DEPARTMENT OF ECONOMIC SECURITY

Your Partner For A Stronger Arizona

DIVISION OF DEVELOPMENTAL DISABILITIES

Sent on Behalf of DES/DDD

QUALITY MANAGEMENT BULLETIN - AUGUST 2023

Target Audience - Qualified Vendors and Providers

Transmittal Date - 08/11/2023

Hello and welcome to monsoon weather in Arizona; perhaps the hope for rain will help everyone forget about July's heatwave! This month's bulletin will be focused on transportation safety issues, as well as some trends the Quality Management Unit (QMU) has seen as incident reports, including triggering antecedent behaviors and Article 9 violations.

Article 9

Article 9 is a statute that solely focuses on protections for the people who the Division serves. The statute defines the appropriate measures to take–and not take–when interacting with those for whom you care. As you may know, green-light techniques are positive teaching techniques; yellow-light techniques are those which may require force, limit rights, and require Program Review Committee approval; and red-light techniques are prohibited measures, such as seclusions and restraints. The main focus should be on using the least restrictive and least forceful techniques to interact with people.

Recently, the QMU received reports on restrictive measures being used inappropriately when a behavior occurs. Extreme restrictive measures, such as physical measures that prevent the movement of the individual in a forceful manner, are prohibited, except in cases to prevent injury or harm to a member or staff. Many incidents could have been prevented if the triggering behaviors were recognized earlier and trauma-informed, de-escalation techniques were used to calm the situation. De-escalation techniques, which reside in the green-light section of Article 9, would have likely prevented the incident.

The Division recognizes there may be times when the incident occurring requires a yellow-light restrictive technique as an emergency. If a direct care worker needs to use a more restrictive technique more than once in a 30-day period, then a behavioral plan must be put in place and approved by the PRC to allow for these techniques when needed. Close follow-up with updating the behavioral plan regularly is also essential.

Overall, careful consideration and the use of green-light measures, de-escalation and trauma-informed discussions with a focus on the members' needs will likely decrease problem behaviors. These techniques will also strengthen the relationship between caretaker and member.

Transportation

Recently, the Division had a few incidents of inappropriate safety measures that took place while driving members to and from various locations. This includes inappropriate securing of wheelchairs, heat-related issues, and member-to-direct-care-worker ratios in the vehicle.

Firstly, wheelchairs should be appropriately affixed to the vehicle using the built-in locking mechanism and straps to prevent it from rolling while the van is in motion. The Division recommends having a checklist every time a person who uses a wheelchair is being transported, as well as a two person check-out. This ensures multiple eyes on the process to prevent steps from being missed. This regular checking will decrease the incidents of injuries occurring while transporting these members.

Secondly, when dropping individuals off at their day programs, please ensure a “warm” handoff to another direct care worker. Members waiting outside in the extreme heat could be detrimental, especially if they are on medications that make them heat-sensitive. Dropping members off at their destinations outside also puts them at risk of elopement.

Thirdly, there have been recent incidents where the member becomes agitated during transport. In these cases, the member has attacked the driver or tried to exit the vehicle while it’s in motion. It is dangerous for both the member and the driver if a second caregiver is not in the van during transport. Consider the use of appropriate ratios in the vehicles when transporting individuals. This protects the driver, as well as the member from possible harm caused by trying to exit a moving vehicle. Ideally, if the member has a 1:1 enhanced ratio, it would allow the driver to fully focus on driving, creating a much safer situation for everyone involved. If you believe the member would benefit from additional support during transports, please discuss this during the planning meeting and document it in the Person-Centered Service Plan.

Incident Reporting and Fact Finding

The new Incident Reporting Form was implemented on August 1, 2023; please be sure to use the new form moving forward. For fact-finding, the Division is continuing its seven-business-day timeline for requesting documents when an incident occurs. As a reminder, the Division may request a shorter response time, typically one or two business days, for serious or time-sensitive incidents.

It is important the Division receive the requested documents within the stated timelines to allow its investigative nurses to complete the investigation and make the proper determinations. If the requested documentation is not received, the Division will continue investigating based on the information available. To assist in requests, please ensure your Quality Management contact person is updated in the CAS system. The Division will be discontinuing the reminder letter in the mail, as it was determined by vendors’ opinion to be unnecessary.

Again, thank you for continuing to care for the DDD community and for your continued collaboration.

If you have any questions, please reach out to one of the District emails below. DDD is here to help guide you through the fact-finding process, as well as work with you as a team to continue supporting those the Division serves.

- District Central - DDDCentralIR@azdes.gov
- District East - DDDEastIR@azdes.gov
- District North - DDDDistrictNorthIncidentReports@azdes.gov
- District South - DDDD2IR@azdes.gov
- District West - DDDWestIR@azdes.gov