DEPARTMENT OF ECONOMIC SECURITY

Your Partner For A Stronger Arizona

DIVISION OF DEVELOPMENTAL DISABILITIES

Sent on Behalf of DES/DDD

QM NEWSLETTER - OCTOBER 2023

Target Audience - Qualified Vendors and Providers

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Hello! Happy Pumpkin Spice month to everyone. October finally brings us cooler morning temperatures and pumpkin-spice flavored everything, which can get scary at times! This month we will be discussing medication management, vehicle safety–including childproof locks–as well as efficiency in remediation.

Medication Management

Recently there have been incidents of medication management errors. The focus today is on transcription errors into the medication administration record (MAR) as it pertains to dosing instructions and understanding generic and brand name medications.

When an order for change of dosing is received, whether verbal or in writing, it is essential that all previous orders be reconciled and canceled. For example: if a medication was originally twice a day, then changed to once a day, this must be indicated on the MAR. Then, the previous twice-a-day order must be removed. If not, this leads to incidents of potentially life-threatening overdoses of medications.

Also, recent incidents have revealed an apparent lack of understanding of a generic medication name and its brand name. For example: Dilantin is the same medication as phenytoin. If it is not understood that these are the same medication and both are represented on the MAR, this becomes a high-risk situation and can lead to a potentially lethal double-dosing of a medication.

In the Arizona Administrative Code Title 6 Chapter 6, there is a requirement to house a pharmacy reference manual written in layman's terms in the group home. This manual provides direct care workers a reference when comparing medications on a MAR and helps them to understand drugs' potential alternate names, potential side effects, typical dosing instructions, and drug interactions. Keeping this resource and using it when training on MAR reconciliation will be instrumental in reducing medication documentation errors. Here is the rule:

- *R6-6-806.H is to require the availability of resource information on all prescribed medications in the community residential setting. The resource information may be in the form of a general reference book on medications (The Pill Book and The Guide to Prescription Drugs are examples); it is recommended that the resource guide be written in non-technical, layperson's terms. Direct care staff who are responsible for administering medication, should be familiar with the location and purpose of the resource information.*

Vehicle Safety Tips

When transporting members who have a history of engaging in unsafe behaviors during transport (physical aggression toward others, attempts to exit the vehicle, etc.), it is important to have a current, approved

behavior plan in place to help support both the member and staff.

There are some universal safety strategies that are recommended for vehicle safety when transporting members.

Prior to Departure

- Have a destination in place.
- If it is hot outside, start the vehicle early enough to cool down prior to leaving.
- Have a first aid kit and water bottles available.
- Seating arrangements - have the member sit furthest away from the driver.
- Ensure the member has items to keep occupied during the ride.

During the Ride

- The driver should drive in the right lane so they are able to pull over quickly. If in a turn lane, after turning, get in the right lane when safe to do so.
- Prime the member of what to expect or what is happening during the ride (narrating as you drive, “We are going to turn right”, “there’s a speed bump, hold on”, etc.).
- If you see an unexpected lane change, traffic jam, or detour, state it calmly.
- Engagement during rides - ask the member for direction help, play games like “ I SPY”, be aware of potential triggers, and avoid them if possible.

If You Need to Pull Over

- Pull the car over into a safe position (off the shoulder, out of the street, away from busy entrances/exits if possible).
- Turn on the hazard lights.
- Engage the emergency brake.
- Keep the car and AC on.
- Once the driver parks and is in a safe place, the driver can support as needed.

For members who engage in unsafe behaviors during transport, and less restrictive options are not effective in keeping the member and others safe, the following can be considered:

- *Enhanced staffing ratios* - Additional staff to support the member 1:1 during transport. If a member has an enhanced staffing ratio, there must be one staff member in addition to the driver. The driver is **not responsible** for managing or supporting unsafe behaviors while driving.
- *Use of child safety locks during transport* - Child safety locks can be considered as part of a member’s behavior plan if there is past history of the member trying to exit the vehicle while in motion. Child safety locks are considered a rights restriction, and in order for PRC to consider use, the rights restriction template must be completed in the DDD standardized behavior plan template. With any restriction (yellow light technique), PRC must review and approve prior to implementing child locks.
- *Use emergency measures* (prevention and support vehicle restraint) if there is an immediate safety risk to the individual or others.

PRC offers technical assistance to planning teams and behavior-plan writers. To request a technical assistance meeting, please contact your District PRC Chair or by emailing DDDPRCAdministration@azdes.gov.

Submit Remediation with Fact-Finding

A Reminder: Vendors can potentially fulfill remediation requirements by submitting anticipated remediation documents along with the requested fact-finding documents. Vendors and QOC investigative nurses see many of the same kinds of incidents and there are common remediations that are usually required for these incidents. If a vendor recognizes this, then the resolution of an investigation can be expedited by submitting this information with fact-finding documentation.

For instance, in the aforementioned incident of medication errors, vendors will report missing a medication dose or a documentation error to the Division. Conclusion of the investigation substantiates the allegation, and the RN requires the vendor to retrain staff on safe medication administration policies.

The vendor can speed up the process by initiating staff training independently and submitting the training materials, sign-in sheet and policy as part of the QOC fact-finding process. In most cases, the nurse will accept this and indicate as much in the Corrective Action Plan (CAP) letter you receive.

Just remember, training is a continuous journey, and the intent of remediation is to avoid or mitigate the occurrence of the event in the future. Therefore, training should be collective and not directed to just one Direct Care Worker, but also inclusive of any staff involved in the care of the specific member(s).

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.

- 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