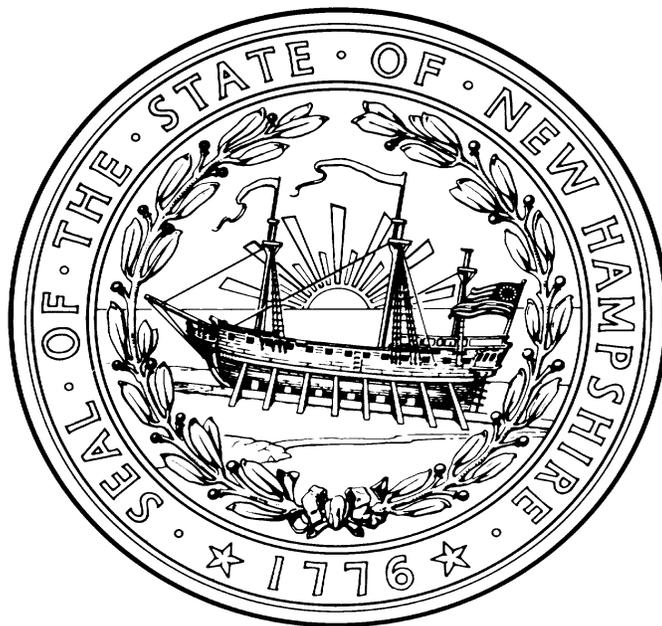


**Department of Health and Human Services
Bureau of Developmental Services
February 6, 2012**



**Preliminary Response to
DRC White Paper Report
of November 29, 2011**

Supporting Individuals with Developmental Disabilities and Acquired Brain Disorders in the Community

I. Executive Summary

New Hampshire's Bureau of Developmental Services (BDS), within the Department of Health and Human Services (DHHS), provides supports to New Hampshire citizens with developmental disabilities or acquired brain disorders to help them live, work, and be contributing members of their communities. These services are provided through a partnership with ten designated non-profit Area Agencies and their subcontractors, the individuals and their families. Through this partnership, the individuals and families are provided with as much freedom, choice, control, and responsibility over the supports they receive as they desire.

This paper provides an initial response to the issues raised in the White Paper Examining Preventable Deaths in the Developmental Services System, A Call to Action – Keeping Vulnerable Citizens Safe from Harm recently issued by the Disabilities Right Center (DRC). The DRC's White Paper seeks to identify areas within the service system that are in need of improvement. In its paper, the DRC takes the position that the DHHS and BDS failed to improve the service system, despite six tragic deaths over the last ten years and prior studies and reports calling to attention the need for such improvements. To assert that the service system is not responsive to the needs of the community it serves demonstrates a failure to recognize the many improvements to the system and the importance of the system's collaborative approach to determining how best to serve individuals with disabilities and their families.

The service system is continuously evolving to better provide services to individuals with disabilities and their families. As the contents of this paper demonstrate, the service system has undergone extensive modifications in the last ten years. Contrary to the notion that the service

system is stagnant, the Area Agencies, subcontracted service providers, BDS, and DHHS continuously collaborate to enhance the service system for individuals with disabilities and their families. This paper identifies in detail the numerous ways that the service system improved, including taking such steps as implementing new programs and tools to assist in assessing needs, providing new and relevant training on health and safety needs, and fundamentally changing the complaint investigation system to improve quality assurance responses. A full description of each of the improvements implemented by the Service System is found in Section III of this paper.

While significant improvements are already implemented, BDS and the service system continually seek ways to enhance its services and are open to further opportunities for improvement. BDS provides this initial response to give a broader context for evaluating the DRC's recommendations for the service system. The development and assessment of plans to improve the system do not lie solely with BDS and DHHS, but must include the involvement of all stakeholders in the system. The New Hampshire Legislature created the Developmental Services Quality Council¹ as the vehicle for this specific purpose. The Quality Council is the appropriate and effective forum for evaluating the concerns raised by the DRC, as well as all other stakeholders. It is also the forum best suited for developing and prioritizing recommendations and plans for improving the service system. BDS will take the lead in collaborating with the Area Agencies, service providers, individuals, and their families to best determine the areas in need of improvement through its work with the Quality Council. BDS

¹ In 2009, the NH Legislature enacted RSA 171-A:33, I creating the Developmental Services Quality Council to provide leadership for consistent, systemic review and improvement of the developmental disability and acquired brain disorder services. The membership of the Quality Council includes representation from all the stakeholders, such as individuals with disabilities, parents/family members, direct support professionals, and representatives from the Area Agency Boards, subcontract agencies, and advocacy organizations, such as the DRC.

values the opportunity to review and improve the quality of its services and will continue to collaborate with the Quality Council to provide consistent, systemic review and improvement of the system.

II. Introduction

For the last three decades, a critical element of BDS' mission has been to provide supports for an individual's safety when he/she is receiving services in the community. To that end, the State's community-based service system instituted a number of regulations and utilized various strategies, processes, and measures to improve its capacity and activities related to safety. Many of these systemic attempts have been shaped by the lessons learned in supporting New Hampshire's citizens with disabilities in diverse community settings and service arrangements.

As demonstrated by the history of the State's service system, supporting individuals with developmental disabilities and acquired brain disorders in community settings is an important but complex undertaking. In 1981, as a part of its response to the court order issued through the Garrity vs. Gallen lawsuit, the State of New Hampshire initiated a regional service system for its citizens with developmental disabilities. At the time, hardly any services were available to support individuals in their own homes and communities. In the absence of community-based service options, many individuals with developmental disabilities lived at the State School in Laconia. Unfortunately, as the findings of Garrity vs. Gallen demonstrated, the supports provided at the institution were painfully inadequate in meeting the needs of the individuals.

In developing community-based service options, the Area Agencies and BDS faced a number of significant challenges, such as acquiring the expertise needed to support people with complex needs in community settings, limited funding, and sometimes local resistance to

establishing community residences in neighborhoods. One of the critical challenges the new regional system faced was general concerns regarding individuals' safety. At that time, the conventional belief was that individuals with developmental disabilities could not be supported safely in regular community settings. This general conviction was also reflected in the State's licensure practices and regulations. The initial Area Agency attempts to support people with significant disabilities in community settings were deemed to be risky and resulted in denials of certification or licensure applications. As a result, in addition to furnishing appropriate supports and installing a variety of safety measures in homes, the Area Agencies were required to secure signed attestations from physicians regarding individuals being "appropriate candidates for community living." This negative orientation about serving people with disabilities in community settings not only resulted in odd documentation expectations but also led to unusual institutional-like licensure requirements for community residences, such as having to mount "Exit" signs throughout homes to "insure safety."

In spite of these complications, the Area Agency system made progress in developing community-based services. In fact, the Area Agencies and their subcontractors made such extraordinary progress that, within a decade, New Hampshire was able to close its institution and become the first state in the nation to support its citizens with developmental disabilities through exclusively community-based service options. This dramatic and historic change was followed by later systemic modifications, such as the shift from serving individuals in congregate settings to providing supports through more individualized service arrangements. This shift reflected the preferences of individuals and their families for more "normalized and customized" service options. In Addition, more recently, regulatory and organizational revisions were made to provide individuals and their families with choice and control over all aspects of their services,

including planning, recruitment of staff/providers, location of services, and, most importantly, decision-making on how the authorized funds would be used.

This openness to change is a strength of New Hampshire's regional system and reflects its fundamental orientation to consider critical "customer input" and engage in a collaborative approach in supporting individuals and their families. DHHS, BDS, Area Agencies, and subcontracted provider agencies have been and will continue to be receptive to reassessing the service system and identifying areas for improvement. The DRC's White Paper represents yet another opportunity for the service system to review what it has accomplished and what needs to be improved regarding individuals' safety.

The DRC's White Paper seeks to identify areas for DHHS, BDS, Area Agencies, and subcontracted agencies to improve the supports provided to individuals with disabilities. More specifically, the document evaluates the services provided to six individuals who suffered accidental and tragic deaths over the last ten years and makes a number of broad conclusions regarding the entire service system based on the particulars of those six cases. The DRC's independent evaluation of these deaths included additional recommendations to improve the service system. The nine specific recommendations focused primarily upon three areas of the service system: the assessment of an individual's needs, improving services to better meet those needs, and responsive quality assurance measures.

Each of the deaths reviewed in the DRC's White Paper is a tragedy. After each incident, DHHS, BDS, and the Area Agencies reviewed the individual's services and circumstances surrounding the death and identified and implemented improvements to the developmental services system. In addition, BDS, and the Area Agencies, and their subcontracted provider

agencies made a number of other improvements to the system over the same ten-year period. Below, BDS addresses the White Paper's recommendations.

III. Recommendations

A. Assessing Individual Needs

In its White Paper, the DRC recommends that the service system improve its process for: (a) assessing an individual's risk of harm to self or others; (b) effectively developing and implementing strategies to address the identified risks; (c) conducting or utilizing quality clinical assessments, including appropriate behavioral evaluations; and (d) enhancing clinical capacity to review and address complex needs.² Over the last ten years, BDS implemented several tools to assist in assessing an individual's risks and developing strategies to address the risks. Likewise, BDS initiated several steps to improve the identification of and services provided to individuals with complex needs. These steps are identified below.

Regulations

BDS has comprehensive regulations designed to support the health and safety of individuals served by the developmental services system. These regulations include such things as annual health assessments, maintenance of medical records, and development of behavioral strategies. BDS also has extensive regulations related to fire safety in community residences. These include, among other things, emergency evacuation plans, fire safety plans for those individuals needing additional assistance, and regular fire drills. The complete regulations that relate to health and safety are found in the attached Appendix A. Moreover, in the past ten years, BDS made various amendments to the regulations in an effort to better serve an individual's health and safety needs. Summaries of these amendments are found in the attached Appendix B.

² DRC's specific recommendations are found in its White Paper at pages 40-46. In this section, BDS seeks to address recommendation (a) on pages 40-41 and (h) on pages 44-45.

Assessment and Screening Tools

With regard to assessing and addressing an individual's health and medical risk, BDS is currently piloting the nationally recognized Health Risk Screening Tool (HRST) in collaboration with four Area Agencies³ and 300 individuals receiving certified day and residential services. The HRST is a web-based screening instrument developed for detecting health destabilization in vulnerable populations, with the objective of improving quality of living and preventing medical complications and untimely deaths. The results of the screening will prompt the agencies/system to create a plan and address the risk areas that are identified. The implementation of this tool will facilitate the identification of health risks and the contact with the individuals' primary health care providers to address the health risks in a systematic and coordinated way.

BDS and the Area Agencies are also taking steps to improve the identification of appropriate individualized support needs. For the last two years, the service system began using a nationally recognized assessment tool called the Supports Intensity Scale (SIS), which is designed to inform the service planning for individuals with developmental disabilities. The SIS measures the supports needed for individuals to live in a regular community setting by evaluating an individual's need for supports related to home living, community living, lifelong learning, employment, health and safety, social activities, protection and advocacy, and exceptional medical and behavioral needs. This is accomplished by a trained interviewer gathering pertinent information from the individual and those who know the person well, such as family members and professionals. Thus far, approximately 1,000 people have participated in the SIS assessment. Once it is fully implemented, an individual will receive an assessment once every

³ The Area Agencies that are participating in this pilot are: Pathways (Region 2), Lakes Region Community Services (Region 3), Gateways (Region 6), and the Moore Center (Region 7).

five years, or earlier if there is a significant change in the individual's condition necessitating an adjustment in services.

Medical and Health Needs

With regard to improving the identification of individuals with complex medical needs, BDS began requiring in 2004 the completion of the Health Information Record for every individual residing in a community residence. This form gathers and organizes an individual's medical history in one document for the health care providers and program staff and serves as a discussion point regarding the individual's health and medical needs. It is reviewed as a part of the regular residential certification inspections. An individual's form is updated as needed and reviewed at a minimum once per year as part of an individual's annual service planning.

Similarly, in 2007, BDS sought to improve the identification of individuals with complex medical needs and amended the Administrative Rule He-M 503, Eligibility and the Process of Providing Services, to include the specification of any health concerns, significant health issues, any changes in health status, and the identification of the individual's health needs in the individual's personal profile. Likewise, expectations related to Service Agreements were added to the regulation to increase and improve the focus and efforts concerning an individual's health, including health promotion and prevention measures.

In 2008, BDS began requiring the Area Agencies to regularly identify individuals considered to be in frail health, and to identify the supports needed to safely maintain each individual in the community. Local agency nurses collaborate with the BDS nurse to visit individuals in their homes to discuss their particular situation and to identify any areas of possible service improvement. The BDS nurse visits a number of individuals from this group each fiscal year.

To further support the individuals identified in frail health, BDS and one Area Agency collaborated on a pilot program, which established a position of Nurse Case Manager to oversee a caseload of individuals identified to be in frail health.⁴ The Nurse Case Manager serves as a bridge between the direct support staff and the medical practitioners to assist in coordinating the health needs of the individual. Outcomes from this collaboration included implementation of Health Care Initiative tools which assist in health screening, medical/healthcare appointment support, and response to health indicators; quarterly discussions with direct care staff regarding the use of the tools; clinical reviews of individuals on the Nurse Case Manager's caseload; and the implementation of the Service Planning Worksheet, another tool to ensure complete documentation of an individual's health supports as part of the annual Service Agreement planning process. The Area Agency also instituted a process whereby Service Coordinators began to work directly with other agency RNs regarding support planning. Based on the positive outcomes of this pilot program other Area Agencies are considering similar enhancements in their regional nursing resources but encountering funding as a significant hurdle.

Complex Needs

In conducting a comparison of contracted, high cost service arrangements for individuals with very significant medical, behavioral, and psychiatric needs, BDS discovered that more than 80% had challenges in more than one area (i.e., they had a combination of medical, behavioral, or psychiatric issues), and almost 30% had needs in all three areas, underscoring the complexity of providing services to individuals with multifaceted clinical issues. In response to this study, the Bureau thoroughly reviewed the Bureau's medication administration regulation, He-M 1201, engaged various stakeholders, and made the following changes in September 2011: (1) A new section was added to the rule dedicated to healthcare coordination requiring the use of certain

⁴ Lakes Region Community Services (Region 3) piloted this program.

health promotion tools; (2) Individual-specific training is required for anyone accompanying an individual to a health care appointment; (3) Direct support staff are required to record and report any changes in an individual's health status; (4) Quarterly reporting of an individual's health status to their service coordinator; and (5) Utilization of recommended annual health screenings based on Massachusetts Health Quality Partnership Adult Preventative Care Recommendations.

The study on high cost services also prompted the development of the START (Systematic, Therapeutic, Assessment, Respite and Treatment) Initiative, which is coordinated through the Institute on Disability at UNH. The START program is intended to establish a statewide infrastructure to expand and improve the Area Agency system's clinical capacity and resources for individuals who have significant psychiatric and behavioral needs. New Hampshire's START plan includes: (1) Training of two or more regional START Coordinators, who will act as lead clinical staff in assessment and addressing of behavioral and psychiatric needs, including development of crisis plans; (2) Establishment of three regional collaboratives, through which the Area Agencies will share clinical resources; (3) Development of respite beds within each collaborative to provide scheduled and crisis respite services; (4) Creation of a mobile crisis team to enable individuals to remain in their current placements and to avoid unnecessary admissions to New Hampshire Hospital; and (5) Development of inpatient neuropsych beds, where more in-depth evaluation of individuals' psychiatric needs can be carried out. By September 2012, all regions will have trained START Coordinators. The START program has, thus far, engaged in a number of significant clinical activities, including: completion of 69 Service Evaluations, 23 psychopharmacology consultations, 18 in-patient referrals, 58 Cross System Crisis Plans, and 52 case presentations for Community Education Teams. Moreover, the clinical resources offered through START could assist the service system

better identify and address those situations where behavioral and psychiatric problems may be masking medical issues.

The introduction of START has been an important addition to New Hampshire's regional service system. Although significant progress has been made to-date, the complete implementation of the START plan will take some time, as the system has to create opportunities to redeploy its current funds to financially support the different elements of its plan. Without the availability of new funds, the progress on this initiative is likely to happen slowly.

B. Improve Services to Meet Needs

In its White Paper, the DRC recommends that the regional system improve its services to better meet an individual's need by: (a) providing additional residential options and (b) improving the training and pay structure of the staff to better support individual needs.⁵ Over the last ten years, BDS initiated several steps to improve its ability to appropriately serve individuals in the community. These steps are identified below.

Meeting Residential Needs

When the Area Agency system was first initiated, the most frequently provided residential option was group homes where typically four to eight people resided and services were delivered by staff. Since the closing of the state institution in 1991, however, the service system aims to provide residential services in more home-like environments in natural community settings. As a result, the majority of individuals receiving residential services currently are served in Enhanced Family Care (EFC) homes. Although this model is not suitable for the needs of some people, it has been selected and approved by many individuals and their

⁵ DRC's specific recommendations are found in its White Paper at pages 40-46. In this section, BDS seeks to address recommendation (b) on page 40, (c) on pages 41-42, and (g) on page 44.

guardians.⁶ Aside from independent living options, this setting provides the most integrated/natural community residential setting with the individual living with a provider and his/her family. Moreover, the shortage of affordable housing around the state and the cost effectiveness of this service arrangement make the EFC model a valuable and frequently used option. Additional services may also be provided to complement and enhance the supports that the individual receives through the EFC home. If a person's needs cannot be supported in an EFC home, then he/she is served in a staffed residential setting where several other individuals may live and receive services.

A third community-based option is for the individual to remain in his/her family home while receiving services that are certified under the BDS rule He-M 521. With regard to this residential model, the DRC specifically recommends that BDS improve residential services by mandating certain life safety measures, such as mandatory fire drills, for the family homes. This recommendation, however, overlooks the purpose of the services in these homes.

The He-M 521 regulation is intended to apply to “services for individuals with developmental disabilities or acquired brain disorders, who reside in their families’ homes” (emphasis added). Prior to the creation of the in-home service option under He-M 521, an individual was required to move out of the family home in order to receive necessary personal care/residential services. During the 1990s, families began to call for the availability and provision of personal care/residential services within the family home, similar to the services provided by home health agencies or independent living centers. In response to such requests, BDS created in-home personal care supports as a service option and established the He-M 521 regulations. In asking for the availability of this services option, however, families also cautioned BDS and Area Agencies against establishing regulations and practices that would

⁶ All residential service arrangements require individual and guardian approval.

“turn family homes into group homes.” In particular, families expressed strong opposition to the creation of requirements regarding safety measures as a condition of receiving services within their own homes based upon the notion that families know how to care for their children’s safety. In accordance with such considerations, BDS avoided creating any safety mandates regarding services provided in individuals’ own family homes. Nevertheless, BDS regulations include some broad statements about safety to provide agencies the opportunity to initiate discussions about safety issues and share information with families to help them make informed decisions. Such general references in regulations are also intended to allow agencies to offer financial assistance to those families with modest means for the purchase and installation of safety items, such as interconnected smoke detectors/alarms.

The developmental services system provides a variety of residential options, with the primarily goal of serving individuals in integrated/natural community settings with the necessary supports, and is open to ideas and input from the various stakeholders on how to best serve individuals in their communities. Given the importance of insuring individuals’ safety, BDS plans to revisit the issue of whether specific safety-related requirements is appropriate for services provided in family homes receiving He-M 521 certified services. Accordingly, BDS will take this matter to New Hampshire’s Developmental Services Quality Council and seek its input. If the Quality Council’s deliberations make it clear that family attitudes about such safety mandates have changed, BDS will revise its regulations.

Whether an individual lives in staffed residences or EFC homes, on occasion he/she may end up changing his/her place of residence. In such cases, the transfer from one home to another may not be straightforward and may present a variety of complications, including creating risks to the individual’s health and safety. To help assess the appropriateness of and successful

transfer to a new residential setting, BDS amended Administrative Rule He-M 1001, Certification Standards for Community Residences, in 2010 to include requirements for: (1) the transfer of an individual's information when an individual moves from one agency to another, to include medical and dental history, current medication, orders, authorization to administer medication, record of medication administration over last two months, and protocols pertaining to seizures, swallowing, medications, or behavioral supports; and (2) additional visits by the service coordinator and a licensed nurse within 5 business days of an individual moving into or changing community residences to determine if the transition resulted in adverse changes in the health or behavioral status of the individual.

In addition, the aforementioned START program is designed to help maintain individuals in their residential setting and better support them in the community. This program provides additional clinical support within the community to enable individuals to remain in their current residential setting and avoid unnecessary admissions to New Hampshire Hospital or other in-patient settings.

Creating the right residential option for individuals with disabilities is not an easy undertaking, but the service system has provided many people with individually tailored service arrangements. For example, there are a number of individuals who have lived in the same EFC home for 15 to 20 years, assimilating into the family life and being a part of the local community. The service system will continue its efforts to secure individualized residential options for people with disabilities.

Well-Trained Staff

In its White Paper, the DRC recommended that BDS, Area Agencies and their subcontractors improve pre-service and in-service training and supervision of direct service staff

and providers.⁷ The service system currently provides a variety of training programs and options and continues to implement new training opportunities as they become available.

BDS regulations currently require training in client rights and safety, specific health-related requirements of each individual, specific communication needs, behavioral supports of each individual served, the individual's fire safety assessment and the community residence's evacuation procedures. In addition, staff with no prior experience in working with individuals with disabilities receive direct oversight and support during the first 16 hours of providing services.

Service Coordinators also participate in regular training sessions. New service coordinators attend a two-day orientation training that covers topics including health and well-being, mental health, supports intensity scale, vulnerabilities, and safeguards. Both new and seasoned Service Coordinators attend trainings throughout the year on current relevant topics such as consumer directed services, assistive technology, and cross systems crisis prevention and intervention.

In 2007, BDS amended the Administrative Rule He-M 506, Staff Qualification and Staff Development Requirements, to include the expectation that staff have a basic understanding of common signs and symptoms of illnesses, especially for people with disabilities who may not be able to communicate. These "Basic Health Observations" were made available electronically and posted on the DDNNH Health & Safety webpage, and included abdominal pain, allergic reactions, constipation, dehydration, diarrhea, dysphagia and aspiration, "just not right", and seizures.

⁷ DRC's specific recommendations are found in its White Paper at pages 40-46. In this section, BDS seeks to address recommendation (c) on pages 41-42.

In 2007, a statewide fire-safety training was conducted in Concord, which included Area Agencies, subcontract agencies, and DHHS personnel. All staff and providers completed the fire safety training, with the “Fire Power” video used as a key piece in the training. To ensure ongoing fire safety training, an orientation module for fire safety was developed for all new staff and providers. Following up on the training, each of the Area Agencies contacted their local fire departments to identify an agency contact person, establish lines of communication, provide information regarding certified residential homes in the area, discuss any concerns, and engage in collaborative efforts for training needs. In addition, supervisory staff conducted fire drills at residences to gauge the effectiveness of the fire safety measures and trainings.

Another training opportunity involved a series of presentations by the BDS nursing coordinator in collaboration with the Director of the Massachusetts Department of Developmental Disabilities Health Promotion and Coordination Initiative. These presentations to Area Agency personnel introduced NH Best Practices, which are tools, instruments, and processes designed by the Center for Developmental Disabilities Evaluation and Research, an affiliate of the University of Massachusetts Medical School and the Shriver Center. These tools included: (1) Preventative Health Screening Recommendations Checklist adapted from the Massachusetts Health Quality Partnership; (2) Tools for a Health Care Appointment that provided protocols to ensure that home providers and staff are prepared with needed information when accompanying an individual to a medical appointment; (3) Health Care Practitioner Encounter form that incorporates information regarding the reason for the visit as well as the treatment recommendations; and (4) Health Status Indicators that ask direct support professionals who interact most directly with individuals on a day-to-day basis to respond to easily observable indicators of health or illness. In addition, BDS established the Developmental

Disabilities Nurses of NH (DDNNH) website where electronic versions of the above-mentioned Center for Developmental Disabilities Evaluation and Research tools for health promotion are available, and included the He-M 1201 Medication Administration Training Curriculum.⁸

The service system continues to seek and develop a capable workforce and to provide on-going training and supports for all direct service staff and providers. BDS also welcomes opportunities to collaborate with the Area Agencies and other organizations to continue to provide current and relevant training and support to the staff.

Staff Pay Structure

In its White Paper, the DRC recommends that the service system enhance its compensation of staff and providers by improving the salary structure and benefits for the direct support workforce.⁹ BDS, Area Agencies and the subcontract agencies have long recognized the importance of appropriate reimbursement and benefit options for staff and providers and documented this systemic need in numerous reports and budget presentations. Unfortunately, since the system receives rare rate adjustments for cost of living increases¹⁰, it continues to face significant challenges in its recruitment and retention efforts.

C. Quality Assurance Measures

In its White Paper, the DRC recommends that BDS improve the satisfaction and safety of services by: (a) standardizing incident reporting, investigation, and remediation process, (b) continuing with independent complaint investigations, (c) analyzing and preserve all

⁸ As a result, the DDNNH was named Nurse Network of the Year in 2007 by the Developmental Disabilities Nurses Association, a national nursing specialty organization that is committed to advocacy, education, and care for nurses who provide services to persons with intellectual and developmental disabilities.

⁹ DRC's specific recommendations are found in its White Paper at pages 40-46. In this section, BDS seeks to address recommendation (g) on page 44.

¹⁰ Between FY 2000 and 2010 the service system has received four rate increases of totaling 9.2% while the general inflation during the same period resulted in an increase of 29.8%.

investigation data, and (d) expanding the current quality assurance process.¹¹ BDS currently employs several methods of ensuring that the services are safe and appropriate and achieve positive outcomes.

Both BDS and the Area Agencies took steps in response to the specific incidents detailed in the White Paper. The specific steps taken by the Area Agencies are described in the attached Appendix C. Likewise, BDS took specific steps in response to each incident, such as following the 2006 Tilton fire, BDS requested and was granted funds for enhancing fire safety measures. These funds have been used to: install interconnected smoke detector upgrades in all levels of approximately 1,000 existing certified residences statewide; replace bedroom windows in a number of community residences to insure second means of egress; and install at least one carbon monoxide detector on each floor of community residences. BDS will continue to provide the necessary funds to Area Agencies and provider agencies to enable them to install similar fire safety measures in all new community residences.

Sentinel Event Reporting

With regard to incident reporting and review, DHHS/BDS instituted the Sentinel Event mandatory reporting policy in 2003 as part of a comprehensive quality assurance program that examines sentinel events involving individuals receiving services funded through DHHS/BDS. This policy requires the reporting of all unexpected occurrences involving death or serious physical or psychological injury or risk thereof, signaling the need for immediate investigation and response. These events are subject to review and, when applicable, the implementation of a quality improvement action plan. The Sentinel Event process involves a root cause analysis performed by involved agencies to determine the causes that underlie sentinel events and make

¹¹ DRC's specific recommendations are found in its White Paper at pages 40-46. In this section, BDS seeks to address recommendation (d) on page 42 and (f) on pages 43-44.

changes to internal and external systems and processes to reduce the probability of such events in the future. The analysis includes descriptions of the precipitating event, the individual's clinical status, the immediate action taken by the agency when the incident occurred, any other administrative/operational issues relevant to the event, and any identified opportunities for improvement.

Independent Investigations

To further standardize and make independent the investigation process, BDS made extensive and fundamental changes to Administrative Rules He-M 202, Rights Protection Procedures for Developmental Services, in September 2011. These amendments shifted the investigation of complaints of abuse, neglect, exploitation, and rights violations from the Area Agencies to the Office of Client and Legal Services (OCLS) within DHHS. The revised regulation requires a more rigorous training and supervision for investigators, an expanded scope of investigation that includes recommendations on systemic improvements, and regular reporting to the Area Agencies, regional Human Rights Committees, and the Quality Council.

BEAS Reporting and Investigations

DHHS and the Bureau of Elderly and Adult Services (BEAS) were also diligent in their effort to improve the reporting of suspected incidents of abuse, neglect, and exploitation. BEAS approaches community providers annually who come in contact with adults that may be victims of abuse and neglect and offers day long conferences, grand rounds, seminars, printed materials and television spots to educate the provider network on how to recognize signs of abuse, neglects and exploitation. BEAS provided educational opportunities to members of local police departments, case management agencies, home health agencies, visiting nurse associations, nursing facilities, residential care facilities, adult medical day programs, service link

organizations, New Hampshire Hospital, Area Agencies, Community Mental Health Centers, and local hospitals.

In addition, BEAS Adult Protective Services' (APS) program began the development and implementation of a system, Structured Decision Making® (SDM), to establish consistency of decision-making during the report, investigation and ongoing case processes that includes an intake assessment, a safety assessment, a risk assessment and a strengths and needs assessment. SDM provides a prevention-oriented, risk-based approach to the management of increasingly more complex individuals to better assess individuals at critical decision points in the life of a report to adult protective services. With the information from the SDM system, APS can determine the urgency of a report, the safety of the alleged victim, the risk of future harm to the alleged victim, the type of response needed to mitigate the risk of future harm, and what services should be engaged to address a client's and his/her primary support person's critical needs. The data produced from this system and the reporting of incidents and external investigations are analyzed annually and contributed to many of the systemic changes described in this report for persons with disabilities.

With regard to retaining investigation materials, BEAS has prepared a final draft for revisions to Administrative Rules, He-E 700, Adult Protective Services Program. Included in those revisions are changes to He-E 706.01 involving the Retention Of Protective Investigation Material. BEAS is committed to retaining investigative material for a period of one year for all material related to investigations of self-neglect that are determined to be unfounded and three years for all other unfounded investigations. All founded investigations are retained for 7 years.

Quality of Services

The service system regularly solicits feedback from the individuals it serves and their families regarding the quality of the services and support they are receiving. Between 1995-2009, BDS conducted the Adult Outcomes Survey that was designed to assess individual and family satisfaction with respect to the quality of services provided within the developmental services system. In 2010, BDS and the Area Agencies began participating in a similar program through the National Core Indicators (NCI) Project that provides similar information as the Adult Outcomes Survey, but also allows BDS to compare its results with other States. The National Core Indicators Project is designed to obtain information from individuals and families regarding their assessments of services, including employment and community participation; information and planning; choice and control; overall satisfaction; access to services; community connections; family outcomes; health, welfare, and rights; preventative health care services; system performance; and service coordination. As BDS and the Area Agencies wait to receive the state's first report from the NCI Project, they remain open to considering recommendations through the Quality Council on whether other or additional methods for incident reporting and quality improvement should be instituted to better serve individuals and their families.

Culture of Individual Rights, Choice and Self-Determination

The DRC further recommends that BDS improve the manner in which it safeguards and promotes a culture of individual rights, choice and self-determination. Specifically, the DRC recommends that BDS: (a) improve staff training on skills and values; and (b) review practices related to the use of guardians and other advocacy organizations, the use of independent case

management, and educating individuals and their families about their rights, choices, and the importance of self and family advocacy.¹²

Training

BDS regulations require area and subcontract agencies to train their staff and providers in a number of topic areas, including: safeguarding individual/client rights, understanding different types of disabilities, knowledge of conditions promoting or detracting from individuals' quality of life, supporting people with behavioral challenges, facilitating social relationships, assisting individuals' independence, basic health and safety practices, and supporting individuals in making their own decisions. Such trainings are offered each year through both agency-based and statewide arrangements. However, area agencies and provider agencies have encountered ongoing difficulties in finding and paying for substitute staff and providers. As a result, staff members who have been working in the system for a while may not be released from their regular duties to attend such trainings. The service system will need to review this issue more closely and identify strategies to address it.

Clients' Rights and Advocacy

Since the inception of New Hampshire's community-based system, BDS regulations have always contained provisions about individuals and families receiving information about individual/client rights. Individuals and families receive rights related information as a part of the annual service planning meetings. In addition, the service coordinator/case manager explains to the individual his or her rights and responsibilities, as a part of the overall systemic effort to maximize the extent to which an individual participates in and directs his or her service planning process. This is typically accomplished by the service coordinator meeting with the individual

¹² DRC's specific recommendations are found in its White Paper at pages 40-46. In this section, BDS seeks to address recommendation (i) on pages 45-46.

prior to the services planning session to share information regarding a variety of topic areas, including client rights, and to elicit information from the individual regarding his or her service needs and personal preferences. The information generated through such discussions between the individual and service coordinator is used to give direction to the service-planning meeting and provide focus to the development of the service agreement.

In addition to the systemic efforts outlined above, the regional and statewide self-advocacy groups that have been in operation within New Hampshire for more than 15 years have a significant interest in client/individual rights and produced a variety of excellent materials that inform individuals regarding their rights. Moreover, the importance of this topic area to the self-advocates resulted in rights related information routinely and frequently discussed during regional and statewide self-advocacy group gatherings.

Guardianship

In addition to the expectations about individual rights, the State rule He-M 503 also contains provisions regarding guardianship. The regulation requires that the annual service planning process include a discussion of the need for guardianship and directs the area agency director to implement any guardianship related recommendations that are identified in the service agreement. To support such efforts to provide guardianships to individuals, the State has contracted with guardianship agencies, which currently provide guardianship services to approximately 550 individuals within the developmental services system.

The service coordinator for each individual plays a major role in discussions and efforts related to guardianship issues. Moreover, the service coordinator is required, as a part of the annual service planning process, to explain to the individual the limits of the decision-making authority of the guardian, and the individual's right to make all other decisions related to

services. Because of these responsibilities, the service coordinators receive trainings regarding guardianship matters. These trainings are typically provided by the DHHS' Office of Client and Legal Services attorney assigned to BDS and include staff from guardianship service agencies. Such presentations typically include information on types of guardianship, alternatives to guardianship, requirements for guardianship, duties and responsibilities of guardians, and the court process for obtaining guardianship.

Independent Case Management

Since 1999, the State regulations for New Hampshire's developmental services system have empowered individuals, families, and guardians to "*select any person, any provider agency, or another area agency as a provider to deliver one or more of the services identified in the individual's service agreement.*"¹³ This important opportunity regarding choice of providers is also applicable to service coordination/case management services. Thus, individuals, families, and guardians are able to receive services from independent case management organizations or some other person of their choosing.

To insure that individuals, families, and guardians are informed about the opportunity to choose providers, BDS began requiring the area agency to advise the individual, family, and guardian verbally and in writing prior to the initial and yearly individual service agreement planning process that the individual has a right to choose his or her own provider(s). In addition, BDS regulations direct the area agency to provide a statewide list of service providers to individuals and guardians who wish to choose providers.¹⁴

¹³ All providers must comply with the rules pertaining to the service(s) offered and meet the provisions specified within the individual's service agreement. They also have to enter into a contractual agreement with the area agency and operate within the limits of funding authorized by it.

¹⁴ The above provisions have already been included in the regulation for Acquired Brain Disorder services (He-M 522) and are in the process of being added to the regulation for Developmental Services (He-M 503).

Given the critical importance of the issues of individual/client rights, assignment of guardians, and choice of providers, BDS will work with the Quality Council to review these topic areas and look for further opportunities to improve regulations, staff/provider trainings, and service outcomes.

IV. Conclusion

New Hampshire's developmental services system experienced an extensive and noteworthy evolution, especially during its last twenty years. This change came about because of the tireless efforts of many people, including families, individuals, advocates, professionals, legislators, and state officials. Fortunately, this progress has created, both at the individual and systemic levels, meaningful life opportunities for those citizens with disabilities, enabling them to live, work, and contribute in their own communities with supports from a variety of sources.

Providing quality of life opportunities must unquestionably begin with, and always include, considerations for individuals' health and safety. Making sure that individuals have the supports that they need to be healthy and safe so that they can achieve and sustain a meaningful life is a communal responsibility shared by the state agencies, area agencies, service providers, families, advocates, and local communities. As the history of New Hampshire's service system demonstrates, the chances for positive outcomes for people are maximized when all stakeholders fulfill their responsibilities and collaborate on behalf of individuals with disabilities. As more diverse and complex service arrangements are created each day, the White Paper issued by DRC serves as an important reminder for continued vigilance and responsiveness regarding the needs of individuals with disabilities. DHHS/BDS pledges to continue to take the lead, to engage various stakeholders, and to use all of its available resources to support the needs of those citizens with disabilities. BDS looks forward to working with the Developmental Services

Quality Council, Area Agencies, and subcontracted provider agencies to continue to make further improvements to all aspects of New Hampshire's service system.

Appendix A

HEALTH AND SAFETY-RELATED ADMINISTRATIVE RULES FOR DEVELOPMENTAL SERVICES

Appendix A includes excerpts from the Developmental Services regulations that relate to providing for the health and safety of individuals served by the system. These excerpts are taken from:

He-M 503 Eligibility and the Process of Providing Services

He-M 506 Staff Qualification and Staff Development Requirements for Developmental Services Agencies

He-M 507 Day Services

He-M 513 Respite Services

He-M 518 Employment Services

He-M 521 Certification of Residential Services or Combined Residential and Day Services Provided in the Family Home

He-M 522 Eligibility Determination and Services Planning for Individuals with an Acquired Brain Disorder

He-M 524 In-Home Supports

He-M 525 Participant Directed and Managed Services

He-M 1001 Certification Standards for Developmental Services – Community Residences

He-M 1201 Healthcare Coordination and Administration of Medications

He-M 503 ELIGIBILITY AND THE PROCESS OF PROVIDING SERVICES

He-M 503.02 He-M 503.02 Definitions

(t) “Personal profile” means a narrative description that includes:

(3) A review of the past year that:

a. Summarizes the individual’s:

4. Challenging issues or behavior;

5. Health status and any changes in health; and

6. Safety considerations during the year;

e. Identifies the individual’s health needs;

f. Identifies the individual’s safety needs;

He-M 503.05 Determination of Eligibility.

(g) The area agency director shall authorize services to be provided prior to the completion of the eligibility determination process if such services are necessary to protect the health or safety of an applicant whom the area agency director believes is likely to have a developmental disability, based upon available information. Such services shall meet the criteria set forth in He-M 503.08.

He-M 503.08 Service Guarantees on Services for Which Funds Are Available.

(b) All services shall be designed to:

(1) Promote the individual’s personal development and quality of life in a manner that is determined by the individual;

(2) Meet the individual’s needs in personal care, employment, adult education and leisure activities;

(3) Promote the individual’s health and safety;

(4) Protect the individual’s right to freedom from abuse, neglect and exploitation;

(5) Increase the individual’s participation in a variety of integrated activities and settings;

(6) Provide opportunities for the individual to exercise personal choice, independence and autonomy within the bounds of reasonable risks;

(7) Enhance the individual's ability to perform personally meaningful or functional activities;

(8) Assist the individual to acquire and maintain life skills, such as, managing a personal budget, participating in meal preparation, or traveling safely in the community; and

(9) Be provided in such a way that the individual is seen as a valued, contributing member of his or her community.

(g) If the area agency determines that a provider chosen by the individual or guardian is posing an immediate and serious threat to the health or safety of the individual, the area agency shall, with input from the individual or guardian, secure another provider and issue a notice to immediately terminate the service contract of the current provider, specifying the reasons for the action.

He-M 503.09 Service Coordination.

(b) The service coordinator shall:

(7) Determine and implement necessary action and document resolution when goals are not being addressed, support services are not being provided in accordance with the service agreement, or when health or safety issues have arisen;

(d) If the service coordinator chosen by the individual or guardian is not employed by the area agency or its subcontractor:

(3) If the area agency determines that a service coordinator chosen by the individual or guardian is posing an immediate and serious threat to the health or safety of the individual, the area agency shall terminate the designation of the service coordinator immediately upon issuance of written notice specifying the reasons for the action and designate a new service coordinator, with input from the individual or guardian, pursuant to He-M 503.09 (a).

He-M 503.10 Service Planning.

(b) All service planning shall:

(2) Include identification by the individual or guardian and the individual's service providers of those services and environments that will promote the individual's health, welfare, and quality of life.

(c) The service coordinator shall, as applicable, maximize the extent to which an individual participates in and directs his or her service planning process by:

(3) Eliciting information from the individual regarding his or her personal preferences and service needs, including any health concerns, that shall be a focus of service planning meetings;

He-M 503.12 Record Requirements for Area Agencies

(b) An individual's record shall include:

(3) Information about the individual that would be essential in case of an emergency, including:

c. Medical information as applicable, including:

1. Diagnosis(es);
2. Health history;
3. Allergies;
4. Do not resuscitate (DNR) orders, as appropriate; and
5. Advance directives, as determined by the individual;

He-M 506 STAFF QUALIFICATIONS AND STAFF DEVELOPMENT REQUIREMENTS FOR DEVELOPMENTAL SERVICE AGENCIES

He-M 506.05 Staff Development Requirements.

(e) A provider agency shall train support staff in the following areas within the first 6 months of employment:

(5) Basic health and safety practices related to:

- a. Personal wellness;
- b. Success in living, working and recreating in the community; and
- c. An understanding of the importance of common signs and symptoms of illness; and

He-M 507 DAY SERVICES

He-M 507.02 Definitions.

(i) "Day services" means habilitation, assistance, and instruction provided to individuals that:

- (1) Improve or maintain their performance of basic living skills, vocational activities, community activities, or any combination of these;
- (2) Enhance their social and personal development; and

(3) Include consultation services, in response to individuals' needs, and as specified in service agreements, to improve or maintain communication, mobility, and physical and psychological health; and

(4) At a minimum, meet the needs of the individual as specified in the service agreement.

(p) "Health assessment" means an evaluation of a person's health status done by a physician or other licensed practitioner for the purpose of making recommendations regarding strategies for promoting and maintaining optimum health.

He-M 507.04 Covered Services.

(a) All day services shall be specifically tailored to, and provided in accordance with, the individual's needs, interests, competencies, and lifestyle, as described in the individual's service agreement.

(b) The following services shall be covered:

(1) Instruction and assistance to learn, improve, or maintain:

- a. Basic living skills;
- b. Personal decision-making
- c. Social skills in different community settings;
- d. Safety skills at home and in the community;
- e. A healthy lifestyle;
- f. Good nutrition; and
- g. Rights and responsibilities as citizens;

(6) Consultation services in response to individuals' needs and as specified in their service agreements, to improve or maintain communication, mobility, and physical and psychological health; and

He-M 507.07 Organization and Administration.

(a) The day services director shall be responsible for the administration of day services and the hiring, training, and supervision of day services staff.

(b) Provider agencies shall have written policies and procedures that address the following:

- (1) The provision of covered services;
- (2) Emergency plans, which shall minimally include:

a. Procedures to follow while at a service site, in a vehicle, or in the community in case of:

1. Behavioral or medical emergencies of an individual; or
2. Fire or severe weather;

b. If individuals gather at a centralized service site to receive services, an emergency evacuation plan including provisions in compliance with the following:

1. Each individual shall be oriented to evacuation procedures upon starting services;
2. If the service site has been evacuated in 3 minutes or less during each of 6 consecutive monthly drills, the provider agency shall thereafter conduct a drill at least once quarterly;
3. If the service site has not been evacuated in 3 minutes or less during each of 6 consecutive monthly drills, the provider agency shall conduct monthly drills;
4. For each individual unable to evacuate in 3 minutes or less, the provider agency shall implement a specific evacuation plan;
5. Evacuation drills shall be held at varied times of the day;
6. A written record of each drill shall be kept on file by the provider agency;
7. Staff shall be trained in all aspects of evacuation procedures; and;
8. Staff who conduct training pursuant to 7. above shall document such training.

(3) A policy for the administration of medication, which shall comply with the requirements of He-M 1201;

(4) A policy on individual rights in accordance with He-M 202 and He-M 310; and

(5) A policy which ensures compliance with applicable local and state health, zoning, building, and fire codes and requires documentation of compliance with fire codes.

(d) The administrative component of each individual's record shall include, for that individual, at least the following:

- (2) A current health assessment.

(e) The service component of each individual's record shall include at least the following:

- (5) The individual's medical status, including current medications, known allergies, and other pertinent health care information;
 - (6) Results of any assessments or evaluations; and
 - (7) For each individual for whom medications are administered during day services, medication log documentation pursuant to He-M 1201.06.
- (f) Records of service operations shall include the following:
- (1) A register of current and prior individuals who received day services, including termination dates when applicable;
 - (2) A daily census;
 - (3) Documentation of all incident reports as defined in He-M 202.02 (o);
 - (4) Evacuation drill records, if there is a centralized service site; and
 - (5) Copies of emergency plans.

He-M 507.09 Staff Qualifications and Training.

- (f) Prior to delivering day services to an individual, the provider agency shall orient staff and consultants to the needs and interests of the individuals they serve, in the following areas:
- (1) Rights and safety;
 - (2) Specific health-related requirements including those related to:
 - a. Current medical conditions, medical history and routine and emergency protocols; and
 - b. Any special nutrition, dietary, hydration, elimination, or ambulation needs;
 - (3) Any specific communication needs;
 - (4) Any behavioral supports;
 - (5) The individuals' service agreements, including all goals and methods or strategies to achieve the goals; and
 - (6) The day services' evacuation procedures, if applicable.

He-M 507.12 Immediate Suspension of Certification.

- (a) In the event that a violation poses an immediate and serious threat to the health or safety of the individuals, the director shall suspend a provider agency's certification immediately upon issuance of written notice specifying the reasons for the action.

He-M 513 RESPITE SERVICES

He-M 513.03 Eligibility and Application for Respite Services.

(e) Prior to providing respite services, the area agency shall obtain the following information from families and individuals requesting respite services:

- (4) Relevant medical information regarding the individual, as applicable, including:
 - a. Prescribed medication;
 - b. Allergies;
 - c. Limitations on activities;
 - d. Special diets;
 - e. Assistive technology devices; and
 - f. Any other specific health or safety needs;

He-M 513.04 Agency Arranged Respite Services.

(g) The staff member who visited the respite service provider's home shall complete a report of the visit that includes a statement of acceptability of the following conditions using criteria established by the area agency:

- (1) The general cleanliness;
- (2) Any safety hazards;
- (3) Any architectural barriers for the individual(s) to be served; and
- (4) The adequacy of the following:
 - a. Lighting;
 - b. Ventilation;
 - c. Hot and cold water;
 - d. Plumbing;
 - e. Electricity;
 - f. Heat;
 - g. Furniture, including beds; and
 - h. Sleeping arrangements.

(j) Each area agency shall arrange for training of respite service providers in the following areas:

(3) Basic health and safety practices including emergency first aid;

(n) The area agency shall provide or arrange for respite services and provider training such that:

(1) Any special health, behavioral, or communication needs of individuals can be met during the period of respite services;

He-M 518 EMPLOYMENT SERVICES

He-M 518.06 Services.

(a) Employment consultants shall provide supported employment services specified in the individual's service agreement, such as:

(9) Monitoring of the individual's health and safety;

He-M 521 CERTIFICATION OF RESIDENTIAL SERVICES OR COMBINED RESIDENTIAL AND DAY SERVICES PROVIDED IN THE FAMILY HOME

He-M 521.03 Services.

(b) Services shall include assistance and instruction to improve and maintain an individual's skills in basic daily living, personal development, and community activities, such as, but not limited to:

(2) Promoting and maintaining safety;

(9) Achieving and maintaining physical well-being;

(10) Improving and/or maintaining mobility and physical functioning;

(12) Attending to personal hygiene and appearance;

He-M 521.05 Administrative Requirements.

(a) Once a family expresses interest regarding He-M 521 services but before services are provided under He-M 521, the area agency shall:

(1) Ensure that the proposed service arrangement:

c. Meets the individual's environmental and personal safety needs; and

He-M 521.06 Medication Administration. When an individual living with his or her family is in need of medication administration, such administration shall:

- (a) Comply with He-M 1201 when administered by area agency or subcontract agency staff, or home providers;
- (b) Comply with Nur 404 when a nurse identified in Nur 404.03 delegates the task of medication administration to providers who are neither family members nor under contract with an area agency or subcontract agency, except in situations where the individuals are living with their families and receiving respite arranged by the family; or
- (c) When performed by family members paid under He-M 521, include discussion between the area agency or subcontract agency and the family about any concerns the family might have regarding medication administration.

He-M 521.07 Quality Assessment. An area agency shall monitor services provided pursuant to He-M 521 as follows:

- (b) The service coordinator or a designated area agency staff shall visit the individual at home and contact the guardian, if any, at least quarterly, or more frequently if so specified in the individual's service agreement, to determine and document whether services:
 - (3) Meet the individual's environmental and personal safety needs; and

He-M 521.11 Immediate Suspension of Certification.

- (a) In the event that a violation poses an immediate and serious threat to the health or safety of an individual, the bureau administrator shall suspend a service's certification immediately upon issuance of written notice specifying the reasons for the action.

He-M 522 ELIGIBILITY DETERMINATION AND SERVICE PLANNING FOR INDIVIDUALS WITH AN ACQUIRED BRAIN DISORDER

He-M 522.09 Service Guarantees on Services for Which Funds Are Available.

- (b) All services shall be designed to:
 - (1) Promote the individual's personal development and quality of life in a manner that is determined by the individual;
 - (2) Meet the individual's needs in personal care, employment, adult education, and leisure activities;
 - (3) Promote the individual's health and safety;
 - (4) Protect the individual's right to freedom from abuse, neglect, and exploitation;

- (5) Increase the individual's participation in a variety of integrated activities and settings;
 - (6) Provide opportunities for the individual to exercise personal choice, independence, and autonomy within the bounds of reasonable risks;
 - (7) Enhance the individual's ability to perform personally meaningful or functional activities;
 - (8) Assist the individual to acquire and maintain life skills such as managing a personal budget, participating in meal preparation, or traveling safely in the community; and
 - (9) Be provided in such a way that the individual is seen as a valued, contributing member of his or her community.
- (h) If the area agency determines that a provider chosen by the individual or guardian is posing a serious threat to the health or safety of the individual, the area agency shall, with input from the individual or guardian, secure another provider and issue a notice to immediately terminate the service contract of the current provider, specifying the reasons for the action.

He-M 522.10 Service Coordination.

- (e) If the service coordinator chosen by the individual or guardian is not employed by the area agency or its subcontractor the following requirements shall apply:
- (3) If the area agency determines that a service coordinator chosen by the individual or guardian is posing a serious threat to the health or safety of the individual, the area agency shall terminate the designation of the service coordinator immediately upon issuance of written notice specifying the reasons for the action and designate a new service coordinator, with input from the individual or guardian, pursuant to He-M 522.10 (a).

He-M 522.15 Allocation of Funds for Current and Future Individual Service Requests.

- (k) For individuals eligible for Medicaid home- and community-based care services or currently receiving such services, an area agency shall request advanced crisis funding to provide services without delay when there are no generic or area agency resources available and an individual is experiencing a significant life change pursuant to (l) below.
- (l) An individual shall be considered to be experiencing a significant life change if he or she is:
- (1) A victim of abuse or neglect pursuant to He-E 700 or He-M 202;
 - (2) Abandoned and homeless;
 - (3) Without a caregiver due to death or incapacitation;

- (4) At significant risk of physical or psychological harm due to decline in his or her medical or behavioral status; or
- (5) Presenting a significant risk to his or her own or the community's safety due to involvement with the legal system.

He-M 524 IN-HOME SUPPORTS

He-M 524.04 Services.

(d) In-home supports shall include:

(1) Personal care services that assist an individual to continue living at home with his or her family, including instruction and skill building to develop greater independence in:

c. Maintaining health and personal safety;

(3) Any of the following consultative services that are not otherwise available under He-W 546:

a. Evaluation, training, mentoring, and special instruction to improve the ability of the service provider, family, and other caregivers to understand and care for the individual's developmental, functional, health, and behavioral needs;

(5) Environmental modifications that:

a. Consist of adaptations to the home environment to ensure access, health, and safety;

b. Consist of adaptations to vehicles to ensure the individual's safety and access to the community; and

He-M 524.08 In-Home Supports Service Agreement.

(a) The service agreement describing services provided pursuant to He-M 524.04 shall:

(3) Include the following:

a. A list of specific activities to be carried out, including those regarding safety;

e. Specific contingency plans for assuring provision of service when the usual providers are not available;

f. Emergency contact information; and

He-M 524.11 Quality Assessment.

(b) The service coordinator shall conduct visits and contacts as established by (a) above and document the individual's, family's, and representative's satisfaction with:

(4) The individual's health and safety supports as identified in the service agreement; and

He-M 525 PARTICIPANT DIRECTED AND MANAGED SERVICES

He-M 525.01 Purpose and Scope.

(b) Participant directed and managed services enable individuals who have a developmental disability or acquired brain disorder to direct their services and to experience, to the greatest extent possible, independence, community inclusion, employment, and a fulfilling home life, while promoting personal growth, responsibility, health, and safety.

He-M 525.05 Service Principles.

(c) Participant directed and managed services shall:

(2) Promote the health, safety, and emotional well-being of the individual;

(f) For an individual who is under the age of 21, participant directed and managed services shall include supports identified in the service agreement for the individual and his or her family, such as:

(5) The following, to the extent that they are not the responsibility of the school district to provide:

c. Acquisition and maintenance of life skills, such as:

5. Maintaining personal safety.

He-M 525.06 Administrative, Service, and Personnel Requirements.

(l) In addition to complying with (k) above, when an individual is 21 years of age or older and lives in a staffed home:

(1) The home shall comply with applicable local and state health, zoning, building and fire codes;

(2) The physical layout and environment of the home shall meet the health and safety needs of the individual;

(3) A signed statement from the local fire official shall be obtained before the individual moves into the home:

- a. Verifying that the home complies with all state and local fire codes; and
- b. Specifying the number of beds that can safely be occupied by individuals living in the home; and

(4) Quarterly fire drills in the home shall be conducted and documented such that:

- a. One drill per year shall be conducted during sleep hours; and
- b. The first drill shall be conducted no more than 5 days after the individual has moved into the home.

(m) In addition to complying with (k) above, when an individual is 21 years of age or older and lives with a home provider who is not a family member, the home shall have:

(1) An integrated fire alarm system with a functioning smoke detector in each bedroom and on each level of the home including the basement and attic, if the attic is used as living or storage space;

(2) A functioning septic or other sewage disposal system;

(3) A source of potable water for drinking and food preparation, such that, if the water for drinking and food preparation is not from a public water supply:

- a. At the time of the initial certification there shall be well water test results less than 2 years old that indicate the water is potable; or
- b. There shall be documentation that bottled water is used; and

(4) Two means of egress.

(n) If the home in which supports are provided is not owned by a family member, a fire safety assessment shall be conducted by staff in a staffed home or a home provider, when not a family member, to address the individual's following risk factors:

(1) Response to alarm;

(2) Response to instructions;

(3) Vision and hearing difficulties;

(4) Impaired judgment;

(5) Mobility problems; and

(6) Resistance to evacuation.

(o) Based on the findings of the fire safety assessment, the individual and other members of his or her team shall develop a fire safety plan that addresses fire drill frequencies, procedures to achieve evacuation within 3 minutes, and other fire safety related strategies determined by the team to be applicable.

(p) When an individual's service agreement specifies unsupervised time and the provider is not a family member, the staff in a staffed home or the home provider shall conduct a personal safety assessment that identifies the individual's ability to demonstrate the following safety skills:

- (1) Responding to a fire, including exiting safely and seeking assistance;
- (2) Caring for personal health, including understanding health issues, taking medication, seeking assistance for health needs and applying basic first aid;
- (3) Seeking safety if victimized or sexually exploited;
- (4) Negotiating one's community, including finding one's way, riding in vehicles safely, handling money safely, and interacting with strangers appropriately;
- (5) Responding appropriately in severe weather and other natural disasters, including storms and extreme temperature; and
- (6) Maintaining a safe home, including:
 - a. Operating heating, cooking, and other appliances; and
 - b. Responding to common household problems such as a blocked toilet, power failure or gas odors.

(q) Based on the findings of the personal safety assessment, the individual and other members of his or her team shall develop a personal safety plan that:

- (1) Identifies any supports necessary for an individual to respond to each of the contingencies listed in (p) above;
- (2) Indicates who will provide the needed supports;
- (3) Describes how the supports will be activated in an emergency;
- (4) Indicates approval of the individual or legal guardian, provider, residential coordinator, and service coordinator;
- (5) Is reviewed by the provider or staff at the time of the individual's service agreement; and
- (6) Is revised whenever there is a change in the individual's residence or ability to respond to the contingencies listed in the plan.

(a) Notwithstanding the provision of He-M 525.09 (e), in the event that a violation poses an immediate and serious threat to the health or safety of the individuals, the bureau administrator shall, in accordance with RSA 541-A:30, III, suspend a service's certification immediately upon issuance of written notice specifying the reasons for the action.

He-M 1001 CERTIFICATION STANDARDS FOR DEVELOPMENTAL SERVICES -- COMMUNITY RESIDENCES

He-M 1001.03 Administrative Requirements.

(g) Prior to hiring or contracting with a person to work in a community residence, the provider agency, with the consent of the person and all household members, as appropriate, shall:

- (1) Obtain at least 2 references for the person;
- (2) Submit the person's name for review against the registry of founded reports of abuse, neglect, and exploitation to ensure that the person is not on the registry pursuant to RSA 169-C:35 or RSA 161-F:49;
- (3) Complete a criminal records check to ensure that the person and all adult household members, excluding individuals, have no history of:
 - a. Felony conviction; or
 - b. Any misdemeanor conviction involving:
 1. Physical or sexual assault;
 2. Violence;
 3. Exploitation;
 4. Child pornography;
 5. Threatening or reckless conduct;
 6. Theft;
 7. Driving under the influence of drugs or alcohol; or
 8. Any other conduct that represents evidence of behavior that could endanger the well-being of an individual; and

(4) Complete a motor vehicles record check to ensure that the potential provider has a valid driver's license.

(k) Living space shall be arranged and maintained to support the health and safety of all household members, as follows:

- (1) Each community residence shall be maintained in good repair and free of hazard to household members; and
 - (2) Each community residence shall be free from environmental nuisances, including loud noise and foul odors.
- (l) A community residence shall provide the following:
- (1) A specific sleeping area designated for each individual;
 - (2) A separate bed for each individual with each bedroom containing no more than 2 beds; and
 - (3) Storage space for each individual's clothing and other personal possessions.
- (m) An individual's right to privacy shall be protected.
- (n) Each bedroom shall be situated such that:
- (1) No individual shall reside in a bedroom that is the access way to another bedroom or to a common area of the house; and
 - (2) Common areas shall not be used as bedrooms by any individual living in the home.
- (o) The community residence shall have:
- (1) At least one indoor bathroom which includes a sink, toilet, and a bathtub or shower for every 6 persons in the household;
 - (2) At least one telephone at all times when an individual is in the home;
 - (3) An integrated fire alarm system with a detector in each bedroom and on each level of the home including basement and attic, if the attic is used as living or storage space;
 - (4) A functioning septic or other sewage disposal system; and
 - (5) A source of potable water for drinking and food preparation, as follows:
 - a. If drinking water is supplied by a non-public water system, the water shall be tested and found to be in accordance with Env-Ws 315 and Env-Ws 316 initially and every 6 years thereafter; and
 - b. If the water is not approved for drinking, an alternative method for providing safe drinking water shall be implemented.

(c) Prior to delivering services to an individual, a prospective provider shall have received orientation in the following areas:

- (1) Rights as set forth in He-M 202 and He-M 310;
- (2) The specific health-related requirements of each individual, including:
 - a. All current medical conditions, medical history, and routine and emergency protocols; and
 - b. Any special nutrition, dietary, hydration, elimination, or ambulation needs;
- (3) Any specific communication needs;
- (4) An overview of developmental disabilities or acquired brain disorders, or both, as appropriate, including the local and state service delivery system;
- (5) Any behavioral supports required of individuals served; and
- (6) Any assistance individuals need to evacuate the residence in the case of emergency.

(e) Within the first 6 months of employment, each provider agency shall ensure that staff working in a community residence are trained in the following:

- (1) Everyday health including personal hygiene, oral health, and mental health;
- (2) The elements that contribute to quality of life for individuals, including support to:
 - a. Create and maintain valued social roles;
 - b. Build relationships; and
 - c. Participate in their local communities;
- (3) Strategies to help individuals to learn useful skills;
- (4) Behavioral support; and
- (5) Consumer choice, empowerment, and self-advocacy.

He-M 1001.06 Health and Safety.

(a) The residence administrator shall arrange for an annual health assessment of each individual by a physician or other licensed practitioner for the purpose of evaluating health status and making recommendations regarding strategies for promoting and/or maintaining optimal health.

(b) The residence administrator shall, in conjunction with the service coordinator, have arrangements to access medical services at all times, including emergency services. The residence shall have a written plan that specifies the procedures to be followed in medical emergencies.

(c) In the event of emergency concerning an individual including hospitalization, serious illness, serious injury, imminent death, or death, the residence administrator or service coordinator shall:

(1) Promptly notify the individual's next of kin, , guardian, and spouse or significant other, as applicable; and

(2) Respect and follow the wishes of the individual or guardian with regard to religious matters, if applicable.

(d) Providers having personal knowledge of an emergency as described in (c) above shall notify the individual's service coordinator immediately, and in writing within 24 hours.

(e) The written notification shall be kept on file at the area agency and a copy of the notice retained in the individual's residential record.

(f) In the event of the death of an individual:

(1) The provider agency shall immediately notify the area agency; and

(2) The area agency shall:

a. Notify the bureau within 12 hours and submit written mortality notification of the following to the bureau within 24 hours:

1. The individual's name, address, date of birth, gender, race, and ethnicity;
2. The date and place of death and whether or not hospice was involved;
3. The individual's medical diagnoses;
4. The names and phone numbers of any family members and guardians notified, and the date of notification;
5. A description of the individual's living situation and whether it had changed within the previous 6 months;
6. The apparent cause of death as recorded by the attending licensed practitioner; and
7. A detailed description of the events surrounding the individual's death, including what happened, what care was provided, and who was involved; and

b. Perform a mortality review as required in (g) and (h) below.

- (g) Each area agency shall assess the relationship of any individual's unanticipated death to service provision and the natural course of any illness or underlying condition.
- (h) Such a mortality review shall evaluate and, where applicable, document the following:
- (1) The individual's medical plan of care;
 - (2) Medical interventions required within the past year;
 - (3) Medical records, including physical exams and hospitalizations within the past year;
 - (4) The individual's health status over the previous 3 months; and
 - (5) The type and amount of residential care provided.
- (i) In any case of known or suspected neglect, abuse, or exploitation, the provider aware of the situation shall:
- (1) Follow procedures as outlined in He-M 310, rights of persons receiving developmental services in the community, and any other applicable rules relative to rights protection procedures; and
 - (2) Report the situation to the division of children, youth, and families in accordance with RSA 169-C:29 and/or the bureau of elderly and adult services as required by RSA 161-F:42-57, as applicable.
- (j) All agency staff and providers who administer medications to any individual receiving services in an He-M 1001 certified setting shall be authorized in accordance with He-M 1201.
- (k) A provider shall have the following responsibilities with respect to an individual's food and fluids:
- (1) The individual's preferences and requirements shall be taken into account;
 - (2) Varied and nutritionally balanced meals, including adequate fluids, shall be provided in the morning, at midday, and in the evening, unless other arrangements for meals have been made;
 - (3) Information regarding the signs and symptoms of dehydration specific to the individual shall be requested and retained;
 - (4) Access to food shall not be restricted unless a licensed practitioner deems it necessary for the health of the individual and the legal guardian consents to the restriction;
 - (5) Special diets, dietary supplements, and dietary restrictions or modifications shall be according to a licensed practitioner's orders or the individual's religious practices;

(6) If an individual requires specific methods or techniques for maintaining adequate nutrition and/or hydration, as determined by a licensed practitioner, such methods or techniques shall be implemented and documented in the individual's clinical record; and

(7) No attempt to feed or hydrate an individual against his or her will shall be made unless medically prescribed by a licensed practitioner and approved by the legal guardian.

(l) Providers shall label toxic substances as to contents and antidote and safely store such substances away from food preparation and food storage areas.

(m) Prior to providing services, a community residence shall develop an emergency evacuation plan that indicates the location of all evacuation routes and exits and provides for the safe evacuation of all persons within 3 minutes.

(n) An individual and his or her guardian shall be notified if any current or prospective household member smokes within the home.

(o) Upon moving to a new community residence, each individual shall be oriented to evacuation procedures by the provider.

(p) Within 5 business days of an individual's moving into a community residence or a change in residential provider, a service coordinator and licensed nurse shall visit the individual in the home to determine if the transition has resulted in adverse changes in the health or behavioral status of the individual.

(q) A service coordinator shall document the visit described in (o) above in the individual's record.

(r) If negative changes are noted, a service coordinator shall develop a remediation plan and include it within the individual's record.

(s) Within 5 days of an individual's moving into a community residence, the provider shall:

(1) Conduct a fire evacuation drill to assess the individual's ability to evacuate the residence in less than 3 minutes; and

(2) Based on the drill, complete and document a fire safety assessment that includes the following individual risk factors:

- a. Response to alarm;
- b. Response to instruction;
- c. Vision and hearing difficulties;
- d. Impaired judgement;
- e. Mobility problems; and

f. Resistance to evacuation.

(t) The fire safety assessment shall indicate:

- (1) The staff or provider to individual ratio during both sleep and non-sleep hours;
- (2) The name and phone number of agency back-up in the event of an emergency; and
- (3) The date completed and signature of the person documenting the individual's risk factors.

(u) For each individual unable to evacuate his or her residence within 3 minutes, a fire safety plan shall be developed and approved by the individual or guardian, provider, and residential administrator that identifies:

- (1) The cause(s) for such inability;
- (2) The specific assistance needed by the individual and to be furnished by the provider; and
- (3) A training approach to reduce the evacuation time to 3 minutes or less.

(v) Evacuation drills shall:

- (1) Be held at varied times of the day;
- (2) Involve all persons in the home at the time of the drill;
- (3) For community residences of 4 or more individuals, comply with He-P 814.23 (k); and
- (4) For community residences of 3 or fewer individuals, include transmission of the alarm signal unless doing so would register as a false alarm to the fire department or alarm company.

(w) A written record of each evacuation drill shall:

- (1) Be kept on file at each community residence; and
- (2) Indicate:
 - a. The names of all the individuals involved;
 - b. The date of the drill;
 - c. The time of day;
 - d. The time taken to evacuate; and

e. The exits utilized.

(x) If a community residence for 3 or fewer individuals has been evacuated in 3 minutes or less during each of 6 consecutive monthly drills, one of which has been a sleep-time drill, the residence shall thereafter conduct a drill at least once quarterly, with one drill per year to be during sleep hours.

(y) If a community residence serves 4 or more individuals, the residence shall conduct monthly drills, with at least 3 drills per year to be held during sleep hours.

(z) A community residence that has a complete sprinkler system and fire alarm system that immediately notifies the local fire department shall be exempt from the requirement to complete a fire drill in less than 3 minutes if documentation is provided that such systems are in compliance with local fire codes.

(aa) If a new individual moves into a community residence for 3 or fewer individuals, the community residence shall:

(1) Conduct monthly drills until all individuals have evacuated the residence in 3 minutes or less for 3 consecutive monthly drills; and

(2) Thereafter conduct a drill at least once quarterly, with one drill per year to be during sleep hours.

(ab) For any individual receiving less than 24-hour supervision, a personal safety assessment pursuant to (ac) below shall be completed.

(ac) The personal safety assessment shall identify an individual's ability to demonstrate the following safety skills:

(1) Respond to a fire including exiting safely and seeking assistance;

(2) Care for personal health, including understanding health issues, taking medication, seeking assistance for health needs and applying basic first aid;

(3) Seek safety if victimized or sexually exploited;

(4) Negotiate one's community, including finding one's way, riding in vehicles safely, handling money safely, and interacting with strangers appropriately;

(5) Respond appropriately in severe weather and other natural disasters, including storms, extreme temperature; and

(6) Maintain a safe home, including:

a. Operating heating, cooking, and other appliances; and

b. Responding to common household problems such as a blocked toilet, power failure and gas odors.

(ad) The individual's team, including the individual, shall develop a personal safety plan if the personal safety assessment determines that the individual needs assistance to respond appropriately to the situations outlined in (ac) above.

(ae) A personal safety plan shall:

- (1) Identify the supports necessary for an individual to respond to each of the contingencies listed in (z) above;
- (2) Indicate who will provide the needed supports;
- (3) Describe how the supports will be activated in an emergency;
- (4) Indicate approval of the individual or legal guardian, and provider, residential coordinator, and service coordinator;
- (5) Be reviewed by the provider at the time of the individual's service agreement; and
- (6) Be revised whenever there is a change in the individual's residence or ability to respond to the contingencies listed in the plan.

(af) The individual or his or her guardian shall approve the personal safety plan prior to the individual being without supervision for specified periods of time. Any revisions to the plan shall require the individual's or guardian's prior approval.

He-M 1001.07 Behavioral Support.

(a) If an individual is demonstrating behaviors that are harmful to self or others, the residence administrator shall notify the service coordinator. In collaboration with others supporting the individual, the service coordinator shall facilitate the planning, implementation, and monitoring of any behavioral change program determined necessary.

(b) A behavioral change program or any form of restrictive strategy shall only be implemented by a community residence when such has been approved in writing by the individual, his or her guardian, the individual's team, and the area agency's human rights committee, established pursuant RSA 171-A:17.

(c) A provider agency shall have written policies and procedures which address behavioral supports. These policies and procedures shall be directed toward maximizing the growth and development of the individual by incorporating a hierarchy of methods that emphasize positive approaches to behavioral support.

(d) Behavioral support policies and procedures shall:

- (1) Address the following concepts:
 - a. Behavior is a form of communication and efforts should be made to understand its purpose;

- b. There are different learning styles, skills, and motivations of individuals;
 - c. Relationships, environments, and personal histories have an impact on effecting behavioral change; and
 - d. Intentional and unintentional responses to behavior, such as ignoring, redirecting, and reinforcing, affect behavior;
- (2) Include the following behavior change strategies:
- a. Preventing behavioral difficulties by adjusting the environment, responses to the individual's behavior, or both;
 - b. Creating opportunities for meaningful participation in daily life, such as employment;
 - c. Teaching mutual respect within relationships; and
 - d. Redirecting and de-escalating behaviors that are harmful to self or others;
- (3) Outline training requirements for providers using the program; and
- (4) Indicate the mechanism to be used to monitor the implementation of any behavior change program and gauge its effectiveness.

He-M 1001.08 Individual Records.

- (f) When service provision is to be transferred from one provider or area agency to another, the transferring agency shall provide the following information regarding the individual:
- (1) Medical history, including diagnosis and annual health assessments for the past 3 year period, if available;
 - (2) Any known allergies;
 - (3) Assessment for self-administration of medication pursuant to He-M 1201.05, if applicable,
 - (4) Current medications and a medication list with the times medications are administered;
 - (5) Current medication orders and medication administration consent forms;
 - (6) Current medication administration authorizations of any staff transferring with the individual;
 - (7) For informational purposes, copies of the past 2 months of records of medication administration performed pursuant to He-M 1201;

- (8) Dental health information;
- (9) Pertinent personal information, such as:
 - a. Use of adaptive equipment;
 - b. Sleep patterns; and
 - c. Preferences and dislikes;
- (10) Any applicable protocols, such as those for:
 - a. Feeding;
 - b. Swallowing;
 - c. Medication administration;
 - d. Behavioral support; and
 - e. Seizures;
- (11) Most recent service agreement; and
- (12) List of contacts and emergency information.

He-M 1001.09 Quality Assurance.

- (a) An area agency shall monitor its community residences and conduct periodic quality assurance visits to each community residence to ensure that services are provided pursuant to He-M 1001.
- (b) Quality assurance visits shall be conducted at least annually, but may be at a greater frequency as determined by the area agency. Such visits may be announced or unannounced to the residential provider.
- (c) The department shall conduct quality assurance visits to community residences. Such visits may be announced or unannounced.
- (d) Each area agency shall review certification deficiencies pursuant to He-M 1001.14 to identify necessary corrective action and maintain compliance.

He-M 1001.17 Immediate Suspension of Certification.

- (a) Notwithstanding the provision of He-M 1001.16 (c), in the event that a violation poses an immediate and serious threat to the health or safety of an individual, the bureau administrator shall, in accordance with RSA 541-A:30, III, suspend a community residence's certification immediately upon issuance of written notice specifying the reasons for the action.

He-M 1201 HEALTHCARE COORDINATION AND ADMINISTRATION OF MEDICATIONS

He-M 1201.03 Healthcare Coordination.

(a) A nurse trainer shall meet with each individual residing in a residence certified pursuant to He-M 1001 and his or her provider within 30 days of the individual's residency, and annually thereafter, to review the level of support provided.

(b) A review pursuant to (a) above shall include:

(1) For each individual;

a. Health history information;

b. Health status; and

c. Supports provided to maintain physical, mental, and social well-being as reflected in the service agreement pursuant to He-M 503.02(t)(1)-(3); and

(2) The identification of individuals in frail health.

(c) For individuals who receive services pursuant to He-M 507 and He-M 518, the area agency or provider agency shall provide the following information to the nurse trainer when initiating services:

(1) Medical history, including diagnoses; and

(2) A list of current medications.

(d) Providers accompanying an individual receiving services pursuant to He-M 1001, He-M 507, He-M 518, He-M 521, He-M 524, or He-M 525 as applicable to a non-emergent medical appointment shall have, at a minimum, the following information:

(1) The reason(s) or purpose for seeking non-emergent care;

(2) A list of the individual's current medications, allergies, and any recent diagnostic or laboratory testing, as applicable; and

(3) The individual's current health status, including:

a. The specific health related needs of the individual; and

b. Any accommodations the individual might need such as assistance with communication or mobility.

(e) The provider shall review with the primary care physician or practitioner the annual health screening recommendations including, but not limited to:

(1) Cancer;

- (2) Hypertension;
- (3) Diabetes;
- (4) Dysphagia and aspiration;
- (5) Infectious diseases;
- (6) Osteoporosis;
- (7) Depression;
- (8) Dementia;
- (9) Thyroid functioning;
- (10) A healthy lifestyle; and
- (11) Any other recommendations specific to the needs of the individual.

(f) For each individual receiving services pursuant to He-M 1001, the provider shall record and report changes of an individual's health status that might be an indicator of illness to the nurse trainer as soon as possible.

(g) A nurse trainer shall maintain documentation pursuant to (a), (e) and (f) above.

He-M 1201.04 Medication Administration.

(a) With the exception of (n) below, administration of medications to individuals shall be performed by authorized providers or licensed persons only.

(b) All individuals shall be initially assessed by a nurse trainer to determine the level of support needed specific to medication administration.

(c) The assessment pursuant to (b) above shall include the individual's:

- (1) Medication order(s) and medications prescribed;
- (2) Health status and health history; and
- (3) Ability to self-administer medications as outlined in He-M 1201.05 (b).

(d) If a guardian with authority to make health care decisions has been appointed for an individual, the provider agency shall obtain the consent of the guardian prior to the implementation of medication orders.

(e) Authorized providers shall maintain a copy of the guardian's consent, including the current contact information for the guardian, in the individual's record.

(f) Authorized providers shall administer only those medications for which there is a medication order.

(g) Authorized providers shall maintain a copy of each individual's medication orders in the individual's record.

(h) Authorized providers shall administer PRN medication in accordance with:

(1) A medication order; and

(2) PRN protocols that shall be:

a. Specific written parameters for medication administration; and

b. Approved by the nurse trainer or prescribing practitioner.

(i) Authorized providers shall administer medications only to the individuals to whom they are regularly assigned or about whom they have current knowledge relative to the individual's medication regimes.

(j) The authorized provider shall obtain information specific to each medication prior to administration of medication, including, at a minimum:

(1) The purpose and effect(s) of the medication;

(2) Response time of the medication;

(3) Possible side effects, adverse reactions, and symptoms of overdose;

(4) Possible medication interactions; and

(5) Special storage or administration procedures.

(k) In the event of discovery of a medication error, or of a medication refusal, an authorized provider shall:

(1) Consult immediately with a licensed person concerning any actions to be taken;

(2) Document each medication error or individual's refusal pursuant to He-M 1201.07 (i) immediately upon discovery of the medication error or the individual's refusal; and

(3) Forward the documentation to the nurse trainer within 24 hours.

(l) In those cases where an individual has a history of medication refusal, immediate consultation and documentation pursuant to (k) above shall not be necessary if a plan has been written by the authorized provider and nurse trainer that includes the actions to be taken to address the refusal and has been approved by the prescribing practitioner and, if applicable, the individual's guardian.

(m) The authorized provider shall maintain copies of medication errors and medication refusal reports in each individual's record.

(n) In family residences where no more than one individual is receiving services from an area agency, medication administration shall comply with He-M 1201 or Nur 404 as determined by the nurse trainer.

He-M 1201.05 Self-Administration of Medication.

(b) An individual who wishes to self-administer medication(s), with the approval of his or her guardian, if applicable, shall be assessed by a nurse trainer and determined to be capable of self-administering medications if the individual demonstrates the ability to do the following:

- (1) Identify each medication;
- (2) Indicate the purpose of each medication;
- (3) Indicate the dosage, frequency, time, and route of administration for each medication;
- (4) Understand the potential consequences of not taking the medication or of not taking the medication properly;
- (5) Indicate circumstances for which assistance should be sought from licensed persons; and
- (6) Seek assistance, if needed, from licensed persons.

(c) For individuals who wish to self-administer medication but do not demonstrate the ability pursuant to (b) above, the provider agency shall:

- (1) Document in the service agreement the individual's need for education in order to self-administer medications;
- (2) Initiate education that includes, minimally, the components outlined in (b) above; and
- (3) After the individual has received the education in (2) above, require a licensed person or authorized provider to directly supervise the individual self-administering medications to prevent medication errors and to evaluate the individual's capability to self-administer medication.

(d) The nurse trainer shall assess individuals who self-administer medications to determine the individual's continued capability to self-administer medications:

- (1) No later than last day of the 12th month from the date of the prior assessment; or
- (2) More frequently if the individual begins to demonstrate that he or she does not meet the criteria in (b) above.

He-M 1201.09 Quality Review.

(a) Within the scope of Nur 404, the nurse trainer shall remain the single authority over compliance with (b)(1) and (d) below.

(b) For all individuals whose medications are administered by authorized providers, a registered nurse or licensed practical nurse shall perform a review that includes the following:

- (1) Elements specified in Nur 404.05 (c)(1)-(3);
- (2) Controlled drug inventory pursuant to He-M 1201.07 (f); and
- (3) Medication storage to ensure compliance with He-M 1201.08.

Appendix B

SUMMARY OF HEALTH AND SAFETY-RELATED ADMINISTRATIVE RULE REVISIONS FOR DEVELOPMENTAL SERVICES

Rights Protection Procedures for Developmental Services rules, He-M 202, were revised as follows:

- Stated the responsibility to report issues to BDS more affirmatively;
- Required annual training for complaint investigators; and
- Established an independent complaint investigation process.

Eligibility and the Process of Providing Services rules, He-M 503, were revised as follows:

- Created an “advanced crisis funding” category to serve individuals in crisis and in need of immediate services;
- Required Area Agencies to take certain actions to support an individual even though funding is not currently available; and
- Revised the services waiting list so that criteria are stated more simply and clearly and area agencies are given discretion in weighing priorities among individuals.

Certification Standards for Developmental Services – Community Residences Rules He-M 1001 was revised as follows:

- Required immediate notification of service coordinator in the event of an emergency;
- Set forth specific requirements regarding a provider’s responsibility for an individual’s food and fluids;
- Expanded the fire safety assessment to include consideration of an individual’s risk factors;
- Required a fire safety packet in residences;
- Extended the timeframe for providers to gather certain personnel information when an emergency placement is made;

- Expanded the safety checks on staff prior to hiring to include checking the BEAS registry and DUI convictions;
- Required carbon monoxide and hard-wired smoke detectors in homes;
- Expanded the mortality notice and review by BDS;
- Established the Sentinel Event reporting process;
- Required the provider to learn the signs and symptoms of dehydration specific to the individual;
- Required notification of the individual and guardian if someone smokes in the home;
- Established a transition review by a nurse to check for adverse changes in an individual's health or behavior after a change in residential services;
- Expanded the requirements on evacuation drills;
- Specified that certain health and safety documents are transferred between service providers; and
- Required the residence administrator to notify the nurse trainer of any deficiencies.

Healthcare Coordination and Administration of Medications rules, He-M 1201, were revised as follows:

- Established a healthcare coordination program to assist with reviewing an individual's level of support; and
- Increased the frequency of quality reviews for individuals beginning services or for individuals receiving services in a new setting.

Appendix C

ACTION TAKEN BY BDS AND AREA AGENCIES IN RESPONSE TO SPECIFIC INCIDENTS DETAILED IN THE WHITE PAPER

As a result of two accidental deaths in the 2006 Tilton fire, BDS/DHHS requested and was appropriated significant funding for: (1) interconnected smoke detector upgrades in all levels of approximately 1,000 existing certified residences statewide; (2) ensuring the adequacy of each individual's bedroom second means of egress including the installation of larger windows as needed; (3) installation of at least one carbon monoxide detector on each floor; and (4) new homes coming online in the future to meet the above measures.

In addition, a statewide fire-safety training was conducted at the Grappone Center in Concord in 2007, which included Area Agencies, subcontractor agencies, and DHHS personnel including the Bureau of Health Facilities and BDS staff. All staff and providers completed the fire safety training, with the "Fire Power" video used as a key piece in the training. To ensure ongoing fire safety training, an orientation module for fire safety was developed for all new staff and providers.

Within each Area Agency, the regional local fire departments were contacted to establish an agency contact person to provide information regarding certified residential homes in the area, discuss any concerns and establish lines of communication for training needs. In addition, program supervisors conducted fire drills at each residence along with providers and staff to observe and provide any additional training or address any issues that arose. Unannounced fire drills have occurred, with an agency-wide expectation of implementing future unannounced drills including unannounced nighttime drills.

The Lakes Region Community Services (LRCS) Area Agency took several steps in recent years, in part in response to the 2006 Fire, to address health and safety concerns of the individuals it serves. These steps include:

- Conducting unannounced nighttime fire drills in each of the certified homes on an annual basis;
- Requiring Enhanced Family Care (EFC) providers to have people in the home necessary to evacuate at all times;
- Communicated to each fire chief in each town that we had certified residence(s) that we have a certified residence in his/her town.
- Developing and conducting a health assessment for all individuals who live in EFC homes, and beginning to conduct assessments for those who live in a staffed home. As part of this process, providers identified what health conditions might occur that would limit their ability to support the individuals in their home. Providers also identified the information needed by hospital personnel to support individuals appropriately. Providers also identified any adaptive equipment, such as bars in the bathroom, which would be beneficial for the individual in their homes.
- Creating a Nurse Specialist Position to help coordinate the medical care with the direct support staff;
- Holding a medical appointment training for direct support staff and home providers;
- Providing continuity of care by requiring a LRCS staff member to attend all medical appointment when an EFC provider has given notice to end services;
- Holding a Consumer Operations meeting twice a month in which Directors screen for and review those individuals who are risk or have a complicated situation; [this was already a standing meeting, we expanded the attendance, scope, and participation.](#)
- Electronically documenting all nursing contacts for review by all nurses and appropriate team members;
- Training all EFC providers and staff to complete the health status indicators checklist on a quarterly basis;
- Training by the fire department was offered to individuals who live independently regarding what it would be like to be in a fire and how to respond; and

- In order to alleviate their fear, individuals who might be frightened by firefighters if they came into the home while fighting a fire were introduced to firefighters dressed in firefighting garb.

Community Bridges Area Agency likewise took several steps in recent years, in part in response to the 2009 Fire, to address health and safety concerns of the individuals it serves. The Agency:

- Created a fire safety information packet and provided it to the families that it serves;
- Discusses with families the need for smoke detectors and overall health and safety concerns as part of the He-M 521 certification process;
- Conducts unannounced fire drills and a departmental review of the homes that present safety concerns;
- Provides training for its Service Coordinators on guardianship, statewide service coordination, and Social Role Valorization and individual rights;
- Receives regular ongoing and immediate feedback regarding incident reports from its Quality Improvement Department;
- Requires additional training on providing proper information and advocacy on the appeal rights of individuals who receive services; and
- Requires additional training on providing proper intervention when rights protection is in question.

Similarly, the Moore Center has taken a number of steps, in part in response to a 2010 choking death, to address health and safety concerns of the individuals it serves. These steps are briefly described below.

- The Moore Center initiated a formal process to review the files for the agency's most involved, complex or fragile consumers. The review process focused on identifying the recommendations made by medical and other experts, and from auditing each client's current annual service and/or Behavioral Medical /Safety plan to ensure that the experts' findings and recommendations were being appropriately addressed. The review also identified if updated or additional assessments were needed. The Moore Center has completed a review of all client files and addressed the issues or concerns identified by the review.

- The Moore Center reorganized its Case Management Department, and appointed a Preventative Services Director to evaluate complex individuals with high-risk needs.
- The Moore Center retained an independent management consultant to help review the vendor's policies, procedures & forms/tools related to client documentation, caregiver/provider training and risk assessment. The review was designed to identify areas of concern, to address them and to identify processes and practices for enhancing the agency's oversight of vendors. The focus of the review was on client safety and quality of care.
- The Moore Center completed a Health and Behavioral survey of all its adult clients who are provided with Case Management services. The results identified current health and behavioral issues or needs to address. Those needs have been addressed.
- A brief checklist was developed with and for case managers to use during their monthly contacts with providers. Checklists are designed to ensure that salient questions are regularly and uniformly posed to providers, on a monthly basis, about a client's health and behavioral needs. The purpose of the checklists is to systematically prompt providers to identify whether a client's needs may have changed, whether new or different needs may have arisen or a particular approach (behavioral, medical) may need to be reassessed; and to document that such systematic oversight is being provided.
- The Moore Center is also part of a pilot project with BDS to evaluate a Screening Tool that will detect health destabilization early based on objective criteria. This tool will develop baseline information about the health of the individuals screened and suggest supports and services to address needs. The state will be conducting this pilot between January and March. 300 individuals will be screened 100 of which are Moore Center clients.
- To enhance our ability to serve clients with complex behavioral needs, the Moore Center contracted with BDS and the Institute of Disability to provide advanced training to its case managers. The purpose of the training is to enhance our case managers' ability to identify and address complex behavioral issues. The Moore Center is working directly with Dr. Joan Beasley and Robert Scholz at the Institute on Disabilities to enable it to better evaluate, assess, and serve clients with multiple needs. The area agency has re-contracted with the Institute for another year of training and support.
- Case Managers receive training provided by Judith Guertin, RN Nurse Manager for Moore Center Services, on identifying and addressing "eating" and related choking issues.
- The Moore Center investigated a detailed training module, together with protocols, on identifying when a client may present with a risk of choking and how to respond to and reduce that risk. The Moore Center is incorporating the module into The College

of Direct Support, CDS curriculum (CDS is a required web based training system mandated by Moore Center for all Direct Support Staff, Case Managers and vendor agencies).

- The Moore Center updated its sentinel-event procedure and trained all case managers in the notification, documentation and follow up requirements.
- Staff and vendors were trained on the need for detailed and timely incident reports and appropriate follow-up and documentation of such.
- The Moore Center is developing new protocols and checklists to enhance its ability to monitor the performance of its vendors and providers. The checklists and protocols are intended to assist our case managers and the agency to provide an even higher level of oversight.
- The Moore Center engages in ongoing communication with provider agencies to address individual client needs, including identifying when funding for clinical assessments and treatment, home modifications and extra staffing support may be needed and to address how to effectively prepare and review behavioral plans.
- The Moore Center issued a bulletin to all vendor agencies stating that child proof locks should not be used as a protection device for adults in securing items that must be kept out of the reach of the adults they serve.

Northern Human Services Area Agency likewise took several steps since the 2000 incident to address health and safety concerns of the individuals it serves. The Agency:

- Established a "Protocols for New Homes or Changed Placements" process;
- Began periodic documented visits to new homes to make sure that the transition was successful;
- Developed a thorough Home Provider Orientation process;
- Created "Steps to Moving a Client" and a "Transitional Visits" documented checklist used by our housing, nursing and service coordinator staff; and
- Worked with the BDS Nurse Trainer to provide training to the staff and Home Providers regarding medical issues to be aware of during transitions, such as ensuring that the person stays properly hydrated.
- Conducted unannounced nighttime fire drills in each of the certified homes on an annual basis;

- Required and verified that Enhanced Family Care (EFC) providers have people in the home necessary to evacuate individuals at all times;
- Developed and conducted a health assessment for all individuals who live in EFC homes, and began conducting assessments for those who live in a staffed home;
- Utilized Nurse Specialist Positions to help coordinate the medical care with the direct support staff;
- Discussed with families the need for smoke detectors and overall health and safety concerns as part of the He-M 521 certification process; and
- Receives regular ongoing and immediate feedback regarding incident reports from local Safety Committees.

One Sky Community Services Area Agency likewise took several steps since the 2004 incident to address health and safety concerns of the individuals it serves. The Agency:

- Developed an extensive Corrective Action and held frequent well-documented meetings with provider agency involved in the incident. This also included hiring a consultant to perform an extensive review of that agency's management structure and operations. When the agency did not meet the expectations of the Corrective Action, their contract was ended in January 2006 and they went out of business. This step involved extensive efforts to inform guardians and assure a smooth and safe transition to a different provider agency.
- Visited all homes operated by that provider agency to assure all other individuals receiving supports needed. The Associate Director and Nurse trainer conducted the visits.
- Hired a Nurse Trainer to help oversee supports to individuals with significant health issues.
- Developed and maintained a list of all 'frail' individuals served by the agency.
- Developed standard form for Service Coordinators and provider agency managers to guide observations and report on home visits. The forms are reviewed by Director of Service Coordination.
- Conducts 'System Reviews' by the Nurse Trainer for 18-24 individuals a year with a focus on frail individuals, homes with significant certification concerns, and other concerns raised by Service Coordinators. Nurse Trainer visits the home, the individual, the care providers and the provider agency program manager. Written feedback is given to the provider agency, Service Coordinator, and Area Agency management with a response required for any concerns.

- In 2008, presented “Assuring Excellent Health Care for Persons We Serve” to all Nurse Trainer’s, provider agency program managers and to One Sky staff.
- Provide annual review of fire safety to individuals receiving Community Support Services from One Sky.
- Expanded Health and Safety curriculum to include the ‘Fire Power’ video for all staff.
- Provided the booklet called “Fire in Your Home” to all provider agencies and all home providers in the region. “Fire in Your Home” booklet is also given to families with He-M 521 certified services in the home. The agency discusses with the family the importance of fire safety awareness along with encouragement to watch Fire Power video.
- Annually review emergency planning and crisis plans with all provider agencies.
- Reviews all Sentinel Events with the Executive Director, Associate Director, Direction of Service Coordination and Board Quality Assurance Committee.
- Reviews all incidents involving falls and injuries with the Nurse Trainer, Associate Director and Director of Service Coordination on ongoing basis.
- At least every other year, the Nurse Trainer provides information to all provider agencies, Nurse Trainers and Service Coordinators about: dysphasia, fall prevention, and data for falls and injuries in the region.
- Since 2006, reviews high-risk individuals with the Preventive Services Committee review.
- Provide a series of Socialization and Sex Ed classes by the Nurse Trainer over many months for individuals first identified by Service Coordinator’s.
- Assured all funding earmarked for increased to direct service providers and home providers was used that way by all provider agencies.
- Each year offer to fund one direct service provider from every vendor to attend annual Direct Service Provider Conference.
- Uses the College of Direct Support for direct service providers and home providers.