Duet-206).

Drug Details in Therap - This provides pertinent information concerning medication, possible

side effects, and efficacy information.

Therap Medication Administration Record (MAR) - The MAR documents all current medications routinely given for that month and any PRN Medications administered as prescribed by a health care professional. PRN follow-up is documented within the MAR. MARs are reviewed by a Duet nurse on a monthly basis.

Therap Self Administration Medication Administration Record - In addition to documentation from the individual's ISP narrative, this form will be used by staff when the person has achieved Level IV Self-Administration status. The form monitors administration through at least weekly medication counts. The original Self Administration Medication Administration Record is reviewed by a Duet nurse on a monthly basis.

Guidelines by Route - Each staff will be trained on individual specific Guidelines by Route, which will include all routes of medication that the individual is taking. Routes include oral, oral liquid, oral sublingual and buccal, topical lotions, creams, ointments and gels, topical transdermal patch, instillation of nose spray, instillation of nose drops, inhalation metered dose inhaler, handi-haler, inhalation diskus, eye ointment, eye drops, ear drops, and rectal suppositories. Staff will sign the back of the guideline page for each specific route indicating that they have received training, understand, and will follow the guidelines for providing medication by the route to the person. Staff should also review the person's Individual Medication Profile for specific individualized instructions and/or information that may pertain to this route.

Therap Health Tracking – Documentation of health supports such as seizure tracking, blood glucose monitoring, height and weight, intake/elimination, menses, and appointments is completed in the Therap Health Tracking Module. Health Tracking documentation is reviewed by a Duet nurse on a monthly basis.

Therap Medical Documentation -Medical documentation and Health Related Service Needs documentation is completed within the Therap ISP Data Module. Completed Medical Documentation is reviewed by a Duet nurse on a monthly basis.

Duet-205 Medication Problem Log - Completed when there are medication problems that have no potential to adversely impact the individual and do not require immediate RN notification. These include:
Illegible count/entry (medication count accurate) Missing initials (medication count accurate)
Missing Medication Return Record
Medication becomes contaminated
No documentation for follow-up/use of PRN medication
No documentation Duet RN instructions/directions for use of PRN Problems with Medical Charting, Seizure Record, or Health Relate Service Needs.

The person who discovers the problem completes a Medication Problem Log. The Medication Problem Log is routed to the Case Management Nurse by the 20th of the following month with medication records. At the direction of the RN, a Therap General Event Report may also be completed for medication problems.

Duet-203 Medication Error Report - Filled out with any error that has the potential to have an adverse impact on the individual that violates the five rights, or other issues that may or may not

have the impact to the individuals. Both types of errors require immediate RN notification and notification to the supervisor within one business day. The person who discovers the error completes a Medication Error Report and it is routed to the Case Management Nurse within 72 hours. This includes:

Wrong person, wrong medication, wrong dose, wrong time, wrong route, missed dose
Count incorrect with potential to impact the individual Newly prescribed order not initiated within 12 hours
If medication provided: expired orders, expired medications, improper storage of medication.

Duet-204 Self Medication Administration Problem/Error Log (SMAPEL) - To be completed when there are medication errors or problems detected regarding the individual who self-administers his/her medication. For any errors/problems, the RN should be notified immediately upon discovery, and the supervisor should be notified within one business day.

Duet-115 Medication Return Record - This form is used to document when medication is returned to the pharmacy. When this occurs, the Medication Return Record is routed and reviewed by a Duet nurse.

Duet-206 Documentation of Training in Additional Route/Special Care Procedures - Training in special care procedures will be documented on the Duet-206. Competency will be demonstrated to the medical professional prior to implementation of the procedure. The original is retained in the IR until the end of the ISP year and then routed to Central Records.

Medical Record:

Therap Appointment Tracking - This provides an ongoing record of all medical appointments, hospitalization and emergency room visits, including admission and dismissal dates and diagnosis. Information regarding hospitalizations or emergency room visits is updated at the time the events occur.

Duet-107 Health Care Professional's Orders - The Duet-107 is used to document any medical visit, including hospitalizations with a health care professional. Additionally, it is used to secure telephone orders. The completed form is copied or uploaded to IR and original routed to Central Records. Copies may be routed to the Nurse, service coordination, and the corresponding setting.

Duet-47 Nursing Observations - This form documents nursing observations, progress and recommendations. Originals are routed to Central Records. Copies are retained in the IR for one year.

Duet-13 Dental Form - The Duet-13 is completed for all persons served. Annual examinations are required for Title XIX persons or as indicated when dental orders or recommendations are made. Copies of completed exams are retained or uploaded for the IR and routed to corresponding settings and service coordination. The original is routed to Central Records.

Duet-12 History and Physical Form - The Duet-12 is completed for all persons served. Annual

examinations are required for Title XIX persons or as indicated by the health care professional's orders or recommendations. Copies of completed exams are retained/uploaded to the IR. The original is routed to Central Records.

Evaluation:

Duet-30 Assessment Results - This form is used to summarize information gathered from any assessments completed and generally reflects a person's strengths and support needs. The original is retained in the IR until the end of the ISP year and then it is routed to Central Records.

Duet-67 TSMI Assessment Checklist/Other Assessment Instrument - These are assessments that are used to assess one or more of the seven developmental areas and identifies a person's strengths and support needs. Completed originals of any or all portions of the assessments will be retained/uploaded in the IR. Original forms are routed to Central Records at the end of the ISP year.

Duet-98 Personal Priorities and Preferences Assessment (PPPA) or other outcome-based evaluations - These tools are used to identify the person's preferences and outcomes. Completed originals are retained/uploaded in the IR. Originals are routed to Central Records at the end of the ISP year.

Duet-20 Power Tool and Equipment Assessment - This form is used when a person is going to operate any power tools or equipment. The person must demonstrate that they understand and follow the safety and operating instructions, and know the limitations and hazards associated with all of the equipment used. Forms are updated annually, and originals retained in the IR.

Speech/Physical/Occupational Therapy Assessment - These reports are generated by outside providers to furnish documentation of treatments recommended, exercises, adaptive equipment and other supportive devices, the individual's progress and assessments. Progress notes will remain in the IR for one year. Evaluations from one or more of these services will remain in the IR until a new one is completed.

Duet-45 Nursing Assessment - The Nursing Assessment is completed by a Duet RN. The individual's medical needs and status are evaluated when a referral to Nursing has been made. Nursing sends an original to Central Records. A copy is retained/uploaded in the IR until a new one is completed.

Duet-46 Care Plan - The Nursing Care Plan is developed utilizing the findings from the Nursing Assessment. Nursing sends an original to Central Records and a copy to the areas. The copy should be retained/uploaded in the IR until a new one is completed.

Duet-48 Assessment for Self-Administration of Medication - This assessment is completed to determine the person's self-administration status. The ISP team will be responsible for approving self-administration using this assessment as a guide.

ISP:

Intake and Planning/Individual Program Plan/Semi-Annual Review/Family Support Plan/ISP

Addendum - These documents are generated by Service Coordination and accessible in Therap.

Positive Behavior Support and Psychotropic Medication Related Documentation:

Duet-118 Health care professionals Orders for Psychotropic Medication - This form documents health care professional visits, orders, and recommendations. The health care professional reviews psychotropic medication at least annually. Copies of the completed forms are retained/uploaded to the IR. Staff observations must be completed with accurate information outlined on the form to assist the health care professional to make informed medication decisions. Original forms are routed to Central Records.

Duet-16 Informed Consent for Psychotropic Medication - The Duet-16 is completed when a psychotropic medication is prescribed. The name of the medication and source for side effects is documented on the Duet-16. All psychotropic medication can be listed on the same form or on multiple forms. If a new medication is prescribed or there is a change in the legal representative, a new form must be completed. The original consent is routed to Central Records and a copy is retained/uploaded in the IR.

Duet-52 Psychotropic Medication Review Summary - This form is completed for all psychotropic medication prescribed and is reviewed by the Human Legal Rights Committee (HLRC). Psychotropic medication refers to drugs that are prescribed to assist in treating symptoms of psychiatric disorders and less commonly, to assist in “managing” stated behavior(s). The form is initiated by the Duet Behavior Specialist in conjunction with medical and behavior documentation from the residential and/or day support staff. After HLRC review, the original is sent to Central Records. A copy is retained/uploaded in the IR. The Duet-52 is updated when there is a new legal representative appointed, or when a new med is prescribed. This form does not need to be updated when medication dosages change.

Duet-55 Request and Informed Consent for Restriction, Behavior Support Plan and Safety Plan- The Duet-55 is completed annually. This form is completed by the Duet Behavior Specialist when a restrictive procedure is proposed as defined in Positive Behavior Support Procedures. Informed consent is documented by the signature of the individual and/or the legal representative. Completed Duet - 55 forms are reviewed by the HLRC. Once the review is completed, the original is sent to Central Records and a copy retained/uploaded in the IR. If a new restriction is proposed or a change to an approved restriction is proposed that makes an approved restriction more restrictive, a new Duet-55 must be completed.

Duet-56 Accessibility Plan - This form is completed for individuals affected by a restriction designed for another person or persons at their residence. An individual is affected when access to what is restricted is in a common living area of the home. The Residential Supervisor or his/her designee completes this form for affected persons when affected by a new restriction, and a new Duet-56 is completed for affected persons in preparation for Annual ISP’s. The completed form is given to a Behavior Specialist familiar with the home or is assigned to the person for whom the restriction was designed. The Behavior Specialist takes the form to the next HLRC meeting for approval and committee signatures. Once the review is completed, the original is sent to Central Records and a copy is retained in the IR.Duet-50(A) Behavior Baseline/Functional Analysis Observation Form, and Duet-50(B) Duet Structured ABC Baseline - The Duet-50(A) and Duet-50(B) serve as documentation of behavioral incidents and the

context in which such behaviors occur. These Duet-50's may be used on a short-term basis or for ongoing data collection when the target behavior occurs infrequently. Staff document information regarding the incident (date, time, place, location and who was involved in the incident). Also documented is how staff and others responded to the behavior, and how the individual reacted to that response.

The Duet-50(A) information is documented per incident, and each sheet of data contain multiple incidents. One page of Duet-50(B) is completed for each incident. Staff checks off categories of location and typical activities that the staff check. Then staff indicate the sequence of the antecedents, behaviors displayed, and the consequences (how others responded to the behavior).

These forms help establish patterns regarding the situation, times, and locations that the person is most likely and least likely to demonstrate problem behavior. It also helps to establish the course of behavior and what is most likely reinforcing the target behavior. The information obtained can be incorporated into a Functional Behavior Assessment (FBA). At the end of the ISP year, route originals to Central Records.

Duet-99 Problem Behavior Inventory - The Duet-99 is used to provide an overall basic assessment of the occurrence of problem behaviors and maladaptive behaviors over the past year and an estimated range of how often these target behaviors occurred. The completed original is retained in the IR until the end of the ISP year and then it is routed to Central Records.

Functional Behavior Assessment - When problem behaviors are to be addressed in a Behavior Support Plan, a Functional Behavior Assessment (comprehensive) must be completed by the appropriate professional. Prior to completing the FBA, data is compiled using the Problem Behavior Inventory (Duet-99) and the Behavior Baseline (Duet-50(A)) or the Structured ABC Baseline (Duet-50(B)). FBA forms describe the individual's highest priority problem behaviors and the environmental context in which they occur.

The FBA defines the target behavior in observable and measurable terms, defines the impact or intensity of the target behavior to self or others. The FBA also assesses the individual's unique characteristics and supports and identifies when the target behavior is more and less likely to occur and develops a hypothesis of the communication function. The communicative function is the intent or purpose (what the person hopes to get or avoid) from doing the target behavior. This evaluation must be updated annually. Copies are routed to the behavior specialist. Original forms are routed to Central Records at the end of the ISP year or after completion/termination of program.

Safety Plan - If an individual has a rights restriction, a Safety Plan must be completed. This Safety Plan describes the restriction, when it is to be used and the data recorded about the use of a restrictive procedure. The Safety Plan also provides a description of safety concerns such as threats of harm to self or others, severe aggression, sexual offenses, extreme property destruction, elopement, or medical conditions related to the need for a behavioral restriction. Safety Plan procedures identify potential stressors and triggers and summarize related BSP interventions. If there are no rights restrictions, a Safety Plan is not mandatory, as BSP may contain a full description of safety related procedures. Originals are routed to Central Records at the end of the Annual ISP year.

Behavior Support Program - The Behavior Support Program (BSP) is the action plan developed from information collected from the FBA. This form identifies proactive plan to target behavior and the rationale for the BSP. Also identified in this process are replacement behaviors, reinforcement procedures, prevention and intervention strategies, identification of strategies for other problem behaviors and data recorded. The originals are maintained with other program documents until the end of the ISP year and then routed to Central Records. Copies are routed to the behavior specialist. Original forms are routed to Central Records at the end of the ISP year or after completion/termination of program

Programs:

Habilitative Support Programs – Support Programs are developed based on the person's expressed interests and desires to learn/attain new skills and are prioritized through the team process. Each support program is documented in Therap. Programs document goal and completion criteria which include a summary of the outcome/intent of the program; assessment information relevant to the goal, information/materials needed to implement the program; strategies/instructions for staff and the person; identification of the data being collected; and how skills are encouraged/taught when data is not being taught. Once written the program is approved on Therap, which makes it available to the service coordinator. Implementation dates for new support programs will be decided at the ISP meeting.

Habilitative Support Program Data – This data serves as monthly data analysis to assess and report progress. All program data is reviewed monthly by Duet manager or designee.

Activity Related Documentation:

Duet-113 Daily Log/Recreational Opportunity Log/Duet-103 Outcome Support Worksheet - Activity related documentation is any information regarding activities that occurred in a person's day that is not necessarily routine. There are a variety of different forms that may be used to document this information, e.g., Daily Log, Recreational Opportunity Log or Duet-103 Outcome Support Worksheet. Original Daily Logs and Recreational Opportunity Logs are maintained in the IR for a minimum of three months and retained on site for one ISP year. The Duet-103 is maintained until the end of the ISP year.

Financial Records:

Therap Financial Account - Financial records are to be kept on Therap. Refer to Procedures for Personal Funds Policy 151 in the Policy and Procedures Manual for the specific instructions on how to complete, maintain, and retain records. All financial documentation is subject to the Agency's auditing procedures, to include ongoing monitoring by Agency supervisory staff. A copy of financial records will be sent to the person or legal representative at least quarterly or as determined by the legal representative.

POSITIVE BEHAVIOR SUPPORTS POLICY

Policy Effective Date: 3/19
Supersedes Policy Number: 710 (4/12)

The purpose of the positive behavior supports policy is to:

1. Provide a framework whereby the agency can support and assist persons to gain skills and decrease challenging and problem behaviors so that individuals may fully participate in and contribute to their communities,
2. Establish rules for the development and monitoring of positive behavior support plans, psychotropic medication, and medication prescribed for behavior control,
3. Identify the roles of the ISP team, Duet staff, and the Behavior Support and Medication Review Committee (BSMRC), and
4. Identify procedural documents and guidelines to be used to implement the policy.

Positive behavior supports (PBS) are supports that emphasize positive approaches directed towards maximizing the growth and development of everyone. Positive behavior support (PBS) is based on the premise that “behavior” is a form of communication. It is an approach that balances what is important to the person with what is important for that person to lead a fully self-directed life. Positive behavior support blends person-centered values with behavioral science to better understand what the person seeks to achieve or to avoid when (s)he demonstrates challenging behavior. PBS extends beyond simply decreasing undesirable behaviors to enhancing quality of life for individuals in their home, work, and community settings. A teamwork approach that engages the person and people that best know the individual is a part of the PBS process.

Positive Behavior Support is based on the belief that anything the person does consistently, including problem behaviors, serves some desired purpose. Such a purpose or function is an attempt to achieve a valued outcome. For instance, the problem behavior may help the person gain something desired or avoid something unwanted. Data records are gathered to learn what may “trigger” the behavior, how the behavior develops (the course of the behavior) and apparent maintaining consequences of the behavior. The data is then analyzed to determine the most likely function(s) that problem behavior is serving. The team then develops individualized strategies to assist and support the person to better communicate and meet his/her needs in more socially acceptable ways.

PBS includes three main components:

- Functional Behavior Assessment,
- Safety Plan (a Plan that includes behavior support strategies) and
- Behavior Support Program (a Program to develop replacement skills related to the individual’s Safety Plan).

Once the ISP team has determined that a Safety Plan is necessary with or without a related Behavior Support Program, the individual's behavior must be assessed. The team must then select goals and objectives, a set of teaching/reinforcement methods, and prevention and intervention strategies. Safety Plans and related Behavior Support Programs are developed in accordance with the following:

1. Safety Plans and related Behavior Support Programs must be based on a data record (baseline) and if applicable, on a Functional Behavior Assessment.

2. Safety Plans using nonrestrictive support strategies such as the use of positive reinforcement shall be utilized and deemed ineffective before considering restrictive procedures.
3. Documentation by collecting meaningful data shall be done in order to allow for monitoring and review of Safety Plans and related Behavior Support Programs.
4. Certain practices are labeled as restrictive. The use of restrictive procedures shall be reviewed and monitored. Due process must be followed before implementation, except in emergency safety situations.
5. In emergency safety situations, when an individual engages in ~~a~~ high-risk behavior dangerous to the individual or to another person, an emergency safety intervention may be necessary to protect the individual or others from harm.
6. Some practices, such as the removal of basic human and legal rights are prohibited and may never be used by agency personnel. Staff who engage in such practices are subject to disciplinary action up to and including termination.
7. The individual, or the legal representative if applicable, must give an informed voluntary consent to a restrictive procedure, including psychotropic medication as described in the person's Safety Plan.

Psychotropic medications refer to drugs prescribed to treat psychiatric disorders and symptoms (behavioral manifestations) thereof. Less commonly, psychotropic medication is prescribed to manage specific behavior(s) that are not identified as symptoms of a mental illness. These drugs include but are not limited to antipsychotic drugs, antianxiety medications, antidepressants, antimania medications, stimulants, and sedative/hypnotics. Other drugs prescribed for a psychiatric condition or problem behavior are also considered to be psychotropic medication. Whether or not a drug is a psychotropic medication depends upon the purpose or condition as written by the person's prescribing healthcare professional (hereafter referred as physician). Drugs prescribed only for medical purposes or conditions (such as seizures or allergies) are not considered psychotropic medications.

As with restrictive procedures, the ISP team must carefully weigh the risks and potential benefits. The team should consider the risk of the medication (potential side-effects) against the risks of non-intervention (not using medication). A consideration of potential benefits and the likelihood that they will be realized should also be considered.

Review Process

Safety Plans, related Behavior Support Programs and restrictive procedures including the use of psychotropic medications are subject to internal and external review and monitoring.

Internal review and monitoring include the following:

1. Safety Plans, related Behavior Support Programs, use of psychotropic medications or any plan that utilizes restrictive procedures must be approved by the ISP team. The person served and/or the legal representative must give their informed consent. It must be explained that consent can be withdrawn at any time.
2. Once approved, the implementation, monitoring, revision and/or termination of the Safety Plan with or without a related Behavior Support Program shall be supervised by designated agency personnel as well as the ISP team.

External review and monitoring involving persons outside of the agency is accomplished through the Human and Legal Rights Committee (HLRC)

The HLRC will review Restrictive Procedures, Restrictive Devices, Safety Plans, related Behavior Support Programs, psychotropic medication and increases in psychotropic medication.

The major functions of the HLRC include:

1. Review of pertinent documentation. Documentation includes Safety Plans, related Behavior Support Programs, consent forms, physician's orders for psychotropic medication and data summaries.
2. Ensure nonrestrictive methods have been tried and determined to not be effective and that due process is followed and when restrictive procedures are proposed or utilized. psychotropic medication or a restrictive procedure.
3. Ensure that when the person is prescribed psychotropic medication to control specific behavior(s) (as contrasted with taking medication for a diagnosed psychiatric disorder), a Safety Plan and related Behavior Support Program is developed for each service setting in which the problem behavior is occurring.
4. Evaluate data trends as presented.
5. Review Emergency Safety Situations and the use of Emergency Safety Interventions.
6. Review persons that may be affected by the restrictions of another and their individualized accessibility plans to lessen or overcome the potential intrusion.

Approved by Duet Director

Duet Director

August 12, 2020

Date

Approved by ENHSA Governing Board

ENHSA Governing Board Chair

August 12, 2020

Date

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PROCEDURES FOR POSITIVE BEHAVIOR SUPPORT

Procedure Effective Date: 3/19
Supersedes Procedure Number: 711(10/11)

Definitions

EMERGENCY SAFETY INTERVENTION: The use of physical restraint (Holding, Interim or Team Control) or separation as an immediate response to an emergency safety situation.

EMERGENCY SAFETY SITUATION: Behavior by an individual that places the individual or others at serious risk of violence or injury if no intervention occurs and may require an emergency safety intervention.

MALADAPTIVE BEHAVIOR: Actions that have a serious negative impact to the person or others, such as physical aggression directed at others, self-injury or self-abuse, property destruction and highly inappropriate sexual behaviors or unlawful actions. Some examples are not truly maladaptive, such as responding in kind when provoked to defend oneself against the aggressive actions of a peer, or safely destroying one's own property. The ISP team has discretion to determine if certain behaviors are truly maladaptive.

*MECHANICAL RESTRAINT: The use of a mechanical device, material, object or equipment attached or adjacent to an individual's body that the individual cannot remove or negotiate around that restricts movement or access to the individual's body to prevent movement is considered to be mechanical restraint. Mechanical Restraint is prohibited.

*NOTE: Devices used to provide support for the achievement of functional body position or proper balance are not mechanical restraint. Also, devices used for specific medical and surgical (as distinguished from behavioral) treatment are excluded. Physician ordered devices for a necessary medical or dental procedure, or to promote healing following such a procedure, or for injuries otherwise sustained are not considered mechanical restraint. Should the ISP team agree that a less intrusive device or procedure is desirable, a discussion of such with the physician is necessary.

BEHAVIORS THAT INTERFERE WITH COMMUNITY ACTIVITIES: While not maladaptive, these behaviors are disruptive, antisocial, offensive or are otherwise interfering responses that significantly impact an individual from participating in tasks or community activities.

POSITIVE SUPPORT STRATEGIES: Such strategies include the maintenance of a rich, stimulating, empowering, rewarding and supportive environment for the individual; social reinforcement, teaching replacement behaviors (serving the same presumed function as the maladaptive or problem behavior), or redirection to a meaningful task or activity, self-monitoring, coping skills, problem-solving skills, behavior rehearsal, and tangible, or activity-related reinforcement. The use of extinction to not let the maladaptive or problem behavior "pay off" in accordance with the problem behavior's hypothesized function is also a positive support strategy. Positive supports strategies do not include the use of restrictive procedures.

PROHIBITED PRACTICES: Prohibited practices include verbal abuse, corporal punishment, denial of a nutritionally adequate diet, dangerous or cruel practices, aversive stimuli, and denial of basic rights (further descriptions and definitions of these practices may be found in these procedures).

RESTRICTIVE PROCEDURES: Restrictive procedures include limiting access to normally available household items or activities and some response prevention procedures (such as

locking access to food). If the ISP team determines that restrictions are necessary, such procedures must be written into a Safety Plan. Restrictive procedures cannot be included in the related Behavior Support Program, if applicable. Behavioral or environmental restrictions must be listed on the Request and Informed Consent for Restrictive Procedure (Duet-55).

RESTRICTIVE DEVICES: The ISP team may determine that a medical, positioning, adaptive or safety device is a rights restriction. When such a medical assistive device is listed as a restriction in the ISP document, the device must be reviewed and approved by the HLRC. Examples include an audio monitor or seatbelts (other than during transit or movement, other straps, bedrails or other devices used to provide support for the achievement of functional body position or proper balance. If deemed restrictive, a current (within the last 12 months) Physician's Order (Duet-107) must affirm that a physician or other healthcare professional agrees that the device can be used. A restrictive device does not necessitate the need for a Safety Plan or a related Behavior Support Program or need to be listed on the Duet-55 Request and Informed Consent for Restrictive Procedure.

SEPARATION: To physically assist or transport an individual unwilling to relocate to another area under staff supervision during an emergency safety situation.

Development of Safety Plan and Related Behavior Support Program

- If a person demonstrates maladaptive behavior on a recurring basis, a Safety Plan and a Behavior Support Program is needed. If the person demonstrates behavior that endangers self or others, a Safety Plan is needed. If the ISP team discusses and documents a person-centered rationale for why a Safety Plan or related Behavior Support Program is not needed, exceptions may be made.
- The ISP team may elect to develop a Safety Plan with or without a related Behavior Support Program for maladaptive behaviors occurring less frequently than once per month.
- If a person is prescribed psychotropic medication for behavior and not related to a symptom of a diagnosed mental illness, a Safety Plan and related Behavior Support Program must be developed.
- The ISP team may decide to develop a Program or other support strategies for other problem behaviors that are less serious that have a negative impact upon the individual or others.
- Behaviors that prevent or interfere with community participation, skill acquisition, interpersonal relationships or everyday activities may be addressed in a Safety Plan, related Behavior Support Program. The ISP team will discuss and determine whether problem behaviors sufficiently interfere with an individual's daily routine, habilitation or community participation warrant that a Safety Plan with or without a related Behavior Support Program is needed.

Once the ISP team has decided that a Safety Plan with or without a related Behavior Support Program is necessary, it must assess the individual's behavior and previous prevention and intervention strategies that have and have not been effective. If a Safety Plan is needed, Antecedent – Behavior – Consequence (ABC) data must be completed. ABC data or a Functional Behavior Assessment (FBA) will guide in the development of the Safety Plan and related Behavior Support Program. If the team decides a Safety Plan is needed, utilize the information in the most recent Provider Bulletins to determine if a Functional Behavior Assessment (FBA) must be completed.

PROCEDURES FOR APPROVAL OF RESTRICTIONS, SAFETY PLANS AND RELATED BEHAVIOR SUPPORT PROGRAMS

Procedure Effective Date: 3/19
Supersedes Procedure Number: 712 (2/19)

Design

The ISP team discusses and determines what prevention and intervention behavior support strategies will be used. Should such a strategy border on or appear to be intrusive or perhaps a restrictive procedure, the ISP team will discuss and document team consensus whether the strategy should be considered a restriction or a support. Considerations to guide this decision follow below.

A Restriction or A Support? Factors for the ISP team to assess

The impact of a procedure from the individual's perspective. From the individual's point of view, is something being lost or denied that is important to that person? Does the procedure functionally impact the person's ability to participate in or access what is denied? To the extent that the person's preferences are functionally impacted, the procedure may best be viewed as a restriction

The individual's motor skills and physical abilities to safely access what may be otherwise considered to be a restriction. For example, if a person cannot safely maneuver stairs or has alternative means to safely gain access, then putting a latch on a basement door may not be considered a restriction. If an environmental adaptation does not functionally impact the person's ability to access or participate, then the procedure may best be viewed as a support

The individual's cognitive skills and how quickly (s)he learns. Is it a reasonable expectation that the individual can acquire a necessary skill set to reduce or to eventually remove the restriction? For instance, persons with dementia or another degenerative condition wherein skill loss is progressive cannot successfully be taught new behaviors. For others who can learn do so very slowly. It may be unreasonable, even with well-chosen individualized teaching methods and strategies, to expect the person to master skills needed to reduce the restriction. Such considerations may influence the team's view that the procedure may best viewed as a support.

If the team determines the procedure in question is restrictive, a Safety Plan and possibly a related Behavior Support Program shall be developed. The Plans shall be designed to lead to a less restrictive alternative to reduce challenging or problem behavior. Ultimately the goal is to eliminate the restriction. The restrictive measure determined necessary for one individual may not negatively impact other individuals. Care must be taken to ensure that others are minimally affected by the restrictions of others

An ISP team may decide that a support strategy is intrusive yet is not determined to be restrictive. When the procedure has the appearance of an unwelcomed intrusion, the ISP team or Agency staff may decide the HLRC shall review the procedure

Approval Process

No restrictive procedures shall be authorized without evidence that non-restrictive positive behavior support strategies have been tried and deemed ineffective. Except as outlined in Emergency Safety Situations, #714, no Safety Plan using restrictive procedures may be implemented until it has gone through the following review and approval process

A. ISP team agreement on the impact of the target behavior. Regarding safety or other important concerns. The team will decide if a Safety Plan with a related Behavior Support Program is needed. If a restrictive procedure is to be used, the team must document Plans containing nonrestrictive (support) methods unsuccessfully tried. There must also be a plan to for the team to reassess whether to reduce or eliminate the restrictive procedure. The plan will include conditions and criteria that when met, will occasion the team to reevaluate a lessoning or removal of the restriction

B. ISP team approval of the Safety Plan with or without a related Behavior Support Program

C. Written informed consent for the restriction by the individual or when applicable, his/her legal representative. If the legal representative's written consent cannot be obtained, verbal (interim) approval is documented on the Duet-55

D. Approval by the Human and Legal Rights Committee (HLRC). The committee will review and will either approve, conditionally approve or not approve the restriction or Plans. Interim HLRC approval may be granted by a committee member, provided (s)he is not a Duet employee. This approval shall be in force until such time as the committee can meet and approve the Safety Plan, restrictive procedure and related Behavior Support Program.

Types of Revision and Approval Procedure

A. Progress is accurately measured and consistently monitored. The Safety Plans will be modified when needed based on data and changes in individual circumstances. Data collection reports will document the review as well as any changes or recommendations made to the programs. Safety Plans will be saved within Therap.
If the individual's behavior has not begun to change in the desired direction after implementation of the Behavior Support Plan (if no progress is seen), the plan should be evaluated for possible revision.

B. Revisions of restrictions in Safety Plans or removal of support strategies require approval of the ISP team in consultation with an Agency's Behavior Consultant.

C. Revisions that add or otherwise alter restrictive procedures require prior ISP team and HLRC approval. This includes new behaviors targeted for restrictive

intervention in Safety Plans that are topographically different. Topographically different means the type of behavior is not like the original target behavior.

D. Revision should be forwarded to the Behavior Consultant and offered to the individual's legal representative and other ISP team members.

Termination of Approved Restrictions and Safety Plan

A. All restrictive procedures, psychotropic medication, Safety Plans, related Behavior Support Programs are subject to re-approval annually at the individual's annual ISP. The individual's ISP team in consultation with the Duet Behavior Consultant have the authority to continue the current plan beyond the annual ISP date until the current procedures can be re-approved or a revised plan can be approved

B. Termination of restrictive procedures, Safety Plans or related Behavior Support Programs requires prior ISP team approval

C. An exception is when the individual and/or the legal representative withdraws informed consent. This results in the immediate suspension of the restriction or other objectional elements in the Safety Plan. If the individual withdraws consent, a team meeting/conference should be called as soon as possible to discuss options. With or without the benefit of a plan, the person and others must be kept safe. Staff shall intervene when necessary to ensure safety, up to and including an Emergency Safety Intervention

When Restrictions Designed for One Individual Affects Another Individual

A. Restrictions approved for one person may have an unintended impact on others sharing a common living area in which the restriction is imposed. Such environmental restrictions in a common area must be designed to minimize the effect on others

B. Affected persons must be given the means to access what is restricted
- throughout normal daily rhythms and routines
- when (s)he communicates a request to access what is restricted.

C. An Accessibility Plan for Environmental Restrictions Designed for Others (Duet-56) is completed for each affected housemate. The plan will contain supports and strategies to provide access and minimize the intrusion of another housemate's restriction.

D. The Duet-56 is submitted to the HLRC for review and approval for each affected individual. A new Duet-56 is completed at each affected person's annual ISP

PROCEDURES FOR PSYCHOTROPIC MEDICATION

Procedure Effective Date: 3/19
Supersedes Procedure Number: 713 (10/11)

Definitions

PSYCHOTROPIC MEDICATIONS: Psychotropic medications refer to drugs that are prescribed to treat symptoms of psychiatric conditions or disorders such as depression, bipolar disorder, anxiety, schizophrenia, etc. These drugs include (but are not be limited to) the following:

- antipsychotic medications, for example, to reduce apparent hallucinations or delusions, or decrease aggression or self-injurious behavior,
- antianxiety medications to reduce nervousness /agitation and related anxiety disorders,
- antidepressants drugs to reduce depression and related responses,
- antimanic drugs to reduce mood swings and related behaviors,
- stimulants to treat attention deficit or related disorders
- sedative/hypnotics to assist with insomnia.

Drugs prescribed for any psychiatric condition or disorder are psychotropic medications. Whether or not a drug is a psychotropic medication depends upon the physician's stated purpose for prescribing the drug. Drugs that have the effect of psychotropic medications yet are prescribed for medical reasons are excluded. For example, Depakote may be prescribed for seizures and for mood stabilization or other psychiatric conditions, whereas diphenhydramine hydrochloride (Benadryl) may be prescribed for allergies or insomnia. Drugs prescribed simply for medical reasons (such as seizures, allergies or other medical conditions) are not considered to be psychotropic medications.

PSYCHOTROPIC MEDICATIONS FOR BEHAVIOR CONTROL: These are medications prescribed exclusively for problem behavior(s), such as aggression or self-injury, and no associated psychiatric diagnosis or mental illness is stated or written by the physician.

Under certain conditions, the use of psychotropic medication prescribed to treat a psychiatric condition or disorder and associated symptoms may be considered a support.

Medication prescribed exclusively for problem behavior(s) is considered a restriction. A Safety Plan and related Behavior Support Program must be developed. Review and approval of psychotropic medication prescribed for behavior(s) follows a similar process to that of restrictive procedures, Safety Plans and/or related Behavior Support Programs.

Before use of psychotropic medications, the ISP team must discuss and document other Plans and systematic approaches that have been tried and deemed ineffective. The ISP team will weigh the risks of the intervention (medication and potential side-effects) against the risks of non- intervention (not using medication). A consideration of potential benefits and the likelihood that they will be realized should also be included.

Relationship Between Psychotropic Medications, Safety Plans and Related Behavior Support Program

Some systematic trial-and-error is most often necessary to arrive at the appropriate medication regimen, that is, the most beneficial type and amount of drug(s). This process is like the way we determine which support procedures are most effective. It is important to keep meaningful and accurate data. Doing so helps the physician and ISP team to objectively assess the effects of the medication.

The individual or as applicable, his/her legal representative and the ISP team must first approve the initial use of, or a dosage increase in a psychotropic medication before the medication can be administered. However, if the physician indicates in writing that the person presents a significant risk of self-injury or injury to others or appears to manifest serious medication side effects (thus requiring a change in medication), the person should begin the new medication without delay, with the team notified as soon as possible. The Duet-118 states the above option for the physician to document on the back of the form

Unless it is otherwise necessary, behavior support strategies should not be changed within the same 2 to 3 weeks that psychotropic medication is introduced or changed. When two changes happen at the same time, it is not possible to separate and assess the effects of each variable that has been altered

Due to many real and potential physical and behavioral side effects of psychotropic medications, only the lowest effective dosages of these drugs should be used. Medication risks may include potentially irreversible changes and are affected by the age and physical condition of the person. Medication risks are lessened with medical monitoring for early detection of side effects and related medical problem

When psychotropic medications are a restriction, there must be a plan criterion that when met, cues the team to consider the possibility of a medication reduction. If the team agrees, a discussion of a safe and gradual reduction in psychotropic medications should be held with the physician. When gradually decreasing medications, it is best to keep the Safety Plan's behavior support strategies procedures constant. Doing so allows us to fully assess the effects of the previous reduction. Unless the physician indicates a medical need to rapidly reduce levels of medications, subsequent reductions should also be gradual.

Whether the psychotropic medication is prescribed for a diagnosed psychiatric condition or disorder or prescribed for the purpose of modifying behaviors, the medication is

- Only given as prescribed by a physician or healthcare professional licensed to prescribe medication. PRN (as needed) psychotropic medications are prohibited
- Reviewed by the ISP team to determine if the benefits outweigh the risks and potential side effects
- Supported by evidence that positive support strategies have been tried and shown to be ineffective
- Reviewed annually by the HLRC and semi-annually by the ISP team to ensure the individual has a person-centered Plan demonstrated by meaningful data
- Not used to deal with staffing issues, ineffective, inappropriate, or other nonfunctional programs or environments
- A Safety Plan is established to address symptoms or related behaviors and if applicable

a related Behavior Support Program.

- The Safety Plan is monitored and documented on an ongoing basis to provide the ISP team and physician enough information regarding:
    - Observed side effects experienced from the medication.
    - Frequency and severity of symptoms/related behaviors (as applicable) and
- When prescribed only for the purpose of modifying behaviors (no diagnosed psychiatric condition), a plan to reduce or eliminate the medication is in place.
- When prescribed for a psychiatric condition or disorder if symptoms or behaviors are not present or occur infrequently, the ISP team may agree that the medication is not a restriction. The team may also agree that a Safety Plan is needed, without a related Behavior Support Program.

Psychotropic medication prescribed for severe and persistent mental illness. Progressive reductions in medication with the possible elimination of such medication is a desirable objective. However, such goals are often not realistic when psychotropic medication is prescribed for a serious mental illness. Such a goal should be re-evaluated for a person that repeatedly presents extreme or dangerous behavior problems and significant mental health difficulties when medications are lowered beyond a defined dosage. In the quest for effective control of symptoms, use of the least number of psychotropic medications and the use of medications with fewer risks of serious side effects is desirable.

Psychotropic medication prescribed for behavior control. Medication reductions with a goal of eventual elimination of the medication is desirable and necessary. As improvements in the rates or severity of problem behaviors occur, the ISP team should agree that a possible medication reduction, however, modest, be considered. This information is communicated with the prescribing physician by Agency staff, and should be documented on the Duet-118, along with a summary of the individual's behavior progress.

Safety Plan and related Behavior Support Program are not required when an individual is prescribed a medication that has the effect of behavior modification yet is used for other medical reasons.

Psychotropic medication prescribed on a PRN (as needed) basis in not allowed.

Requirements Before Using Psychotropic Medications and Psychotropic Medications for Behavior Control

Proposals for initial use must first be approved by

1. The individual or if applicable, his/her legal representative. Informed consent is needed for all psychotropic medications. Informed consent is documented by interim approval or a signature on Informed Consent for Psychotropic Medication, Duet-16. Reported potential side effects of the drugs will be provided to the person who can legally consent.

2. The ISP team
3. The Human and Legal Rights Committee. Committee approval of the medications is documented on the Psychotropic Medication Review Summary (Duet-52).

The physician must provide a diagnosis and purpose/condition for the medication.

The ISP team must decide upon behavioral symptoms (specific behaviors) to be affected. (When psychotropic medication is prescribed only to control behaviors, the specific target behaviors recorded must correspond to the physician's purpose/condition, such as aggression or self-injury)

Staff must keep data on specific symptoms or related behaviors and summarize these findings to the physician on the Physician's Orders for Psychotropic Medications (Duet-118). Describe target symptoms or related behaviors in the "staff observations/concerns" portion of the Physician's Orders for Psychotropic Medication (Duet-118). Include a statement of overall progress (whether symptoms or related behaviors have been increasing, decreasing, or occurring at the about same rate) since the last visit to the prescribing physician. The statement of progress shall be consistent with data and/or graphs of symptoms or related behaviors furnished to the physician. It is also the duty of the attending staff to, when possible, read the Physician's Orders for Psychotropic Medication (Duet-118) to ensure that the physician has fully completed (made an entry in) each section of the form to include

1. Diagnosis/Purpose /Condition (Rationale) for the medication
2. Medication orders (which includes the name of each medication, dosage, frequency, purpose, etc.) an
3. Recommendations if further medical evaluation/testing is recommended. This may include bloodwork for medication levels or other testing related to potential side effects of or reactions to the medication
4. Approximate timeline for follow-up appointment.

Ideally, all changes in types of medication would first be reviewed and approved by the ISP team and the HLRC. However, the prescribing physician may elect to make-medication adjustments. In this case, the ISP team should review the changes as soon as reasonably possible and submit the relevant information to the HLRC for review at the next scheduled meeting.

If the ISP team believes that the physician is prescribing medication that is not in the best interest of the person, team representatives should attempt to express concerns to the physician and obtain additional information. If the ISP team determines that there continues to be a disagreement with the physician, a decision to seek a second opinion from another physician should be considered. ISP team actions to resolve disagreements should occur as soon as possible since, in the interim, a physician's written orders need to be followed

Persons receiving only day services. People who receive Duet vocational/day services and who are not receiving Duet residential services may be placed on psychotropic medication for symptoms of a psychiatric condition or disorder or for behavior control at the request of a parent, family member or other residential provider. This may occur at times without regard to ISP team discussion and HLRC review and approval. In these circumstances the team will discuss and determined if a Safety Plan or a related Behavior Support Program is needed.

PROCEDURES FOR EMERGENCY SAFETY SITUATIONS: INTERVENTIONS FOR IMMINENT DANGER

Procedure Effective Date: 3/19 Supersedes Procedure Number: 714 (4/12)

An Emergency Safety Situation is present when there is an imminent danger that a person will (1) seriously injure self, (2) seriously injure others, or (3) destroy property with the potential for serious injury to self or others. In such cases, an Emergency Safety Intervention such as Holding, Interim or Team Control or Separation may be needed. In these situations, staff must quickly assess the situation and weigh potential risks to self or others. When weighing the risks of physically intervening against the risks of not doing so, staff should carefully consider the individual, their current behavior and how (s)he may respond, and apparent risks. Emergency Safety Intervention procedures are to be used as a last resort. Behavioral interventions should be reasonable and proportionate to the level of risk a person's behavior presents. "Restraint" or Separation procedures are performed in response to the potential of serious injury until danger is diminished. Our Agency uses verbal and physical interventions consistent with those of Crisis Prevention Institute (CPI).

More often, staff will find themselves in less serious emergencies that will require intervention, with or without the benefit of a Safety Plan or defined intervention strategies. In such cases, a progression of interventions from verbal intervention to disengagement or a brief physical redirection shall be followed in accordance with what can be reasonably assumed to be the least restrictive procedure.

Safety interventions may include prompting or assisting others to move away from the acting-out person. Other methods include setting limits, distraction, introducing or reducing environmental stimuli, disengagement skills such as deflecting and moving to minimize attempts to strike at others or using leverage and momentum to escape a grab that has the potential for serious injury. Techniques may also include encouraging the person acting out to move to another area where there is less danger.

When persons present safety risks, safety techniques and disengagement strategies may need to be individualized for each setting. Verbal intervention, safety strategies and disengagement skills as applicable, are included in a Safety Plan; not within a related Behavior Support Program.

Momentary physical redirection, physical prompts or cues up to 10 seconds in duration, CPI approved disengagement strategies such as hair, clothing, bite or other grab releases, deflecting or blocking kicks or strikes and pass through maneuvers are not considered a restriction of rights or restraint. Likewise, for example, offering choices to cue an individual to relocate with a staff to another area is not considered separation and is not a rights restriction. The ISP team has some discretion to decide and document their rationale as to whether a strategy is a (non-restrictive) support or restrictive procedure.

When severe behaviors are directed at others or are directed at property and there is immediate danger of serious physical harm, Separation procedures, holds, Interim/Team Control or other actions may be necessary to protect the individual or others from harm. Staff must use non-violent physical interventions consistent with CPI. Prone or supine "floor" restraint is prohibited. Care must be taken to protect the person's airway by not applying force to the diaphragm or abdomen. Aversive procedures such as inducing pain or discomfort, or hyperextension of joints must never be used.

The goal of any necessary physical "hands on" intervention is to protect people from harm. As

such, it is not always necessary to continue to physically intervene until the person is “calm”. Because people respond differently, intervention procedures should be individualized based upon knowledge of the person, their history and what is deemed to be the least restrictive or intrusive procedures needed to ensure safety.

If there is an imminent serious risk of injury to self or others and staff are unable to safely intervene, it may be necessary to contact law enforcement (911). In less serious emergency safety situations when staff are unable to apply acceptable procedures to reasonably keep all individuals safe, contact the supervisor on call or the chain of command for back-up support. Staff involved must notify the supervisor as soon as it is safe to do so following use of emergency safety intervention. Factual and accurate information must be provided and included in the Therap General Event Report (GER) on the use of Restraint. Describe the type of hold such as Interim or Team Control, or “hands on” Transport as used in Separation and the approximate duration used.

When an Emergency Safety Intervention (Holding, Interim or Team Control or Separation,) is used, the ISP team will review such instances. The team should reevaluate behavior support strategies and interventions in the Safety Plan for possible changes. If a Safety Plan is not in place, the ISP team shall decide whether a Safety Plan with or without a related Behavior Support Program will be developed. The HLRC reviews whether each use of an emergency safety intervention appeared to be necessary, and if implementation was consistent with instruction of CPI intervention strategies. The committee also evaluates if the person’s Safety Plan procedures appeared to have been followed.

PROCEDURES FOR INFORMED CONSENT AND RIGHT TO WITHDRAW CONSENT

Procedure Effective Date: 3/19
Supersedes Procedure Number: 715 (10/11)

Safety Plans, related Behavior Support Programs for maladaptive and problem behaviors, restrictions, and psychotropic medication shall not be started unless the individual or if applicable, his/her legal representative has given voluntary, informed consent. Such consent is documented in the ISP and on Duet forms. Consent must be obtained from an individual who has reached the age of majority (age 19) or their legal representative.

There are three basic dimensions of legally valid consent, all of which must exist before an effective consent can be given. These three dimensions are

- the consenting party's capacity to consent
- enough information is communicated on the consenting party's level of understanding and
- freedom from coercion or voluntariness as a condition under which consent is given.

A brief definition of each of these three elements is given below.

Capacity refers to the person's present ability to understand the information communicated to him/her and to process it well enough to come to an informed decision. The ISP team must determine whether the individual has the present capacity to consent to a Safety Plan and/or Behavior Support Program. The following three questions might be asked in order to make this determination

A. Can this person select and express his or her choices
B. Does the person presently possess the ability to understand what is told him/her
C. Does the person have the present ability to evaluate information and use it to make rational decisions

Communication of information depends a great deal on the extent of capacity. Enough information about the proposed plan must be disclosed to him/her, in a manner that he/she can understand and evaluate, so that his/her consent, if given, will truly be an informed one. The kinds of information to be given includes the following

A. A thorough explanation of the proposed procedure
B. A description of the risks or discomforts involved in the proposed procedure
C. A description of the risks or discomforts likely to result if the person does <u>not</u> comply with the proposed procedure
D. A disclosure of the expected benefits of the procedure
E. An explanation of the proposed alternatives to the procedure
F. Instruction to the person that he/she may withdraw consent at any time
G. An offer to answer any questions the person has or may have later

All the above must be given in language the person can and does understand

Voluntariness refers to whether a person gives consent without undue duress. It is necessary that the individual be presented the choice in as objective a manner as possible. It is preferable for an advocate or other neutral person to be present when informed consent is explained to the individual. Consent must be scrutinized more closely when intrusiveness or irreversibility are present to a significant degree. Restrictions and safety techniques written into Safety Plans utilized by this agency usually entail little risk, and changes that occur should be reversible

Psychotropic medications present risks. Medications have physical and behavioral side effects. Some side effects may be short-term or present when only when taking the medication. Others may be lifelong. Therefore, the lowest effective dose of these drugs should always be used. Medication risks may also include potentially irreversible changes and are affected by the age and physical condition of the person. Medication risks can increase unless the person is medically monitored for early detection of potentially serious side effects and related medical problems.

Psychotropic medications, restrictions and some disengagement or safety interventions may represent an intrusion on the physical body or on the thoughts and actions of an individual. If a strategy, a behavioral intervention or a medication is determined to be a rights restriction, consent should be scrutinized to ascertain whether capacity, information and voluntariness exists in sufficient degree. The following is a list of options (arranged from least restrictive to most restrictive) from which the ISP team should choose. If the team determines that person may not be able to give informed consent, then the following options should be considered

- Decide not to implement an intrusive or restrictive procedure, if feasible.
- Develop a Safety Plan with additional (non-restrictive) prevention, support and intervention strategies to make it more likely to elicit the person’s consent. For example, include additional strategies, such as incentives to increase the likelihood the person will consent.
- Develop and implement a Behavior Support Program with positive support strategies to teach skills that would, once mastered, reduce or eliminate the health or safety risk.
- The individual may have the capacity and the information necessary yet refuses to consent. If the individual's behavior is dangerous to self or others, the team shall determine if (s)he needs a legal representative who can give a valid informed consent to the proposed safety procedures and safety restrictions.
- If the team determines that behavior is dangerous to self or others and that the person served is mentally ill, present the person's case to the county Mental Health Board for possible declaration that the individual is mentally ill and dangerous to self or others. If this finding is made, ask the Mental Health Board to place the individual either in a treatment plan the ISP team deems appropriate or in a mental health facility.
- Some individuals have enough capacity and information to give or withhold consent and choose not to give it or may choose to withdraw it. If the individual or if applicable his/her legal representative does not give consent, and the behavior is dangerous or significantly disruptive to the individual's plan and the provision of effective services, our Agency’s chain-of-command may decide to give notice to terminate services

PROHIBITED PRACTICES

Procedure Effective Date: 3/19
Supersedes Procedure Number: 716 (10/11)

The following practices may not be used as discipline or as part of a written plan

Verbal abuse: screaming, swearing, derogatory name calling (including calling a person by a name that is either not preferred or desired), mimicking, cruel teasing, telling lies, taunting or any other verbal activity which is demeaning to the individual or could reasonably be expected to damage self-respect

Corporal punishment: spanking~~,~~ slapping, hitting, or in any other way applying a painful stimulus to the body as punishment or consequently for behavior (such as forcefully wiping a person's mouth or hands)

Seclusion: placing an individual in a room with closed doors that (s)he cannot open, not under observation nor in response to an emergency safety situation, and not as part of a systematic separation Safety Plan that meets all the requirements set forth in these procedures. Seclusion also includes locking or tying a bedroom door closed at night to prevent wandering

Denial of a nutritionally adequate diet

Dangerous, aversive~~-~~or cruel practices: feeding in a supine position, giving dangerous substance by mouth (including such things as soap, vinegar or Tabasco sauce), delaying normal access to meals for more than one hour; forcing the individual to receive a cold bath or shower and other practices which could reasonably be considered to be dangerous, aversive or cruel

All forms of abuse: (emotional, physical or sexual), neglect, exploitation or harassment

Aversive stimuli or aversive conditioning practices. An individual’s dislikes and fears are unique and must be considered and respected. Aversive stimuli may include spraying a person with water, tickling, or intentionally startling someone sensitive to noise or touch

Denial of basic rights (reference 510 Rights of Persons Receiving Services). Rights may never be denied unless due process has been provided to the individual

Medication shall not be used as punishment, for the convenience of staff, as a substitute for a Plan or in quantities that interfere with a person's ability to participate in their daily life

Physical interventions that entail excessive risk of pain or injury to the individual. This includes hyperextension of joints, prone or supine floor restraint which compromises the person’s airway and other procedures that unnecessarily place the individual or others in danger

Persons receiving service shall not intervene to discipline other persons receiving services in any above manner

Employees who use or allow use of such procedures are subject to disciplinary action up to, and including, termination of employment and potential legal action.

PROCEDURES FOR COMMITTEE REVIEW: THE HLRC

Procedure Effective Date: 3/19
Supersedes Procedure Number: 717
(4/12)

Composition and Appointment to the Committee.

The Duet Director or designee shall appoint membership. The committee members must be free from conflict of interest and who will ensure the confidentiality of information related to the individuals served. The person responsible for approving the person's program and any staff who provides direct services to the person cannot participate as a decision maker. At least half of the committee members must be individual's family or other interested persons who are not provider staff.

Review.

The committee reviews the following:

- Behavior Support Plans associated with maladaptive behavior occurring at least on a monthly basis, or if teams decide a BSP is needed because other behaviors significantly interfere with community participation.
- Restrictions, when in Safety Plans, or other restrictive procedures not written into a Safety Plan.
- Revisions that add or otherwise alter restrictive procedures or the addition of new behaviors targeted for restrictive interventions in Safety Plans that are topographically different.
- Emergency safety situation interventions (the use of "restraint" as Interim/Team Control or Separation procedures) at least every six months
- Psychotropic medication to control symptoms of a mental illness, at least every 6 months.
- Psychotropic medication prescribed for the express purpose of behavior control. This is reviewed every 6 months.
- All new psychotropic medications and increases.
- Accessibility plans for individuals affected by restrictions designed for others.
- All investigations related to possible abuse or neglect
- All High level General Event Reports (GER)

All persons taking psychotropic medication and receiving Duet residential services must be reviewed through the HLRC. Persons living with another DD provider and attend Duet day services must also have their psychotropic medication reviewed.

Persons that receive a Duet service yet do not live with a residential DD provider (such as living at home or with relatives) must have their psychotropic medications reviewed by Duet's HLRC if the language of the ISP states these medications are a rights restriction. When the ISP agrees and the ISP documentation states that psychotropic medications are a support and not a restriction, psychotropic medications must be reviewed by the committee.

Interim Review and Approval

Proposals to use Restrictive Procedures (with or without a Safety Plan), newly prescribed psychotropic medication or increases for persons served.

- Staff will contact a Duet Behavior Consultant to request interim approval from a HLRC Committee member. The consultant will contact an outside member of the Committee (not a Duet employee) to request approval.
- The committee representative may approve, request additional information, or not approve.
- Once approval is given for the medication or restrictive procedure to begin, this information is documented and communicated to the individual's staff~~,~~ supervisor or chain of command.

Annual and Subsequent Review

HLRC members will receive notification of changes in type of drug or medication increases for each person's psychotropic drug regimen, allowing for potential responses.

- Changes in the <u>type</u> of such medications as recorded on the Physician's Order for Psychotropic Medication (Duet-118) shall be reviewed at a subsequent meeting. A new Duet-52 and Duet-16 must be completed for newly prescribed behavior medications. Changes to or from a trade name medication (such as Zoloft) to or from the equivalent generic medication (sertraline) of the same dosage need not be reviewed.
- Increases in the <u>quantity</u> of approved medications will be reported. Review and approval status will be reflected in the committee minutes. (In this case, a new Duet-52 does <u>not</u> need to be completed.)
- Addition of new restrictive procedures or a change of the type of restrictive method used, or major phase changes in the written Safety Plan requires committee review. New behavioral Safety Plans also require committee review. Minor nonrestrictive adjustments in the person's plan need not be reviewed.
- The HLRC may request more frequent reviews or additional documentation on a case-by-case basis.

Committee Functions.

Major functions of the committee include, but are not necessarily limited to, the following:

- Review Request and Informed Consent for Restrictive Procedure (Duet-55) and Informed Consent for Psychotropic Medication (Duet-16).
- Check to ensure that rights are not violated, due process is followed, and rationales for use of restrictions and psychotropic medication are person-centered.
- Review Physician's Order for Psychotropic Medication (Duet-118).
- Evaluate data trends as presented, when applicable.
- When the ISP team proposes the use of restrictive methods, check to ensure that less restrictive methods have been tried and were unsuccessful. When evaluating psychotropic medication, check to ensure that Behavior Support Strategies without concurrent usage of psychotropic medication have been tried and demonstrated to be ineffective.

- Review all GER incidences of Emergency Safety Interventions (use of restraint) approximately every six months to determine if Safety Plan behavior support strategies and procedures were followed, whether the use of a restraint or separation appeared to be justified. The committee will also review a comparative analysis of 6-month data trends on the use of Emergency Safety Interventions.
- Review of accessibility plans (Duet-56) for persons affected by a restriction designed for another individual.

Documentation of Review.

A. Interim Approval. After contacting an external Committee member, the Duet Behavior Consultant documents the status of interim approval on the Interim Approval Log.

B. Evidence of Review and Approval of Restrictive Procedures in Safety Plans or other restrictions is documented on the Duet-55.

C. Evidence of Review and Approval of the use of "Restrictive Devices" when the ISP team deems such devices to be listed as a rights restriction in the ISP or addendum. Examples of potential restrictive devices include safety belts and straps, standers or bedrails. If considered a restriction, review the current (within the last 12 months) Physician's Order (Duet-107) indicating use of such devices is affirmed by a physician or healthcare professional. Evidence of review of restrictive devices shall appear in the committee minutes. Due the dependent nature of restrictive devices to ensure one's physical safety, a plan to reduce or eliminate the use a restrictive device is rarely needed.

D. Evidence of Review and Approval of Psychotropic Medication:

   - New medications are documented on the Duet-52.
   - A new Duet-52 is initiated corresponding with the Annual ISP.
   - Increases in medication are noted in HLRC Meeting Minutes.

HLRC Meeting Minutes and Communication of Information.

- Committee meeting minutes and summaries of administrative follow up actions related to issues of interim or conditional approval shall be provided to the Duet Director and Area Directors - as appropriate.
- The committee shall approve, conditionally approve, or not approve, Restrictive Devices, Psychotropic Medications, restrictions and accessibility plans. If the committee concludes that follow-up is needed (conditionally approve or not approve), these problems will be documented in the minutes.
- The Area Director or designated appointee provides a written response to the Duet Director explaining specific actions taken to correct the problems. Copies of follow-up from the area shall be forwarded to the Committee. The HLRC may recommend further action or review upon subsequent examination of the Area Director's response.

QUALITY ASSURANCE PLAN

Procedure Effective: 8/19
Supersedes Procedure Number: 810 (11/14)

Purpose

The Duet Quality Assurance (QA) Program is designed to evaluate and monitor the services provided to persons receiving services and to promote quality supports within available resources. Inherent within the services and supports offered by Duet, individuals receive quality services as demonstrated by:

- Remaining free from abuse, neglect, mistreatment and exploitation
- Maintaining their health, safety and well-being
- Treating individuals with consideration, respect and dignity
- Honoring preferences, interests and goals
- Providing daily opportunities to make choices and participate in decision making
- Providing activities that are meaningful and functional
- Maximizing the growth and development of everyone for maximum community participation and citizenship
- Living in a manner that is most inclusive
- Experiencing being part of the community; and
- Expressing their wishes, desires and needs.

The following are the goals of the QA Program:

1. Identify problems that adversely affect ongoing delivery of services as well as outcomes from the delivery of services.
2. Initiate a problem-solving process for correction of identified problems and improvement of services.
3. Monitor the implementation of corrective actions.
4. Establish safeguards for nonoccurrence of already identified problems that affect quality services.
5. Reassess the effectiveness of the QA Program on an annual basis.
6. Ensure compliance with recognized state and federal standards.

Authority and Organization

Each Area Management Team will be responsible for implementation of the Duet Quality Assurance Program. The Management Team will work with the Quality Assurance Team to manage the QA activities.

The Team is responsible to coordinate, schedule, and document activities to bring services in Duet in compliance with recognized standards and Duet policies and procedures. Each Area is responsible to maintain specific QA documentation conducted by staff to ensure quality of supports. Area staff will submit to the QA Team a summary of activities conducted. The QA Team will submit a report of QA activities to the Director for Administrative review and action. A summary of QA activities will be submitted to the Governing Board for review.

Methods/Activities

A program review process will be used to assess supports provided and will be conducted as follows:

Area staff conduct ongoing program reviews.

1. Each Area will, on a quarterly basis, monitor and provide a review of the monitoring activities of services and settings to the QA Team. Each Area will maintain documentation of monitoring activities.
2. The Area Management Team is responsible for reviewing the information and ensuring a plan of improvement is implemented.
3. The QA Team will review the information quarterly and provide to the Director a written report of concerns that affect services.
4. The Area Director will review the written report for systems and individual issues that may affect services and provide management action.
5. The Governing Board is provided quarterly information regarding QA activities and reports.

The Quality Assurance Team will:

1. Conduct an independent review of residential and day settings, habilitation services, behavioral and medical supports in each Area. A copy of the findings will be provided to the staff. A document will then be submitted on how the concerns will be resolved.
2. Conduct follow-up and on-site surveys to ensure the plan of improvement activities are implemented in response to State and Federal licensing and standards.
3. Conduct administrative audits to ensure the implementation of Duet policies and procedures and State regulations.
4. Conduct an independent outcome evaluation of service provided in each Area.
5. Provide reports to Director regarding results for action to correct problems that may affect services.
6. Maintain documentation of Central Office QA activities.
7. Maintain documentation and communication regarding all plans of improvement, remediations of final ruling, and citations received from the State.
8. Ensure compliance of all GERs with current State requirements.
9. Ensure renewal of State certifications.
10. Assign and monitor investigations, their outcomes, and any follow-up as needed.

Evaluation

At least annually, the QA Team will evaluate the QA Plan. Each activity of the plan will be reviewed. Results of the evaluation, with recommendations, will be forwarded to the Duet Director for management action.

PROCEDURES FOR QUALITY ASSURANCE

Policy Effective: 8/19
supersedes Procedure Number: 811 (6/14) (7/14)

Purpose

The State regulations specify that each provider shall deliver quality services. Documentation of such quality must be achieved through a system of quality assurance that monitors the delivery of service.

These procedures provide the guidelines for the implementation of the Duet Quality Assurance Plan. The bottom line in quality assurance is the benefit that occurs to individuals as a result of quality services. Quality Assurance is a process for making informed judgment about how actual performance meets the preferred standard of performance.

Quality Indicators

The Duet Policy and Procedures Manual specifies what is the preferred performance for agency operations. The Quality Assurance system is to provide documentation that the performance standards outlined in policy and procedures are occurring. Documentation of quality services will be provided by completing a series of monitoring activities to identify and correct programmatic and administrative problems.

Monitoring activities may include setting checks, record reviews, quarterly reports, investigations and any audits.

Time Frame for Completion of Monitoring and By Whom

Each residential setting will be reviewed quarterly. For each item found to be a concern, a follow-up check will be conducted until the item is corrected.

Each Shared Living Provider setting will be reviewed quarterly. For each item found to be a concern, a follow-up check will be conducted until the item is corrected.
Day Service Setting reviews

Each day setting will be reviewed quarterly. For each item found to be a concern, a follow-up check will be conducted until the item is corrected.

Record Reviews

An Annual Record Review for everyone will be completed within 60 days of the new ISP year.

Status Reports

A status report is completed to document any identified problems found during a review of a setting or record. A plan of action will document how the problem was corrected.

Employee Training Record Reviews

QA Team reviews staff training records annually.

Duet Survey

The QA Team will make a satisfaction survey available to people supported and their families. The survey information is reviewed and reported to the Executive Director.

Organization and Reporting

Each Area maintains specific quality assurance documentation conducted by staff using the appropriate quality assurance checklists or other agency records to ensure services are being provided at the preferred standard of performance.

Quality Assurance documentation shall be stored at the Area/Division office. The Area/Division Director or designee reports quarterly quality assurance activities to QA Coordinator. QA Coordinator submits a report to the Director of quality assurance activities for administrative review and action.

For requests for Quality Assurance documentation, only pertinent information related to the person served, will be made available to the staff, the individual, the families, legal representative, advocate, and quality review teams. The request must be submitted to the Director.

The Governing Board will be provided information on a quarterly basis to ensure quality services are provided.

THERAP GENERAL EVENT REPORT POLICY

Policy Effective Date: 12/19 Supersedes Policy Number: 820 (8/19)

It is the policy of Duet to report and document incidents and events that occur in accordance with State regulations and guidelines. Reports will contain the essential facts of the incident/event and will seek to identify, when applicable, any actions which might have prevented the incident/event as well as the immediate efforts to address the situation and prevent recurrence. Reports will be compiled, reviewed and analyzed quarterly to identify trends and problematic practices which may be occurring in order to take appropriate corrective action as needed.

The State of Nebraska requires that certain specified events be reported on Therap. Timelines established by DHHS for reporting events and submitting/approving events will be followed.

Along with documentation on Therap, staff will notify all applicable parties.

Approved by Duet Director

Duet Director

August 12, 2020

Date

Approved by ENHSA Governing Board

ENHSA Governing Board Chair

August 12, 2020

Date

PROCEDURES FOR GENERAL EVENT REPORTING

Procedure Effective Date: 12/19
Supersedes Procedure Number: 821
(8/19)

The State of Nebraska requires that certain specified events be reported on Therap in the General Event Report (GER) module.

The Division of Developmental Disabilities (DHHS-DD) defines reportable incidents as situations that adversely affect the physical or emotional well-being of a participant, suspected cases of abuse, neglect, exploitation, or mistreatment, and emergency safety situations which require use of emergency safety intervention.

The following incidents are reportable and should be reported at a high notification:

1. Allegation or suspicion of abuse, neglect, or exploitation of a child or a vulnerable adult.
2. Injuries which require medical attention by a physician.
3. Acute, episodic illness or change in medical condition requiring medical attention by a physician.
4. Injuries to participants resulting from a fall.
5. Injuries to participants resulting from any use of restraint.
6. Injuries of unknown origin which raise suspicion of abuse or neglect.
7. Injuries or displacement of participant as a result of fire, flood, or other similar emergency or natural disaster.
8. Medication error resulting in injury, serious illness, or hospitalization.
9. Use of emergency safety intervention or PRN psychotropic medication.
10. Use of prohibited practices for any reason.
11. Behavioral episodes resulting in use of emergency safety intervention or PRN psychotropic medication use, injury or potential for injury of the participant or others, or damage to property of total value of $150 or greater.
12. A participant leaving provider supervision where the safety of the participant or others is potentially threatened, or a participant being identified as a missing person.
13. Use of an emergency room or an urgent care facility for treatment.
14. Possible criminal activity or law enforcement contact by a participant or by a staff person suspected of criminal activity towards a participant.
15. Seizure that lasts over five minutes or over the timeframe set by the participant's physician, or which requires treatment at an urgent care center, emergency room, or hospital.
16. Incidents of choking or airway obstruction.
17. Death of a participant.
18. Hospitalization of a participant.

All other incidents are reported at a low notification including financial incidents outside of suspected exploitation.

The document titled *Incident Reporting: Completing General Event Reports (GERs) in Therap* will be used for further instructions on how to complete GERs. This document is electronically available via the DHHS and Duet websites.

NOTIFICATION

For any high notification event documented in Therap, immediate notification to the following:

- Supervisor
- Administrator
- Service Coordinator
- Family/Legal Representative
- Law Enforcement and/or CPS/APS - allegation of abuse/neglect, death, an allegation of financial exploitation, leaving staff supervision (if applicable)
- Behavior Consultant - use of emergency safety intervention
- Duet Nurse - injury that requires medical attention.

REPORT OF EVENT

Staff will provide a detailed description of what happened prior to the event and what transpired during the event. Times, severity and notification are important aspects of the report. If there is an injury, staff should provide a complete description of the affected area including size, color, location of where the injury occurred, body parts affected, severity of the injury and whether they received medical treatment. If there were witnesses to the event, they should be identified in the report.

FOLLOW UP

Corrective Actions Taken (immediate interventions that took place) are required for GER submission.

Plan of Future Corrective Actions (what will be done to prevent recurrence) are required for GER submission.

Following approval of the GER a 14 day follow up on status of incident is required.

REPORTING REQUIREMENTS

The GER is submitted within 24 hours of becoming aware of event. The Therap report must be approved by management designee within 48 hours of submitting the report on Therap.

MONITORING

All High notification events reported on Therap are reviewed by the HLRC and are retained with the Duet Executive Assistant.