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# Adult Protective Services

The purpose of Chapter 23c is to outline Quality Assurance and Quality Improvement activities for the Adult Protective Services (APS) Division.

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### *Ask an Expert*

For Quality Assurance related questions, please email the Adult Protective Services Quality Assurance Team at [APSQAUnit@dshs.wa.gov](mailto:APSQAUnit@dshs.wa.gov).

## **QUALITY ASSURANCE OVERVIEW**

Starting January 2016, Adult Protective Services (APS) Headquarters (HQ) Program Managers (HQ PMs) began completing Quality Assurance (QA) process reviews and entering data into the QA Monitor Tool. Additionally, in 2017 Field Supervisors and Subject Matter Experts (SME) began completing QA reviews in the QA Monitor Tool.

Timely completion of quality assurance activities helps protect the health and safety of clients and provides oversight of operations. Activities include completing QA reviews to ensure compliance with quality measures; data analysis to identify gaps in the processes being used based on QA review results; developing proficiency improvement plans and creating solutions using feedback from staff at all levels. Identified deficiencies are addressed and improvement plans are developed and monitored to ensure continuous quality improvement. Through these functions, APS will obtain more predictable outcomes that ensure protection of adults who are vulnerable with consistent and timely investigations while offering protective services, supports and referrals.

### **Statewide Quality Assurance Objectives**

1. Analysis of external and internal issues that affect the quality of service delivery that is relevant to the division's purpose and its strategic plan;
2. Evaluating and ensuring ongoing compliance with State and Federal law;
3. Ensuring that policies and procedures are clearly documented, and information is available, useable, and updated when needed;
4. Identifying areas in the process that need improvement and developing appropriate counter measures to address areas of concern at all levels – individual, local unit, Regional, and statewide;
5. Completing QA process reviews that will assess compliance with existing regulations, policies, and standards;
6. Gathering a consistent and broad range of information to identify trends, strengths, and areas for improvement across the division;
7. Identifying best practices within APS with the purpose of sharing strategies across the state;
8. Developing Proficiency Improvement Plans (PIP) with the objective of continuously improving current processes that affect the quality of service delivery and ensure the health and safety of vulnerable adults;

9. Ensuring a continuous flow of communication between all levels of APS.

## HQ QUALITY ASSURANCE UNIT PROCESS OVERVIEW

- QA process review occurs at headquarters.
- The 12-month QA Activities and Schedule is available on the [APS Intranet site](#).
- A statistically significant sample is pulled for each Regional/HQ area based on the number of completed Investigations and Investigations Closed No APS that were processed for each Region in an annual time period.
- A statistically significant sample will be pulled for screened-in intakes and screened-out intakes that were processed for APS Central Intake within an annual time period.
- QA Review Entrance letters are sent at the start of each process review cycle.
- An Exit Conference may be conducted via Microsoft Teams at the completion of the review.
- APS Central Intake and the Regions have 30 business days from receiving the initial QA proficiency reports to complete the necessary remediations and to also submit change requests.
- APS Central Intake and the Regions then have 5 business days to complete remediation if necessary for findings that were upheld by the change committee.
- APS HQ QA PM(s) conduct a 30-day HQ QA review to document remediation.
- Issues identified in the 30-day HQ QA Review as not fully remediated must be completed immediately by APS SME/QA Representative.
- APS HQ QA PM(s) complete the Final Report which is a summary of all QA Unit finding.
- A Proficiency Improvement Plan (PIP) will need to be developed for QA questions designated by APS Director and/or the Aging and Long Term Support Administration (AL TSA) Assistant Secretary.

### QA Review Schedule

A QA review schedule will be distributed through a Management Bulletin prior to the annual review cycle. The schedule will include the following activities:

1. APS Central Intake's and each Region's review cycle and timeline
2. Exit Conference date
3. APS Regional/Central Intake 30-day Remediation & Change Requests
4. Final Report due date
5. PIP due date

## Sampling Overview

The number of QA reviews being completed will be based on the number of investigations that were processed for each Region per year. The number of QA reviews being completed for intake will be based on the number of screened in and screened out intakes processed by APS Central Intake per year. The QA team uses Raosoft's Sample Size Calculator to determine statewide sample sizes. The QA unit applies a margin of error of 5% and a 95% confidence level for investigations, and a margin of error of 3% and a 95% confidence level for intake.

- Regional data sample ratios of 60% Investigation and 40% No APS are used for each review type.
- APS Central Intake data sample ratios 30% Intake Screen-Out and 70% Intake Screen-In are used for each review type.
- The sample will be pulled from the three months after the PIP interventions are completed if possible.
- Regional sample is based on the percentage of cases closed by unit during the time frame.
- The random sample of cases to be reviewed are then generated by usage of the RAND function in Microsoft within the DataMart tool.
- This sampling process repeats for each Region and APS Central Intake.

### Sampling Examples:

6,900 Investigations and Closed No APS for Region X, during designated period of time

6,900 entered into RaoSoft = 364 (statistically significant sample)

$364 \times .60 = 218$  Investigations

$364 \times .40 = 146$  No APS

Total investigations in designated period of time = 4,075

Total Closed No APS in designated period of time = 2,825

Unit A closed 5% of 4,075 Investigations and 7% of 2,825 Closed No APS.

- Sample size calculation size for Unit A:
  - $218 \times .05 = 11$  Investigations,
  - $146 \times .07 = 10$  Closed No APS

Unit B closed 1% of 4,075 Investigations and 2% of 2,825 Closed No APS.

- Sample size calculation size for Unit B:
  - $218 \times .01 = 2$  Investigations,
  - $146 \times .02 = 3$  Closed No APS

Unit C closed 7% of 4,075 Investigations and 3% of 2,825 Closed No APS.

- Sample size calculation size for Unit C:
  - $218 \times .07 = 15$  Investigations,
  - $146 \times .03 = 4$  Closed No APS

9,525 total intakes processed during X timeframe

9,525 entered into RaoSoft = 370 (statistically significant sample)

$370 \times .30 = 111$  Screen Out

$370 \times .70 = 259$  Screen In

## **QA Review Process Review Schedule**

The QA Review Process Review Schedule is sent prior to the monitoring of each area and provides information about:

1. The review process
  - a. Changes to the review process, tool, or questions from the previous year
  - b. The number of investigations/intakes to be reviewed
  - c. Schedule
  
2. Due Dates
  - a. Exit Conference
  - b. 30-day Remediation & Change Requests
  - c. Proficiency Improvement Plan (PIP)

## **Exit Conferences**

1. Exit Conferences will be held via Microsoft Teams with the following staff:
  - a. HQ staff, including the APS Office Chief, Training, Policy & Intake, Deputy Director, Director and AL TSA QA Senior Administrator
  - b. Regional/APS Central Intake Management and line staff
  
2. The QA Unit presents the following in PowerPoint format:
  - a. What the QA Unit reviewed;
  - b. Case breakdown by review type;
  - c. QA questions that met or exceeded proficiency;
  - d. QA questions that did not meet expected proficiency;
  - e. Why proficiency was not met;
  - f. Trends
  
3. 30-day Remediation, Change Request process, and PIP due dates

## **30-Day Remediation**

Remediation is required on QA findings at the individual level.

1. All QA findings that require remediation must be completed within 30 business days from the date that proficiency reports are received. Remediation documentation completed by APS Central Intake and the Regions is analyzed by the APS HQ QA PM(s) during the HQ 30-day remediation review.
  
2. Remediation completed by APS Central Intake and the field must be documented in a Review Cycle Note (RCN) when an action is completed to remediate findings. Using the “Initial Review” drop down, the Review Cycle Note (RCN) must include information about how the finding(s) was remediated.

3. All QA findings that are still outstanding at the HQ 30-day remediation review will be reviewed with the SME or QA Representative, who will then be expected to have the QA finding fully remediated.
4. The SME or QA Representative must inform the APS HQ QA PM(s) when the finding is fully remediated so that final analysis can be completed.
5. All remediation not completed within the time frame that cannot be resolved will be forwarded to the Executive Management team for action.

### **Change Request Committee Review**

The intent of the Change Request Committee review is to interpret policy, make decisions on change requests, and make recommendations if policy is not clear.

1. Change Request Committee Members:

- a. Deputy Director of APS;
- b. APS Office Chief, Training, Policy, & Intake;
- c. APS Office Chief, Legal & Records
- d. APS HQ QA PM(s);
- e. APS Senior Policy Advisor
- f. QA Regional or QA Central Intake Representative(s)

2. Change Request Process:

- a. Prior to submitting a change request, the SME/QA Representative will verify in the [SharePoint database](#) if the finding in question has been previously heard by the Change Request Committee and thus a precedent-setting decision was made.
- b. For change requests that may be taken to the Change Request Committee, the SME/ QA Representative will document the requested change in the Review Cycle Notes (RCN), using the “Change Request” drop down. The APS HQ QA PM(s) will review the requests.
- c. APS HQ QA PM(s) review the issue and make corrections if a review error has been made. Consultation with the APS HQ policy team may occur if needed for clarification.
- d. The APS HQ QA PM(s) reviews prior decisions by the Change Request Committee. If the issue is the same and policy has not changed, the APS HQ QA PM(s) will make the change based on the Change Request Committee’s prior decision. These issues are not forwarded to the committee.
- e. Issues not corrected by APS HQ QA PM(s) that have not had a previous decision are forwarded to the Change Request Committee and documented on the Change Request Committee Review spreadsheet located in the [SharePoint database](#).
- f. The APS HQ QA PM(s) schedules the Change Request Committee Review meeting with at least a one-week advance notice of the meeting date according to the QA calendar. All

change request documents will be sent to the committee members for review 7 business days before meeting.

- g. The APS HQ QA PM(s) invites the appropriate staff who may attend via phone or in person.
- h. The Change Request Committee:
  - i. Reviews the change request documentation;
  - ii. Hears the Region or Central Intake QA representative's analysis;
  - iii. Hears the APS HQ PM(s) analysis; and
  - iv. Makes a final decision based on policy
- i. If a decision cannot be made within the Change Request Committee, the Deputy Director of APS will have it addressed with the Director of APS whose decision is final.
- j. The APS HQ QA PM(s) documents the committee decision in the RCN.
  - i) If the QA finding is overturned, the APS HQ QA PM(s) will change the "no" to a "yes" or "N/A".
  - ii) If the finding is upheld, the SME/QA Representative will ensure that any appropriate remediations are completed within 5 business days of the Change Committee meeting.
- k. The APS HQ QA PM(s) documents the decision on the Change Request Committee Review spreadsheet located in the [SharePoint database](#).
- l. If changes to policy are recommended, the Director of APS will identify who will be responsible for follow-up and response to, or completion of, the recommended policy change.
- m. At the end of the review cycle, the APS Deputy Director and the Director of APS review the change requests for possible impact on the next review cycle.

### **Final Report Summary**

1. After the HQ 30-day remediation review, the APS HQ QA PM(s) prepare the "Final Report Summary" which includes:
  - a. Attachments of the proficiency reports
  - b. The Proficiency Improvement Plan template; and
  - c. Root cause analysis instructions
2. The QA Unit Manager who also is the supervisor of APS QA staff, reviews and signs the report
3. The APS HQ QA PM(s) sends the signed Final Report to the SME/QA Representative and Regional Administrator within 30 calendar days after completion of the HQ 30-day remediation review.

## **Proficiency Improvement Plan (PIP)**

Both APS HQ, APS Central Intake and the Regions are responsible for developing and implementing a PIP when requested by the APS Director. APS QA HQ PM(s), and other HQ APS staff are available to assist in development and revision of the PIP.

1. Action is required for PIP development (based on initial findings). A PIP is **not** required for the current QA Unit review cycle:
  - a. When proficiency is reached on all QA questions.
  - b. When the APS Director has requested HQ to develop a PIP on a QA question that does not meet proficiency at a statewide level.
  - c. For any QA question(s) designated by APS Director and/or the ALTSA Assistant Secretary to not require a PIP even if expected proficiency is not met for the current QA review cycle.
2. PIP development and completion is the responsibility of the Region, unit, or area where the proficiency level was not met. Regions and Central Intake will work with APS QA Unit Manager on data analysis and PIP development.
3. APS Executive Leadership Team will identify items that need to be addressed at a statewide level and develop a HQ PIP if necessary. Information about the HQ PIP status will be maintained on the [QA intranet site](#).
4. APS Central Intake and the Regions are required to address all other items that did not meet proficiency except those items being addressed in the HQ PIP or otherwise indicated by APS Director or ALTSA Assistant Secretary as not required for current QA review cycle. Items being addressed by APS HQ may also be addressed on a local PIP if focus is wanted on improving local proficiency. APS Central intake and the Regions will support and reinforce strategies to increase proficiency and supervisors will continue to work with individual staff to increase proficiency in identified areas.
5. The PIP is due to the ALTSA QA Senior Administrator within 30 business days from the date the Final Report summary was emailed to the QA contacts. APS QA HQ PM(s) tracks the time frame, follows up and offers assistance if not received on time.
6. HQ Review and Approval
  - a. The PIP should be submitted directly to the APS Deputy Director who will review and provide feedback if necessary. The APS Deputy Director will submit the PIP to the ALTSA QA Senior Administrator by the HQ QA PIP due date that is listed on the QA Review schedule.
  - b. The APS Deputy Director will be contacted via email by the ALTSA QA Senior Administrator if there are recommended changes. If changes are needed, the revised document is returned to the APS Deputy Director within 5 working days.
  - c. The APS Deputy Director will provide the revised document to the ALTSA QA Senior Administrator within 5 working days of receiving it.



- d. If recommended changes are accepted, the APS Deputy Director will submit the signed PIP to the ALTSA QA Senior Administrator.

## 7. Reporting Progress

- a. APS Central Intake and Regions
  - i. Progress reporting is unique to each item within the PIP
  - ii. APS Central Intake and the Regions completes the “Check and Act” sections and sends it to the APS QA HQ PM(s), when due. If the progress report is not received on time, the APS QA HQ PM(s), will follow-up with the SME/ QA representative and notify Executive Management if necessary.
- b. HQ
  - i. Upon review of the progress report the APS QA HQ PM(s), or other management staff may share other ideas or strategies for quality improvement.
  - ii. The APS QA HQ PM(s), reports the HQ PIP status on an “as needed” basis to management at regularly scheduled Executive meetings.

## APS CENTRAL INTAKE & REGIONAL QUALITY ASSURANCE REVIEW

The QA reviews completed by APS Supervisors and SMEs in the Regional offices and APS Central Intake are very important because they ensure staff are protecting our vulnerable adults by following policy, procedure, and conducting thorough investigations. Supervisor QA reviews help identify training and policy concerns. The supervisors review QA questions ensuring the health and welfare of the alleged victim. As a result, the Supervisor/SMEs role is a critical part of the foundation for overall APS quality compliance and consistency.

- a. APS reviewers include Supervisor(s), SHPC(s), SME(s), and PM(s).
- b. APS Supervisors and SME(s) complete reviews.
- c. Regional PM(s) may assist with reviews or assign the responsibility to a supervisor-level staff person or above.
- d. All reviews are completed within the QA Monitor Tool.
- e. All remediation activities must be completed, and the review cycle closed within 30 days of initial review.

Review activities are performed throughout the entire calendar year. Minimum review standards are in policy as follows:

### **Mandatory minimum yearly review standard for Supervisors:**

#### **Intake Supervisory Reviews:**

Selection of 5 Intakes per year, per worker

- 2 Screen In
- 3 Screen Out

**Investigation Supervisory Reviews:**

**New staff:** (probationary/trial service period):

Selection of 6 Investigations per year, per worker (3 completed in the first 6 months of employment)

- 2 Unsubstantiated
- 2 Inconclusive
- 2 No APS

**Established Staff:**

Selection of 4 Investigations per year, per worker

- 1 Unsubstantiated
- 1 No APS
- 2 Inconclusive

**Mandatory minimum quarterly review standards in each Region is as follows:**

- 10 “Closed No-APS”
- 10 Investigations (5 Unsubstantiated & 5 Inconclusive)

**\*Each Region will determine which SMEs/PMs will complete mandatory reviews.**