

ST. MARY'S HOME FOR CHILDREN
PQI Quarterly Report
July-September 2011

The PQI quarterly report encompasses a review of PQI Committee processes, policies and procedures, PQI initiatives and survey results. Active committees during the Third quarter of 2011 included: Critical Incident Review; Case Record Review; Intake/Admissions; Safety; Staff Relations; Improvement; Risk Management and PQI. The Grievance Committee did not meet this quarter as there were no grievances filed.

COMMITTEE REPORTS

The Critical Incident Review Committee

This committee meets weekly to review all incidents of physical restraint, AWOL, medication errors and psychiatric hospitalizations and other incidents of a critical nature. During the third quarter, there were a total of 45 incidents of physical restraint which is a 48% decrease from the total of 73 incidents in the second quarter. The Mauran Unit had accounted for forty-one of the seventy-three restraints during the second quarter. During the third quarter, the total number of restraints on the Mauran Unit was fourteen, a significant improvement over the previous two quarters. After identifying patterns and trends associated with staff interactions with the boys and other contributing factors related to unit programming, an action plan was developed which was implemented during the second quarter. This action plan included ongoing training in collaborative problem-solving, implementation of therapeutic activities groups, enhanced strengths-based language, use of Indicators of Trauma-Informed Care checklists and increased physical activity. The action plan seems to have had the intended effect with an 82% reduction of physical restraints on the Mauran Unit from the first quarter high of seventy-six to the third quarter's fourteen.

Regarding AWOL behavior, there were a total of five AWOLS this quarter. Last quarter, there were nine. The Hills shelter accounted for three AWOLS and the Harding ARTS program, two. We had particular concerns about the AWOLS from the Acute Residential Treatment Services program as it houses our most acute residents and is equipped with delay lock mechanisms on the exits of the living area. In both instances of elopement from the ARTS program, the child exited the building from a door near the classroom - a door that is not equipped with a delay lock mechanism. The agency is obtaining estimates for the electrical work needed to secure the exits that do not have delay locks.

Calls to Child Protective Services totaled six. These calls were in relation to children's disclosures of alleged abuse in their homes. Two of these disclosures were made by day students. One came from a resident in our ARTS program. One child in our residential treatment program alleged that another child touched his butt, to which the accused child admitted. CPS decided not to investigate this incident. One CPS call involved a child alleging that a staff member had punched him in the face. This was unfounded as there was an eyewitness account of the incident as well as security camera evidence. The last

call to CPS involved inappropriate use of TCI techniques by a residential counselor. This was a serious violation of agency policy and the employee's employment was terminated.

Regarding psychiatric hospitalizations, four children were stepped up to that level of care this quarter. This is the same number of hospitalizations as noted last quarter.

The agency initiative regarding 100% compliance with assessment of physical restraints, showed some improvement. During the second quarter, only 42% of the restraints included documentation. During the third quarter, 55% of restraints included assessment documentation. We continued to examine the systematic issues that have contributed to this concerning trend, listened to feedback provided by the agency Improvement Team and concluded that the re-instatement of the campus supervisor position may provide the support needed to ensure that assessments are completed.

The Staff Relations Committee

The Staff Relations Committee recognized the need to clarify its purpose and define its goals. For a significant period of time, the same three members comprised the committee and the focus had drifted. The Committee was charged with developing aspirational goals and objectives, soliciting new membership and developing strategies to improve morale at the agency. This group successfully recruited three additional members representing a cross section of departments and has as its purpose, "To be a catalyst for enhancing departmental functioning and staff satisfaction throughout the agency by examining the issues that negatively impact morale, accountability and transmission of communication. This committee uses a solutions-focused perspective when developing, communicating and implementing a plan of action."

Risk Management

During this quarter, the Committee reviewed the Risk Prevention section of the PQI Plan, COA Risk Management standards and table of evidence, and all risk prevention issues addressed within the last year.

Risk Prevention issues addressed and acted upon include: licensing, fiscal accountability, insurance coverage limits, staff training, volunteer policies, roles and oversight, security of client information, review and revisions of agency policies and procedures, financial risk, conflict of interest policy update, employment practices, health and safety issues, medication management, and staff training.

The committee discussed specific strategies that have been utilized to address the larger areas of risk. Some of these include: obtaining a comprehensive IT audit, independent financial and pension audits, creation of a Paid Time Off system, complete revision of the employee guidebook, training on home visit safety, creation of a social networking policy, ensured Board review of contracting practices and compliance, liability insurance and umbrella coverage and privacy practices.

Safety Committee

The Safety Committee report contained information and suggestions for the following: need to reinforce TCI procedures to reduce staff injury; updating the agency phone tree; reduction of storm damage; purchase of materials for first aid packs and training for avoidance of slip and fall accidents. Specific items addressed by the committee included having a pre-crisis meeting to plan for meals during an emergency (in response to complaints about food choices) and ensuring that all units have multiple flashlights and extra batteries for cell phones. In addition, the committee recommended finding grant funding to purchase a generator. Emergency first aid kits will be distributed to staff by 11/28/2011. The Emergency Phone tree will be updated and tested during the fourth quarter. Upon questioning, it was discovered that these recommendations hadn't been communicated to all the appropriate parties. These recommendations will be communicated to those who can implement the action plans. Through this review process, we discovered a communication problem that needs to be rectified in the future.

Improvement Committee

The Improvement Committee formed in May 2011. This committee identified a number of issues that have negatively impacted morale and overall efficiency in the residential program. The committee agreed that improvement is needed in the area of scheduling to ensure appropriate staffing ratios and skill levels on each shift. The solution proposed and adopted involved re-instituting scheduling meetings and clarifying the expectations for agency per-diem personnel.

The Improvement Committee recognized that overtime has been over-utilized as has "freezing-in" staff due to unscheduled absences and staff lateness. The Committee recommended either taking the campus point people out of the ratio on the units, or re-instating the campus supervisor position. The Campus Supervisor position was re-instated to provide greater oversight to the campus, supervise per diem staff and provide solutions to staffing issues. In addition, the hours and days that the campus floaters work will change to better meet agency needs. Both of these solutions will be implemented in mid-October.

Overall communication agency-wide was addressed. The Committee determined that the campus supervisor log needed to be updated to provide additional details so that those responsible for the care of the campus would have the most up to date and accurate information possible.

CASE RECORD REVIEW REPORTS

Residential File Audits

Clinical records are audited on a monthly basis by the residential peer review team. After review, the clinician responsible for each audited file is given a copy of the audit sheets and is required to ameliorate the deficiencies noted. During the third quarter, there was a significant improvement in the percentage of files that were complete. In both July and August, only 33% of the files were deemed complete. In September, 71% of the files that were audited were complete. This improvement can be attributed to an improvement initiative developed by the peer review team to revise the file audit forms and clarify the time frames on all necessary documentation for each program. In addition, the peer review team will work with MIS to develop a reminder calendar for due dates on some agency documentation.

Shepherd File Audits

During this quarter 50% of the client files were considered complete. This is a decrease from the second quarter when 56% were complete, but still an improvement from the first quarter's 40%. The peer review team recognized that the File Audit form they had been using was in need of revision. The revision allows the team to measure the timeliness of documentation and critical factors in treatment effectiveness in the areas of family involvement and aftercare planning. This quarter yielded a lower percentage of complete case records. It is felt that with two key staff members out on leave that the additional responsibilities shared among the remaining staff may have made it difficult for the clinicians to track paperwork deadlines. This team has asked MIS to develop a "tickler" system to track deadlines.

Enhanced Outpatient Services (EOS) File Audits

This was the first quarter that the EOS peer review team conducted a file audit. Issues noted during the audit included: documentation not completed within time frames, case supervision notes not in the file and lack of documentation regarding family involvement in treatment. Documentation protocols will be reinforced in staff meetings as will the necessity of family involvement.

Medical File Audits

During this quarter 50% of the residential medical files were complete. During the second quarter, 42% were complete and during the first quarter 35% of the medical file audits were complete. Three of the issues that have been identified consistently are expiration of agency releases and consents, missing Medication Administration Records (MARs) and missing immunization records. Nursing communicated the problem about missing releases to the agency records keeper and clinicians, who were working on obtaining the missing documentation. Regarding the MARS, we had an 80% compliance rate in the first two quarters. This fell to 67% during the third quarter. We suspect that the absence of two of the unit supervisors on FMLA may have played a role in the decreased compliance. The Residential Director was made aware and was asked to

reinforce the importance of compliance on these issues. The use of KIDSNET has helped improve the facilitation of immunization records.

INTAKE/ADMISSIONS REPORTS

Residential Intake and Admissions

The greatest number of referrals to St. Mary's comes from Beacon Health Strategies to our Acute Residential Treatment Services program. BHS was responsible for 52% of all referrals. This is consistent with the findings of the last quarter. United Behavioral Health was the second greatest source of referrals this quarter; having accounted for 20% of all referrals. This is an increase of 11% since the last quarter. DCYF was the third greatest source of referrals, having accounted for 14% of all referrals. Admissions this quarter included 30 into ARTS/Crisis Stabilization and 5 into the Hills Shelter. There were no referrals for Residential Treatment. Regarding access to service issues, the agency is able to accept referrals for crisis stabilization, hospital diversion, teen girls' shelter, and respite immediately. Referrals for ARTS/hospital step down have typically taken approximately six days from the time of the initial contact with the referral source to the time of admission. This six day delay can be attributed to the fact that hospital personnel are contacting us in preparation for a child's discharge well in advance of the child's discharge. We will be monitoring this situation to see if our decision to suspend interviews with the children prior to admission to our facility facilitates a more timely admission process. As the agency prepares for the new System of Care commencing on January 1, 2012, a decision has been made to close one teen girls' unit and move those girls into an existing unit with the capacity for ten. In response to the overwhelming number of referrals to our ARTS program, we have submitted a proposal to Beacon Health Strategies for a small four bed ARTS unit for adolescent girls. This proposal has not been acted upon by the health insurer as of this writing. To ease the intake process for our Hispanic clientele, we have had all intake paperwork translated into Spanish.

Shepherd Intake

During the third quarter of 2011 seventy-six clients were referred to the Shepherd Program. Fifty-seven clients were assigned during this quarter. Those assigned included some clients that had been referred during the second quarter. The waiting list, at one point was up to 16 weeks. Clinician availability was the greatest obstacle to timely case assignment in both the Outpatient and EOS programs. Timely access to services continues to be a concern for our clients. In an effort to improve this area, an action plan was developed which includes recruitment of fee-for-service clinicians, increased fee-for-service rate, and centralized scheduling and reinforcement of the agency no-show policy.

OUTCOME AND SATISFACTION SURVEYS

Residential Client Outcome and Satisfaction Survey

A total of 20 Youth Satisfaction Surveys were reviewed and analyzed during the third quarter. These surveys were completed by youth who were treated in the ARTS program. Surveys were administered prior to discharge. Statements that had a 90% rate of agreement or better included: When I first got here, staff helped me feel welcome and safe; Unit Staff explained the program and answered my questions; Staff told me the rules for visiting and calling my family; I was treated fairly by staff; the staff helped me when I asked for help; I feel better; My behavior is better.

When examining the results of the self-reported outcomes, it was clear that the majority of the youth who completed the questionnaire felt that they benefited from their treatment. One area worth exploring further may be developing better strategies for securing resident's school work from their home school districts as 20% of respondents disagreed that our school program helped them with their studies. This issue will be brought forward at ARTS administrative rounds.

The Parent Outcome and Satisfaction Survey

This survey completed by parents of youth in our ARTS program revealed 90% agreement with the following: Admissions staff were courteous and professional; Unit staff explained the program and answered my questions; my child was treated in a respectful and professional manner; the skills taught to my child will help us in the future; the Doctor offered valuable assistance; the clinician offered valuable assistance; and I would recommend this program to other parents.

The majority of parents responded positively to their child's treatment. Based on the responses to their survey, areas for improvement include ensuring that all parents receive a copy of the Parents Handbook, enhancing caregiver education and enhancing strategies for symptom reduction in a short term intensive treatment program. We saw many more "not sure" responses regarding improvement of symptoms and both the child and parent feeling better equipped to handle difficult situations.

We have seen an increase in completed youth and parent outcome and satisfaction surveys since we added this item to the discharge checklist. This was an action plan item implemented during the last quarter to increase the completion of the surveys.

Youth surveys from those residing on the Hills Shelter were overall positive. Residents clearly felt respected and well cared for by the unit staff. We did not receive any surveys from children or their parents who have received treatment from our residential treatment program. This is an ongoing area for improvement.

Shepherd Program Outcome and Satisfaction Surveys

There were a total of 10 outcome questionnaires examined during this quarter. All ten respondents expressed satisfaction with the therapist, the Shepherd Staff in general and the treatment they received. Two areas that consistently received strong support from our clients over time are their ratings that there has been a positive change in the original problem and they feel they have improved significantly in their handling of the original problem. Some comments included: "I felt worthless, and my therapist made me feel worth something and made me realize it wasn't my fault." "I think St. Mary's is fantastic and I'm very, very happy to have received such help for my recovery". The therapist was the best my child has ever had."

OTHER SURVEYS AND FOLLOW-UP ITEMS

Staff Survey follow-up

Regarding the action plan that had been developed and communicated to staff, there has been moderate progress. Themes noted were unclear expectations, poor communication and lack of funds/resources. Action items are listed below with a note about the status of progress on each.

- 1) Inconsistent supervision/Holding supervisors accountable for providing weekly supervision – minimal progress, will be reinforced in group supervision with new lines of supervision
- 2) Agency policies and procedures reviewed, revised and updated – significant progress, over 200 policies updated
- 3) Poor communication –re-instate the monthly agency newsletter – minimal progress, working on content, planned 1st distribution of newsletter in November 2011
- 4) Ensuring therapeutic milieu – training- moderate progress – training in collaborative problem solving has begun. Agency re-structuring to take place.
- 5) Clarifying/enforcing rules – accountability needed to deal with unscheduled absences and issues with lateness. Minimal progress. System to be developed to track those occurrences and generate reports to supervisors..

Volunteer Survey

Nineteen agency volunteers completed our volunteer survey. The results are as follows: 100% of the volunteers indicated that they knew what was expected of them and received information about the agency; 68% were still volunteering at the agency and the majority agreed that the work they were doing supported the organization and children served. Volunteers indicated that they saw a positive relationship between themselves and our staff and felt that they were valued by St. Mary's.

Some of the feedback we received which led to the development of an action plan included: Feeling that there was a lack of materials and inconsistent staff support;

volunteers have not taken advantage of agency trainings, staff not clear about what to do with volunteers.

The Action Plan involves: incorporating staff participation in the planning process for unit activities and a staff member will be assigned to serve as the “point” person when volunteers are expected; providing increased communication with staff about scheduling and expectations; encouraging staff and volunteers to make requests for materials in advance of the activity; providing notification of agency trainings via electronic communication to volunteers.

Strategic Plan goals review

A review of the agency’s strategic plan goals took place during this quarter. During this review, the agency leadership team discussed progress toward goals. The following is a summary of the organization’s progress:

Goal 1) Re-define Program Portfolio

Key results: Diversify revenue and lessen dependence on state funding. By 2013, St. Mary’s revenue will be 30% from State Contract and 70% from other sources.

Progress: 45% of our funding comes from DCYF, down from 65% three years ago.

Goal 2) Create a Network of Supportive Relationships

Key Results:

- Specifically identified and articulated position with Ocean State Network
 - Progress: Strong relationship with Network partners
- A marketing plan with clearly defined roles for Program managers and Board
 - Progress: Marketing Plan still needs to be developed
- Improve website
 - Progress: Web designer significantly improved look and utilization of website. Updates need to be better systematized.
- Board competence in marketing our public relations
 - Progress: Will discuss at Board retreat

Goal 3) Adjust organizational infrastructure to better support strategic goals. This goal will be discussed with Risk Management Committee

- Board will give at 100% level
 - Progress: Board gave at 100% level in FY 2011
- Increase annual giving by 10% per year
 - Progress: Annual giving increased by 10% from 2010 -2011
- Use sale of Norwood facility to help restore endowment
 - Progress: At the time of the retreat, there was an offer on the property. At the end of the quarter, the offer was revoked
- Commit to monthly return of funds to the endowment.
 - Progress: Agency has been unable to designate funds to the endowment. All funds are needed for operations

- Balance budget annually
 - Progress: FY 2011 not balanced at year end, but deficit was significantly reduced from previous year.
 - Plan for capital campaign
 - Progress: Decision made to not move forward due to the economy.
- Goal 4) Refocus on Quality Assurance and Organizational Learning
- Meet COA Standards
 - Progress: Agency had conducted 2 self-studies and reviewed and updated policies and procedures.