

AGING AND LONG-TERM SUPPORT ADMINISTRATION
RESIDENTIAL CARE SERVICES
"Transforming Lives"

CHAPTER 10 – QUALITY ASSURANCE (QA)

Quality Assurance– Overview

A Quality Assurance (QA) or Quality Management System (QMS) is a common sense approach of organizing the business and support processes that affect the quality of regulatory and service delivery. While an individual is critical to the success of the system, they are only one component. The success of any QMS relies upon clearly documented policy and procedures, adequate training, review of the processes being used, and when necessary, a plan for improvement.

The RCS QA Unit's purpose is to complete process reviews that will provide data to help identify areas for improvement, and to work collaboratively with Field Operations and Headquarters (HQ) to promote continuous improvement.

RCS must comply with the following federal regulations, WAC and RCW chapters:

- [SOCIAL SECURITY ACT 1819\(g\)\(2\)\(D\)](#)
- [SOCIAL SECURITY ACT 1919\(g\)\(2\)\(D\)](#)
- [42 CFR § 488.312 CONSISTENCY OF SURVEY RESULTS](#)
- [RCW 43.17.385 QUALITY MANAGEMENT, ACCOUNTABILITY, AND PERFORMANCE SYSTEM](#)
- [RCW 74.39A.051 QUALITY IMPROVEMENT PRINCIPLES](#)
- [SOM Chapter 7 Section 7800 – 7800.2 Consistency of Survey results: Measuring Consistency](#)

This chapter contains information about the RCS Quality Assurance process. The content is relevant to RCS staff, external stakeholders, and anyone seeking to understand how RCS QA process reviews are conducted.

SUBJECT MATTER EXPERT

QA Unit Manager, Tracey Rollins (360) 725-3226 or tracey.rollins@dshs.wa.gov

CHAPTER 10 –QUALITY ASSURANCE INDEX

This section contains the Standard Operating Procedures (SOPs) that RCS staff are required to follow for Quality Assurance. Additional sections include resources and links to forms as listed below.

OVERVIEW

[STANDARD OPERATING PROCEDURES](#)

[APPENDIX A: RESOURCES AND FORMS](#)

[APPENDIX B: CHAPTER 10 CHANGE LOG](#)

10A – QA STANDARD OPERATING PROCEDURES

This section contains the Standard Operating Procedures that RCS staff are required to follow.

A. QA PROCEDURES

1. [GENERAL GUIDELINES](#)
2. [PROCESS REVIEW SCHEDULE](#)
3. [QA QUESTION DEVELOPMENT](#)
4. [SAMPLE METHODOLOGY](#)
5. [PROCESS REVIEWS](#)
6. [EXIT CONFERENCE](#)
7. [REMEDATION](#)
8. [CHANGE REQUESTS](#)
9. [THIRTY-DAY REVIEWS](#)
10. [FINAL PROFICIENCY REPORT](#)
11. [PROFICIENCY IMPROVEMENT PLAN \(PIP\)](#)
12. [RECORD RETENTION](#)
13. [ANNUAL STATEWIDE FINAL REPORTS](#)

[Change Log](#)

[Back to Top](#)

10A1 – GENERAL GUIDELINES

BACKGROUND

The RCS QA team was developed as part of AL TSA’s Quality Management System (QMS) to improve processes within RCS. In February of 2014, six positions were approved via the Roads to Community Living grant. The original grant included a Unit Manager, four Social and Health Program Consultants (SHPCs), and one Management Analyst. The unit continues to maintain the same staffing level and was added to the RCS budget as of July 1, 2018.

The purpose of conducting QA Process Reviews is to ensure RCS licensing, inspection, certification, complaint intake, and complaint investigation processes are in compliance and continue to remain in compliance with minimum licensing standards, current RCW, WACs, and relevant federal regulation. The primary focus is on resident’s rights and their safety and well-being.

This procedure provides background information about the timing and general purpose of QA process reviews.

PROCEDURE

A. PROCESS REVIEW FREQUENCY

1. RCS conducts QA process reviews annually. For a list of the process reviews and information about the setting or program area, see section [10B1](#) of this chapter.

B. GENERAL INFORMATION – QA UNIT WILL:

1. Conduct annual process reviews to determine compliance with minimum licensing standards or federal regulations.
2. Follow all procedures to ensure consistent QA process reviews.
3. Complete process reviews in a timely manner.
4. Monitor the RCS Quality email in-box with a goal that responses are sent within two business days to all emails.
5. Clearly communicate findings and trends.
6. Minimize the disruption of daily routines for staff during process reviews.
7. Always maintain professional and respectful conduct.

DEFINITION OF ROLES WITHIN THE QA UNIT:

A. UNIT LEADERSHIP

1. Means the QA Unit Manager and the QA Management Analyst.

2. Coordinates with policy, training, and field staff to ensure QA questions are updated based on their information needs.
3. Gathers information as to how to review those questions and ensures it is available to the QA team and RCS staff prior to the start of each review cycle.
4. Spot checks the work of QA Consultants for quality, consistency, and interrater reliability.

B. PROCESS REVIEW COORDINATOR

1. The Process Review Coordinator is the QA Unit Team member who has been assigned as the contact person, liaison, and coordinator for a specific process review.
2. Communicates with the appropriate staff for the program to ensure that there is open and positive communication with each location the team will visit.
3. Ensures all information and files are available for the process review by requesting information in a timely manner.
4. Responds to or requests information from field staff or forwards requests as appropriate.

C. QA CONSULTANT

1. The QA Consultant is a member of the QA team who works with and completes reviews as directed by the QA team leadership and the Process Review Coordinator.
2. Completes process reviews in the manner prescribed in the instructions and in this chapter.
3. Works within the team to ensure all work is completed in a professional and collaborative manner.

QA UNIT MANAGER RESPONSIBILITY

- A. The QA Unit Manager:
1. Recruits, hires, and ensures that new staff are trained.
 2. Ensures staff are able to demonstrate a working knowledge of policies and procedures.
 3. Conducts periodic reviews of staff process review work to ensure policies and procedures are followed.
 4. Requests clarification from headquarters and leadership as needed.

QA MANAGEMENT ANALYST RESPONSIBILITY

- A. The QA Management Analyst:
1. Conducts periodic reviews of staff process review work to ensure policies and procedures are followed.
 2. Coordinates the statistically valid sample for all process reviews.
 3. Act as QA Monitoring Tool Subject Matter Expert for RCS.
 4. Monitors Proficiency Improvement Plans.

QUALITY ASSURANCE REVIEW

A. This procedure will be reviewed for accuracy and compliance at least every two years.

[Change Log](#)

[Back to Top](#)

10A2 – PROCESS REVIEW SCHEDULE

BACKGROUND

The Quality Assurance Unit maintains a 12 month QA Process Review Schedule which is available on the RCS [QA intranet site](#).

PROCEDURE

- A. The QA Unit Manager must publish a Management Bulletin (MB) at the beginning of each year to update the process review schedule. If the dates or the number of reviews change from the original release, staff will be directed to review the updated information on the RCS [QA intranet site](#) communicated via the *RCS Weekly Update*.
- B. The Process Review Schedule will include the following for each process review cycle:
 1. Each process review cycle and timelines;
 2. Entrance dates;
 3. Exit Conference and initial proficiency report dates;
 4. Change request due dates;
 5. Change Request Committee dates;
 6. Final Proficiency Report due dates;
 7. Proficiency Improvement Plan (PIP) due date; and
 8. Statewide Final Report due date.
- C. Click this link to view the current [Process Review Schedule](#)

QA UNIT MANAGER RESPONSIBILITY

- A. The QA Unit Manager:
 1. Ensures staff are able to demonstrate a working knowledge of this policy.
 2. Conducts periodic reviews to ensure staff are following the policy.
 3. Ensures that the QA Team Schedule is created and disseminated.
 4. Creates and disseminates the annual MB with updated process review information.
 5. Assures that weekly updates are sent for posting as required.

QUALITY ASSURANCE REVIEW

- A. This procedure will be reviewed for accuracy and compliance at least every two years.

[Change Log](#)

[Back to Top](#)

10A3 – QA QUESTION DEVELOPMENT

BACKGROUND

The Quality Assurance Unit is responsible to complete process reviews using specific questions developed by the Policy Unit, the Training Unit, and Subject Matter Experts for the area being reviewed. The questions are approved annually by the QA Steering Committee which consists of the RCS Director and all Office Chiefs.

Questions are developed based on current policies, procedures, the [ALTSA Strategic Plan](#), federal legislation, state legislation, current issues the division is experiencing, or in response to external audits. The information gathered from QA process reviews is intended to assist the division in process improvement activities and act as an internal control.

The current QA questions are found on the [QA intranet site](#) and are listed by area or program.

PROCEDURE

- A. QA Unit Leadership will meet with program, training, and area specific subject matter experts to review QA questions, the “no responses”, the remediation, and the “how to review” documents at least once each year to review, update, and revise the questions and the “how to review” documents.
- B. Once final drafts are completed, QA Unit Leadership reviews all question material with the QA Steering Committee for final approval.
- C. QA Unit Leadership updates and distributes all QA question materials.

QA UNIT MANAGER RESPONSIBILITY

- A. The QA Unit Manager:
 1. Ensures QA staff are able to demonstrate a working knowledge of this policy.
 2. Meets with program specific subject matter experts as needed to review and edit any questions, “no responses”, remediation, or instructions.
 3. Reviews all documents with QA Steering Committee for final question approval.
 4. Researches and responds to all inquiries from the QA Team regarding questions or issues with the question documents.
 5. Conducts periodic reviews to ensure QA staff are following the policy.

QA STEERING COMMITTEE RESPONSIBILITY

- A. The QA Steering Committee:
 1. Reviews all questions and “how to” documents once annually.

2. Grants final approval.

QUALITY ASSURANCE REVIEW

- A. This procedure will be reviewed for accuracy and compliance at least every two years.

[Change Log](#)

[Back to Top](#)

10A4 – SAMPLE METHODOLOGY

BACKGROUND

The QA Unit uses statically valid sampling methodology recommended by the Centers for Medicare and Medicaid Services (CMS). 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.

There are cases in which the universe (the entire population subject to review) is too small to use only a sample of the population. In these cases, using only a sample would not provide statistically significant results. As such, the entire universe is reviewed.

PROCEDURE

- A. The QA Management Analyst determines the total sample size required for the entire state using the methodology noted above. If the program being reviewed is not a Headquarters program, the number of files to be reviewed per region is based on that region's pro-rated share.

Example of a Nursing Home Sample Calculation:

1. There are 226 Nursing Homes in the state. (This is our universe, as it is the entire population subject to review)
 2. When 226 is entered into Raosoft, a statistically significant sample size is calculated at 143. Therefore, statewide, 143 Nursing Facilities will be reviewed to provide a statistically significant result.
 3. Region 2 has 98 Nursing Homes, which equals 43% of the total universe.
 4. Because 43% of 143 is 61, region 2 will have 61 Nursing Home files reviewed.
- B. The selected sample will be sent via email to the regional designees at least 15 working days (3 weeks) prior to the start of the process review as described in section [10A5](#) of this chapter.

FIELD STAFF RESPONSIBILITY

- A. Any paper files must be available for the QA Unit by the beginning of the review period as noted on the QA [Process Review Schedule](#).

QA UNIT MANAGER RESPONSIBILITY

- A. The QA Unit Manager:
1. Ensures QA staff are able to demonstrate a working knowledge of this policy.

2. Ensures sample methodology meets required standards.
3. Conducts periodic reviews to ensure staff are following the policy.
4. Requests training or clarification from headquarters as needed.

QUALITY ASSURANCE REVIEW

- A. This procedure will be reviewed for accuracy and compliance at least every two years.

[Change Log](#)

[Back to Top](#)

10A5 – PROCESS REVIEWS

BACKGROUND

Process reviews may be conducted at headquarters (HQ) or in regionally located offices throughout the state, depending on where the records for the program are housed. The QA team is responsible for determining whether specific proficiencies were met based on a prescribed set of questions. See section [10A3](#) of this chapter for information about question development.

The process review discussed in this section is defined as: the entrance, the initial process review work completed by the QA Team, and a process review exit.

Each process review is assigned a Process Review Coordinator who is responsible for ensuring that process review activities are completed as outlined below. They are considered the liaison and the subject matter expert for QA activities for the areas to which they are assigned. For information about which QA Team Member is assigned as Process Review Coordinator for a specific area, please email rscquality@dshs.wa.gov.

PROCEDURE

Entrance:

- A. The QA Management Analyst will email the leadership team of the area being reviewed the entrance correspondence as well as the request for records and provide a general overview for the process review at least 15 working days (3 weeks) prior to the start of the process review.
- B. The entrance correspondence will include the following information:
 1. The process review expectations.
 2. The sample and how each region's sample size was derived.
 3. File review information including:
 - a. The QA Team schedule for the process review.
 - b. The QA questions.
 4. Initial report and exit conference date.
 5. Change request process date.
 6. Final proficiency report date.
 7. Proficiency Improvement Plan (PIP) development due date.
- C. The Process Review Coordinator will email the designated representative (the HQ contact, office Regional Administrator (RA), Regional Quality Improvement Coordinator (RQIC), and any other designees) to communicate any questions, concerns or needs of the team at least 15 working days (3 weeks) prior to the start of the review process.

This process is intended to:

1. Open the line of communication between QA and the program or process being reviewed.
 2. Establish the team of people who need to be included in any communication about the process review.
 3. Ensure all file requests, due dates, and expectations have been received and any related questions are answered or forwarded as necessary.
- D. The Process Review Coordinator will respond to any questions or concerns and will email the team identified during the contact listed in section C above at 10 days (2 weeks) prior to the start of the review and again at 5 days (1 week) prior to the start of the review to discuss any issues or concerns and coordinate the QA Team's work. The email will also contain a request for a contact person at each office for the team to contact upon arrival.
- E. The Process Review Coordinator is responsible for ensuring that communication between the field and the QA Team occurs as questions arise.
- F. The Process Review Coordinator creates any working documents and gathers any files the team requires in order to complete the review.
- G. The Process Review Coordinator will track any issues with the questions or question documents in the team's communication tool. This information is gathered for QA Team Leadership so that any issues are addressed at the next meeting between QA Team Leadership and subject matter experts for question development.

Initial process review work:

- A. On the first day of the process review, the Process Review Coordinator will contact the person established (see D above) and immediately let that person or persons know that the team has arrived at the office.

The Process Review Coordinator must establish the following:

1. All files and data are available for the QA Team.
 2. Any keys, entry codes, or visitor badges are checked out for entry/exit.
 3. Times when the QA Team may enter and exit are established.
 4. How the field office would like the QA Team to return their files and data.
 5. How to communicate any issues or needs.
 6. Open the line of communication for the process review.
 7. Who will be at the exit meeting.
 8. Any other pertinent information.
- B. During the process review, the Process Review Coordinator will:
1. Track issues or missing files and work with the person or people identified in D above to resolve issues.

2. Notify the office contact at the end of the last day at that office of any remediations that need to be addressed within three (3) working days including what is due and the date they are due.
3. Pull reports to identify any items still open or any issues that must be resolved before the team leaves the office.
4. Ensure any notes or communications with the QA team or other parties are completed before leaving the office.

Process review exit:

- A. Once the process review has been completed at each location, the Process Review Coordinator will meet with the staff identified in section C above to conduct an exit meeting. This meeting will be an overview of any identified issues or trends found only at that location and provides an opportunity to answer any questions or address concerns.
- B. As the team leaves an office or workspace, the Process Review Coordinator will make sure that the space is left clean and anything used is put away or replaced in the manner the office has requested.

QA UNIT MANAGER RESPONSIBILITY

- A. The QA Unit Manager:
 1. Ensures QA staff are able to demonstrate a working knowledge of this policy.
 2. Conducts reviews of QA staff work to ensure staff are following the policy.
 3. Work with QA staff during the process review to address any concerns or specific questions related to how to complete any part of the review.
 4. Requests training or clarification from headquarters as needed.

QUALITY ASSURANCE REVIEW

- A. This procedure will be reviewed for accuracy and compliance at least every two years.

[Change Log](#)

[Back to Top](#)

10A6 – EXIT CONFERENCE

BACKGROUND

An Exit Conference will be conducted at the completion of each process review to discuss the initial proficiencies and trends found during the statewide review. The initial proficiencies are the preliminary results prior to any changes made during the change request process and at the Change Request Committee meetings and are subject to change once all results are finalized. Finalization of results occurs after the 30 day process review described in section [10A9](#) of this chapter.

PROCEDURE

- A. The Process Review Coordinator will coordinate and facilitate the Exit Conference.
- B. The following individuals will be sent an invitation to attend either by email or through an Outlook Calendar meeting invitation and may share the invitation at their discretion:
 - AL TSA’s QA Administrator.
 - Office Chief overseeing the area being reviewed.
 - Regional Administrator(s) (RA) of the area being reviewed.
 - Regional Quality Improvement Coordinators (RQICs) of the area being reviewed.
 - HQ Field Manager(s) of the area being reviewed.
 - HQ Business Manager of the area being reviewed.
 - Policy, Training, and QA Office Chief.
 - Policy Unit Manager.
 - Training Unit Manager.
 - Any other Regional or Headquarters Management staff determined appropriate.

The exit conference is an open meeting for anyone invited by their leadership.

- C. The Exit Conference will include the following information:
 1. QA questions included in the process review and how those questions were reviewed;
 2. QA questions that met or exceeded proficiency and examples of improvements or continued excellence;
 3. QA questions that did not meet expected proficiency with specific examples;
 4. Process review trends and positive outcomes since last review;
 5. Any new information regarding question development;
 6. The change request process, due dates, and meeting dates;
 7. The initial proficiency report; and
 8. Proficiency Improvement Plan (PIP) due date.

- D. The Process Review Coordinator will send all documentation to the QA Unit Manager and QA Management Analyst for review prior to the meeting.
- E. Once finalized, the QA Management Analyst will send a request that all documentation, presentation materials, and initial proficiency reports be posted on the [RCS QA/QI intranet site](#) after completion of the exit presentation.
- F. The QA Management Analyst will replace the Initial proficiency report with the final proficiency report once all remediation and change requests are completed.

QA UNIT MANAGER RESPONSIBILITY

- A. QA Manager to conduct the following activities in relation to this procedure:
 - 1. Train new staff and ensure they are able to demonstrate they understand this procedure.
 - 2. Attend Exit Conferences.
 - 3. Conduct periodic reviews of this procedure to ensure staff are following it correctly.
 - 4. Request training or clarification from headquarters as needed.

QUALITY ASSURANCE REVIEW

- A. This procedure will be reviewed for accuracy and compliance at least every two years.

[Change Log](#)

[Back to Top](#)

10A7 – REMEDIATION

BACKGROUND

Remediation provides verification that any findings, or “no responses”, found during the process review were corrected. Remediation must be completed within 30 days of the exit conference. The only exception are background check reviews required by certain programs; these remediations must be completed within three (3) working days. MB [R18-032](#) explains the process by setting type in detail.

There are times when remediation is not possible. The QA question documents identify these questions and the QA team will use the remediation response that corresponds during their 30-day review cycle to show remediation and allow the system to close the review cycle in the QA Monitoring Tool.

PROCEDURE

- A. As the QA team works through the questions during a review cycle, the responses are entered into the QA Monitoring Tool.
- B. The Process Review Coordinator must advise an identified field staff member if any of the findings require remediation within three (3) working days. An email will be sent on the last day of the process review before the QA Unit leaves each field office, or if at HQ, within three (3) working days, providing a specific due date.
- C. The Process Review Coordinator must advise identified staff of any findings due at 30 days by providing a Pending Action Report at the exit conference. Staff may also pull the Pending Action Report from ADSA Reporting to determine what needs remediation.
- D. Staff must then review the findings that require action and provide verification of any remediation completed by entering a Review Cycle Note (RCN) into the QA Monitoring Tool and sending an email to rcsquality@dshs.wa.gov with any documents required.
- E. The Process Review Coordinator must periodically check the RCS Quality mailbox during the 30-day cycle and track that all remediations are completed.
- F. The Process Review Coordinator facilitates a meeting with the QA Unit staff at the end of 30 days to review any outstanding remediations that must be completed by QA Unit staff.
- G. QA Unit Staff are given the due date as to when their 30 day findings must show remediated in the QA Tool. For more information about 30 day reviews, please see section [10A9](#) of this chapter.
- H. See section [10A8](#) of this chapter information on change requests.

QA UNIT MANAGER RESPONSIBILITY

- A. QA Manager to conduct the following activities in relation to this procedure:
1. Train new staff and ensure they are able to demonstrate they understand this procedure.
 2. Attend all team meetings and act as final determination if there is not agreement as to how to proceed with a remediation or a change request.
 3. Conduct periodic reviews of this procedure to ensure staff are following it correctly.
 4. Request training or clarification from headquarters as needed.

QUALITY ASSURANCE REVIEW

- A. This procedure will be reviewed for accuracy and compliance at least every two years.

[Change Log](#)

[Back to Top](#)

10A8 – CHANGE REQUESTS

BACKGROUND

The purpose of a change request is to provide Field Operations and HQ staff the opportunity to communicate with the QA Unit if they disagree with any QA finding(s). All change requests must be submitted not more than 30 days after the date of the exit conference.

PROCEDURE

Requesting Changes to QA findings:

- A. The Field/HQ will: For findings where the field or HQ-based unit or setting is not in agreement with QA:
 1. Review the QA question and instructions showing how the team reviewed the question to verify understanding of what was being asked and how the QA team determined the “no response” was valid.
 2. Review historical Change Request Committee (CRC) decisions location on the [RCS QA/QI intranet site](#) to determine whether a decision about this issue has been made. If the CRC has historically upheld QA determinations, the change request will not be sent to the CRC. If the issue is different or has not been heard at CRC, the change request may be sent to the Process Review Coordinator for consideration.
- B. To send a change request to QA, the field must submit a change request in the QA Monitoring Tool by entering a Review Cycle Notes (RCN). The contact code “**Change Request**” must be selected in order for the request to be reviewed and considered. Any supporting documentation must be sent to the QA Unit’s centralized email box at rsquality@dshs.wa.gov by the specified due date provided at the exit conference.
 1. There very limited and specific circumstances when the QA Monitoring Tool cannot be used for change requests. In these cases, the change request process should follow the process above, except that the change request would be submitted using the “Change Request Form” found on [RCS QA/QI intranet site](#). This form should not be used unless there is no way to submit the change request in the QA Monitoring Tool.
- C. The QA Unit will:
 1. Review each request;
 2. Request additional information or forward questions to appropriate subject matter experts (e.g. Training, Policy, Regional Staff, etc.) as needed; and
 3. Work toward a resolution of the issue.

- D. When a resolution is not achieved, the Process Review Coordinator will notify the staff requesting the change and email the disputed item and all supporting documentation to the CRC members at least 24 hours prior to the meeting.

The Change Request Committee (CRC):

- A. Purpose: To meet with RCS Leadership to make determinations on new change requests related to QA findings with which the field or HQ does not agree. Each topic area or finding will be discussed during the meeting and a determination will be made by the voting members as to the outcome of the QA finding.
1. CRC meetings are scheduled by the QA unit in advance, dates are located on the [QA Process Review Calendar](#)
 2. CRC does not repeat change requests that have been decided in historical committee meetings
 3. CRC does not hear change requests that have clear policy guidance, internal, state, or federal
- B. The CRC consists of the following members:
1. QA Unit Management Analyst;
 2. Field Staff (e.g. RQIC, RAs, FM, or designees);
 3. HQ Unit contact for HQ based programs (e.g. CRU);
 4. Office Chiefs;
 5. RCS Director;
 6. HQ Managers for the area subject to review; and
 7. The QA Unit Manager may attend as an observer.

In the case that the named individuals are not available, a designee will be sent in their place with the exception of RCS director and ALTSA QA Administrator.

- C. Voting members of the CRC consist of the following individuals:
1. All Office Chiefs who do not directly supervise the program subject to the review;
 2. The Policy Unit Manager or designee;
 3. The Training Unit Manager or designee;
 4. The RCS Director; and unless otherwise determined
 5. The ALTSA QA Administrator.
- D. The CRC will:
1. Review the change request and all supporting documentation;
 2. Hear arguments for and against the decision made by QA;
 3. Hold discussion about any questions or issues; and
 4. Vote to uphold the QA finding or to overturn the QA finding.
 - a. If the CRC upholds the QA finding, the field must remediate the finding with 10 working days when remediation is possible.
 - b. If the CRC overturns the QA findings, QA must reverse the finding and update any proficiency reports.

- c. If the vote is a tie, the RCS Director will make the final decision.

QA UNIT MANAGER RESPONSIBILITY

- A. QA Manager to conduct the following activities in relation to this procedure:
1. Train new staff and ensure they are able to demonstrate they understand this procedure.
 2. Attend all CRC meetings to listen and to provide any clarification QA staff are not able to address.
 3. Conduct periodic reviews of this procedure to ensure staff are following it correctly.
 4. Request training or clarification from headquarters as needed.

QUALITY ASSURANCE REVIEW

- A. This procedure will be reviewed for accuracy and compliance at least every two years.

[Change Log](#)

[Back to Top](#)

10A9 – THIRTY DAY REVIEWS

BACKGROUND

Once the Change Request Committee process is complete, the thirty-day review is completed by QA staff to show that all work is finalized and all remediations are complete. All QA findings which require remediation must be remediated within 30 calendar days of the exit conference date. Any outstanding QA findings can be reviewed on the “Cases Requiring Action” report found in ADSA Reporting.

PROCEDURE

- A. The QA Consultants analyze all QA findings requiring remediation 30 calendar days after the date of the exit conference.
 1. If the QA finding is not able to be remediated, the QA Consultant will open a new 30-day review cycle and update the finding from “NO” to “N/A” and choose the correct remediation response from those available.
 2. If the QA finding is able to be remediated, the QA Consultant will work with designated field staff, review the Review Cycle Notes (RCN) and any supporting document sent to RCSQuality@dshs.wa.gov. Once acceptable documentation is received, the QA Consultant will either:
 - a. Input a 30-Day cycle with a “YES” response showing that the QA finding was remediated; or
 - b. Change the “NO” to a “YES” on the initial finding if documentation shows that the original finding should have been yes.

QA UNIT MANAGER RESPONSIBILITY

- A. QA Manager to conduct the following activities in relation to this procedure:
 1. Train new staff and ensure they are able to demonstrate they understand this procedure.
 2. Conduct periodic reviews of this procedure to ensure staff are following it correctly.
 3. Request training or clarification from headquarters as needed.

QUALITY ASSURANCE REVIEW

- A. This procedure will be reviewed for accuracy and compliance at least every two years.

[Change Log](#)

[Back to Top](#)

10A10 – FINAL PROFICIENCY REPORT

BACKGROUND

Once all change requests and the thirty day review process are completed, all proficiencies are re-calculated and the final proficiency report is issued.

PROCEDURE

- A. The final proficiency report includes:
1. The questions which met or did not meet proficiencies; and
 2. The “no responses” and frequency of each “no response”.

QA UNIT MANAGER RESPONSIBILITY

- A. QA Manager to conduct the following activities in relation to this procedure:
1. Train new staff and ensure they are able to demonstrate they understand this procedure.
 2. Review and sign the final proficiency report.
 3. Send the report to the Office Chief for review and signature.
 4. Conduct periodic reviews of this procedure to ensure staff are following it correctly.
 5. Request training or clarification from headquarters as needed.

QUALITY ASSURANCE REVIEW

- A. This procedure will be reviewed for accuracy and compliance at least every two years.

[Change Log](#)

[Back to Top](#)

10A11 – PROFICIENCY IMPROVEMENT PLAN (PIP)

BACKGROUND

QA question proficiency levels are established either by the Centers for Medicare and Medicaid Services (CMS), the DSHS Strategic Plan or by the RCS Director. A Proficiency Improvement Plan (PIP) outlines a plan for addressing QA questions that are below the expected proficiency level.

The action required for PIP development is based on the initial findings of the process review once all change requests are considered. A PIP is not required when the statewide proficiency level is reached on all QA questions.

PROCEDURE

- A. PIP development and completion is the responsibility of the region, unit, or area where the proficiency level was not met. The QA Unit is not involved in PIP development activities. The use of Lean and Continuous Improvement tools are encouraged. Information and tools for ALTSA's Lean program can be found [here](#).
- B. The completed PIP must be submitted to the RCS Director for final approval. A copy of the approved PIP must be provided to the QA Management Analyst as soon as it is signed by the RCS Director.
- C. PIP Monitoring:
 1. Once a PIP is finalized, a copy must be sent to the QA Management Team, which includes the Unit Manager and Management Analyst (MA).
 2. The QA Management Analyst reviews the PIP and tracks due dates.
 3. The QA Management Analyst conducts meetings with individuals named on the PIP to track completion.
 4. The QA Management Analyst will provide RCS leadership with status reports as required.

QA UNIT MANAGER RESPONSIBILITY

- A. QA Unit Manager to conduct the following activities in relation to this procedure:
 1. Train new staff and ensure they are able to demonstrate they understand this procedure.
 2. Conduct periodic reviews of this procedure to ensure staff are following it correctly.
 3. Request training or clarification from headquarters as needed.

QUALITY ASSURANCE REVIEW

A. This procedure will be reviewed for accuracy and compliance at least every two years.

[Change Log](#)

[Back to Top](#)

10A12 – ANNUAL STATEWIDE FINAL REPORT

BACKGROUND

The QA Unit Manager develops an Annual Statewide Final Report to publish results of the annual QA process review cycle for RCS. This report outlines the results for each area being reviewed on a statewide basis and compares any historical data for the reader's analysis.

PROCEDURE

A. The QA Unit Manager creates a report and posts the report as required.

QA UNIT MANAGER RESPONSIBILITY

- A. QA Manager to conduct the following activities in relation to this procedure:
1. Creates and distributes any required final reports.
 2. Request training or clarification from headquarters as needed.

QUALITY ASSURANCE REVIEW

A. This procedure will be reviewed for accuracy and compliance at least every two years.

[Change Log](#)

[Back to Top](#)

10A13 – RECORD RETENTION

BACKGROUND

Records are retained for historical information, data, and public disclosure purposes. For RCS records retention information, please visit the [record retention](#) intranet site. This section will provide an overview of how the QA Unit retains records of process reviews completed.

PROCEDURE

- A. QA unit members may use paper checklists while completing the process review to ensure all process review questions are answered and all are answered correctly.
- B. Once the review is completed for a file, the review must be entered into the QA Monitoring tool as soon as possible. All information pertinent to the findings must be included in the processing comments in the QA Monitoring Tool.
- C. QA unit members will retain any paper checklists until the 30 day reviews are completed and the full review process is closed.
- D. All documents related to the QA process review must be shredded in confidential shredding to avoid the release of any resident names or other protected information.

QA UNIT MANAGER RESPONSIBILITY

- A. QA Manager to conduct the following activities in relation to this procedure:
 - 1. Creates and distributes any required final reports.
 - 2. Request training or clarification from headquarters as needed.

QUALITY ASSURANCE REVIEW

- A. This procedure will be reviewed for accuracy and compliance at least every two years.

[Change Log](#)

[Back to Top](#)

APPENDIX A – RESOURCES AND FORMS

BACKGROUND

In 2016, the [RCS QA/QI Intranet Site](#) was developed to provide more information about quality assurance and quality improvement activities within RCS. The QA team schedule, the questions we ask, and any current Management Bulletins that pertain to QA are typically posted here as soon as feasible.

Members of the QA team have access to the team’s QA Unit SharePoint site. This site is only accessible to those on team as it provides the tools, templates, and information needed to complete process reviews.

In addition, the [QA Workspace SharePoint](#) has been created as a means of communication with field staff, HQ staff, Policy, Training, and anyone at RCS interested in RCS QA. The intent of this site is to promote communication within the division related to QA. Anyone may ask the QA Team a question or provide feedback through this site.

PROCEDURE

A. PROCESS REVIEW AREAS AND PROGRAMS

(For more information on each of these settings/programs, please review the [SOP Manual](#))

1. Certified Community Residential Services and Supports (CCRSS)

- a. CCRSS has historically been known as Supported Living. Typically, there are between 4 and 10 residents residing in their own homes who hire specific Supported Living providers to assist with their identified care needs.
- b. RCS completes complaint investigations for these facilities and regulates the companies who provide direct care for clients.
- c. The Developmental Disabilities Administration (DDA) is responsible for assessing resident care needs and authorizing services.
- d. CCRSS is assigned to Chapter 14 of the [SOP Manual](#), which has not yet been published.
- e. QA reviews the following areas:
 1. Evaluations
 2. Statements of Deficiency
 3. Complaints

2. Skilled Nursing Facilities

- a. A Skilled Nursing Facility (SNF), also known as a Nursing Facility (NF), or Nursing Home (NH) provides 24-hour supervised nursing care, personal care, therapies, nutrition, activities, social services, room & board, and laundry. Currently, there are about 239 facilities in Washington.
- b. RCS Surveyors are also referred to as State Agencies (SA) and are contracted by the [Center for Medicare and Medicaid Services \(CMS\)](#) to conduct annual Recertification and Complaint Investigation Surveys.
- c. RCS re-certifies facilities each year based on Federal Regulations and [State Operations Manual \(SOM\) guidelines](#).
- d. Nursing Facilities are assigned to Chapter 17 of the [SOP Manual](#).
- e. QA reviews the following areas:
 1. Surveys
 2. Re-visits
 3. Statements of Deficiency
 4. Complaints

3. Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)

- a. ICF/IIDs are facilities that meet the needs of four or more individuals with Developmental Disabilities. A range of clients are served and facility sizes vary. Currently, there are 12 ICF/IIDs in Washington.
- b. RCS Surveyors are also referred to as State Agencies (SA) and are contracted by the [Center for Medicare and Medicaid Services \(CMS\)](#) to conduct annual Recertification Surveys and Complaint Investigations.
- c. RCS re-certifies facilities each year based on Federal Regulations and [State Operations Manual \(SOM\) guidelines](#).
- d. ICF/IIDs in the community are certified settings. The ICF/IID Policy is assigned to Chapter 17 of the [SOP Manual](#); however, is currently under development.
- e. QA reviews the following areas:
 1. Surveys
 2. Statements of Deficiency
 3. Complaints

4. Complaint Resolution Unit (CRU)

- a. The CRU receives and prioritizes complaints of alleged incidents of abuse, neglect, or exploitation of vulnerable adults. Complaints may be received from anyone in the community and must be disseminated properly.

- b. The CRU is assigned to Chapter 4 of the [SOP Manual](#).
- c. QA reviews the following areas:
 - 1. Intakes

5. Assisted Living Facilities (ALF)

- a. ALFs, formerly known as Boarding Homes, provide housing, basic services, and assume general responsibility for the safety and well-being of residents. ALFs may house seven or more residents. Currently, there are about 500 ALFs in Washington.
- b. RCS regulates ALFs and conducts licensing visits every 9-18 months and investigates complaints made against the facilities.
- c. ALFs are assigned to Chapter 13 of the [SOP Manual](#).
- d. QA reviews the following areas:
 - 1. Inspections
 - 2. Follow-ups
 - 3. Statements of Deficiency
 - 4. Complaints

6. Adult Family Homes (AFH)

- a. AFHs are residential homes that are licensed to care for between two and six residents. They provide residents with room & board, meals, laundry, supervision, and personal care. There are about 2,858 AFHs in Washington.
- b. RCS regulates AFHs and conducts licensing visits every 9-18 months and investigates complaints made against the facilities.
- c. AFHs are assigned to Chapter 12 of the [SOP Manual](#).
- d. QA reviews the following areas:
 - 1. Inspections
 - 2. Follow-ups
 - 3. Statements of Deficiency
 - 4. Complaints

7. Residential Inspection and Quality Assurance (RIQA)

- a. RIQA, also known as “Initial Licensing” performs pre-occupancy on-site inspections of ALF, AFH, and ESF settings.
- b. RIQA is assigned to Chapter 11 of the [SOP Manual](#).
- c. QA reviews the following areas:
 - 1. Initial licensing pre-occupancy inspections for ALF, AFH, and ESFs.

8. Enhanced Services Facilities (ESF)

- a. ESFs provide community placement options for individuals for whom complicated personal care and behavioral challenges do not rise to a level that requires institutionalization. Rather than extended stays in State Hospitals, individuals who are stable and ready for discharge can be referred for placement in an ESF through Home & Community Services (HCS).
- b. RCS regulates ESFs and conducts licensing visits every 9-18 months and investigates complaints made against the facilities.
- c. ESFs are assigned to Chapter 15 of the [SOP Manual](#), which is currently under development.
- d. QA reviews the following areas:
 1. Inspections
 2. Follow-ups
 3. Statements of Deficiency
 4. Complaints

ADDITIONAL INFORMATION:

- A. Complaints are reviewed for AFH, ALF, CCRSS, ESF, ICF/IID, and SNF settings. The policies specific to complaints are housed in Chapter 20 of the [SOP Manual](#), not in the chapter for the specific setting.

QA UNIT MANAGER RESPONSIBILITY

- A. QA Manager to conduct the following activities in relation to this procedure:
 - 1 Train new staff and ensure they are able to demonstrate they understand this procedure.
 - 2 Conduct periodic reviews of this procedure to ensure staff are following it correctly.
 - 3 Request training or clarification from headquarters as needed.

QUALITY ASSURANCE REVIEW

- A. This procedure will be reviewed for accuracy and compliance at least every two years.

[Change Log](#)

[Back to Top](#)

APPENDIX B –QUALITY ASSURANCE (QA) CHANGE LOG

EFFECTIVE DATE	CHAPTER SECT #	WHAT CHANGED? BRIEF DESCRIPTION	REASON FOR CHANGE?	COMMUNICATION & TRAINING PLAN
7/3/18	Chapter 10 All Sections	MB & SOP issued	To ensure all staff are familiar with QA processes and procedures.	Reference MB R18-049  R18-049 - SOP Chapter 10 QA.doc
6/2018	10A9 added, renumbered later sections	Added 30 day review process	Previously missing	Added upon publication
6/2018	Chapter 10 All Sections	All QA Policies and Procedures transitioned to formal RCS SOP format from historical Policy and Procedure format.	To ensure all staff are familiar with QA processes and procedures.	MB forthcoming

[Back to Top](#)