Performance and Quality Improvement

Annual Impact Plan & Report

Fiscal Year 2021-2022

OUR MISSION

Providing nurturing care and life-changing services for youth and families in need.

OUR VISION

To be a community leader that exceeds industry standards of care, pursues innovative practices, and equips youth and families to achieve healthy independence and sustainable success.

The Children's Attention Home is a 501(c)3, tax exempt organization, Federal ID: 57-0527092.
attentionhome.org • 803-328-8871 • P.O. Box 2912, Rock Hill, SC 29732 • @childrensattentionhome

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About the Children's Attention Home

The Children's Attention Home was established in 1970 as an emergency shelter for victims of child abuse with capacity for 9 children. Since then, the campus has grown and is now able to provide care for up to 36 children at a time. Services expanded to include access to full-service, long-term developmental care. The Home serves approximately 115 children each year and has served over 8,500 since its inception. The Home continues to grow, developing and implementing new programs to best meet the needs of the children entrusted to its care and ensuring better outcomes for their futures.

PQI Program Overview

The Performance and Quality Improvement Program (PQI) at the Children's Attention Home is a structured system of processes to help measure and improve overall organizational health, using data to compare actual performance to clearly defined goals. By tracking and aggregating data and setting specific outcome-based goals, Home is able to impact overall quality in line with strategic goals and objectives of the organization. To read the full plan, refer to the Children's Attention Home PQI Plan.

Stakeholder Involvement

Stakeholder involvement and feedback is instrumental to the development and implementation of the PQI process. CAH defines stakeholders as any person, group or organization that has a vested interest in the services provided by the organization. CAH's key stakeholders share the aspirations to achieve organizational excellence. CAH teammates and board members play vital roles in the PQI success, and new teammates are introduced to the PQI during orientation.

CAH organizational stakeholders include:

- Residents
- Board of Directors
- Director Team
- CAH Teammates
- Volunteers
- Community Partners
- Funders/Major Donors

Impact Report Overview

This impact report consists of the annual PQI plan and progress tracking throughout the year. Information is updated throughout the year to provide progress reports and identify opportunities for improvement. The main sections of this report include:

Program Outputs: This section provides an overview of key metrics of program productivity. While these numbers do not show programmatic improvement or change, these indicators provide valuable information understanding the scope of service provided by the Children's Attention Home.

Performance & Quality Improvement Scorecard: This section provides a summary snapshot of the program outcome goals and progress. Further detail for each outcome is provided in the Program Outcomes section.

Program Outcomes: This section provides expanded information on sustainable change that is being achieved across the organization. Specific goals in all areas of the organization are identified each year as opportunities for improvement. Data visualization, detailed information on these measurements, and notes for improvement are included in each section.

For questions about any information included in this report, please contact info@attentionhome.org.

Program Outputs

This section provides an overview of key metrics of program productivity. While these numbers do not show programmatic improvement or change, these indicators provide valuable information understanding the scope of service provided by the Children's Attention Home. These numbers are updated monthly, with quarterly updates indicated where appropriate.

	Owner	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Resident Census Data		**Q1** *(Jul - Sept)*			**Q2** *(Oct - Dec)*			**Q3** *(Jan - Mar)*			**Q4** *(Apr - Jun)*		
# of New Crossroads Residents (Intakes)	Tara	2	1	2	0	0	2	0	0	0	0	0	0
# of New DSS Residents (Intakes)	Tara	28	4	2	1	5	13	7	6	6	2	3	8
# of New Residents by Age Group													
0-6 years (new)	Tara	0	0	0	0	0	0	1	0	0	0	0	0
7-12 years (new)	Tara	1	0	0	0	0	1	0	0	1	1	1	0
13+ years (new)	Tara	29	5	4	1	4	14	6	6	5	1	2	8
Gender of Residents													
New Male Residents	Tara	12	1	2	0	3	5	1	1	1	0	0	2
New Female Residents	Tara	18	4	2	1	2	10	6	5	4	2	3	6
New Transgender residents	Tara	0	0	0	0	0	0	0	0	1	0	0	0
# of New Sibling Groups Admitted	Alicia	1	0	0	0	0	0	1	0	0	0	1	0
# of Discharged Residents	Tara	5	8	5	3	7	9	7	2	7	1	4	10
Days of Service (Total)	Tara	804	719	687	579	516	570	607	649	766	786	776	709
Days of Service – DSS GC1	Tara	626	518	470	393	428	456	448	473	479	462	439	400
Days of Service – DSS GC2	Tara	94	70	81	93	22	12	7	47	122	120	143	125
Days of Service – DSS GC3	Tara	33	53	42	0	0	2	59	68	103	144	132	124
Days of service (Crossroads)	Tara	51	78	94	93	66	100	93	61	62	60	62	60
Unaccepted Placement Requests	Alicia	34	7	9	28	39	39	28	38	33	37	15	25
Due to space	Alicia	16	4	1	20	38	34	6	23	9	14	3	3
Due to level of care	Alicia	18	3	8	8	1	5	22	15	24	23	12	22
# of Sibling Groups	Alicia	1	0	0	0	0	0	1	1	1	1	2	2
% of Youth in Sibling Groups	Alicia	13	0	0	0	0	0	7	7	6	7	14	17
Social Work		**Q1** *(Jul - Sept)*			**Q2** *(Oct - Dec)*			**Q3** *(Jan - Mar)*			**Q4** *(Apr - Jun)*		
# of Social Work Groups	Alicia	6	5	7	7	6	0	8	7	9	9	8	4
Ages 7-12	Alicia	0	0	0	0	0	0	0	0	0	0	0	0
Ages 13-15	Alicia	0	0	0	0	0	0	0	0	0	0	0	0
Ages 16+	Alicia	6	5	7	7	6	0	8	7	9	9	8	4
Education		**Q1** *(Jul - Sept)*			**Q2** *(Oct - Dec)*			**Q3** *(Jan - Mar)*			**Q4** *(Apr - Jun)*		
Youth Eligible for Diploma / GED	Alicia	4	1	2	0	0	1	3	5	5	5	5	0
High School Diploma / GED	Alicia	0	2	0	0	0	1	0	0	0	0	4	0
# of ESL Residents	Alicia	2	2	3	3	3	3	3	3	3	3	3	2
# of Residents with Communication Barriers	Alicia	2	2	3	3	3	3	3	3	3	3	3	3
Vocational		**Q1** *(Jul - Sept)*			**Q2** *(Oct - Dec)*			**Q3** *(Jan - Mar)*			**Q4** *(Apr - Jun)*		
# of Youth Eligible for Employment	Alicia	7	3	1	0	0	2	12	17	12	15	14	15
# of Youth Employed	Alicia	7	3	1	0	0	2	8	8	7	8	10	11

Aftercare Services		**Q1** *(Jul - Sept)*			**Q2** *(Oct - Dec)*			**Q3** *(Jan - Mar)*			**Q4** *(Apr - Jun)*		
# of Aftercare Services Provided (including when the kids reach out to us for help)	Alicia	0	5	5	6	5	6	0	2	5	6	4	4
# of Kids Attempted to Contact	Alicia	0	4	5	5	5	5	0	2	3	4	4	2
# of Kids Contacted	Alicia	0	3	2	2	3	3	0	2	3	3	2	2
Development & Marketing		**Q1** *(Jul - Sept)*			**Q2** *(Oct - Dec)*			**Q3** *(Jan - Mar)*			**Q4** *(Apr - Jun)*		
# of Active Donors*	Katy	1344			1623			1508			1505		
First-time Donor Retention Rate	Katy	3%			15%			17%			18%		
# of Videos Produced	Katy	5			3			4			3		
Human Resources		**Q1** *(Jul - Sept)*			**Q2** *(Oct - Dec)*			**Q3** *(Jan - Mar)*			**Q4** *(Apr - Jun)*		
# of Teammates	Tara	54	52	50	59	61	60	59	59	58	58	61	61
Full Time	Tara	31	28	27	31	31	31	32	32	31	31	33	33
Part Time	Tara	23	24	23	28	30	29	27	27	27	27	28	28
Employee Turnover (# Separated)	Tara			8			6			7			5
Teammate Engagement Survey Results (85%)	Tara					95%							
Volunteers		**Q1** *(Jul - Sept)*			**Q2** *(Oct - Dec)*			**Q3** *(Jan - Mar)*			**Q4** *(Apr - Jun)*		
# of Individual Volunteers	Tara	21	38	25	7	1	11	8	10	43	54	47	64
# of Volunteers Hours	Tara	70	124	58	36	15	39	21	31	91	136	118	191
# of Direct Hours	Tara	0	0	0	0	1	1	19	24	4	36	32	125
# of Indirect Hours	Tara	70	124	58	36	14	38	2	7	87	100	86	66
# of Meals Provided	Tara	16	9	20	16	20	26	16	12	24	34	23	13
# of Collection Drives	Tara	7	5	3	3	2	7	0	0	1	4	1	3

**Number of donors that have given in the past 12 months*

Performance & Quality Improvement Scorecard: 2021-2022

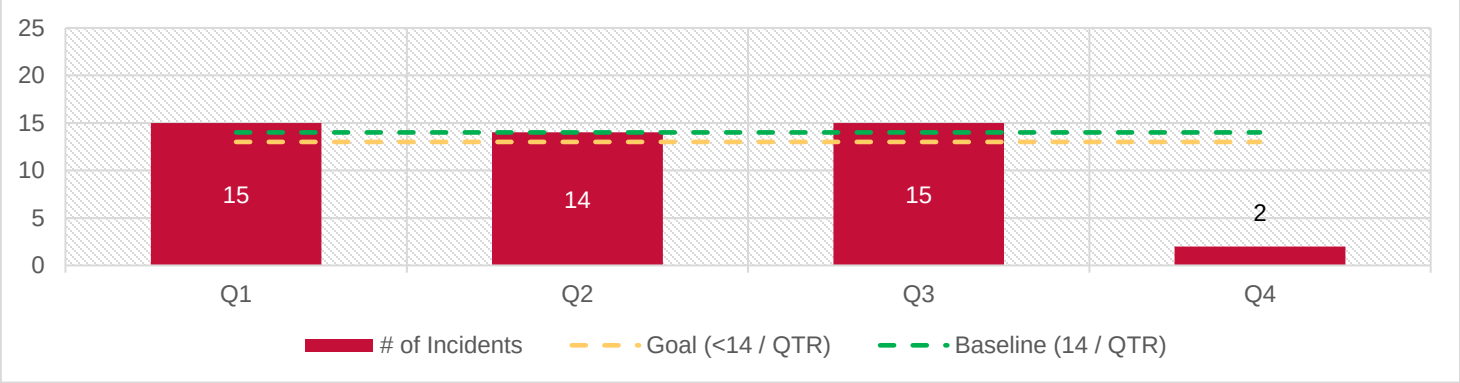
Quality Measure	Goal Statement	Baseline	Q1	Q2	Q3	Q4
Critical Incidents	Reduction in behavioral critical incidents, runaways	14 per quarter (56 total for 2020-2021)	15 *(+6 out of school suspension)*	14 *(+8 out of school suspension)*	15 *(+6 out of school suspension, 4 medical, 2 mental health)*	2 (+5 out of school suspension, 2 medical, 2 mental health)
Placement Disruption	Reduction in emergency placement disruptions	11 out of 50 for (2020-2021)	2 out of 12 discharges	2 out of 20 discharges	6 out of 15 discharges	0 out of 16 discharges
Transition Planning	80% of residents 16+ receive transition planning services prior to discharge	N/A	36% (4 out of 11 completed- started beginning of Sept.)	44% (4 out of 9 residents completed)	78% (7 out of 9 residents completed)	63% (5 out of 8 residents completed)
Assessment Process	90% of residents receive a CANS assessment	N/A	79% (19 out of 24 completed- started mid-August)	62% (5/8 residents that were admitted. 8 residents excluded due to length of stay less than 14 days)	100% (20 youth total- 17 received, 3 excluded due to length of stay)	100% (5 out of 5 residents that were admitted. 8 excluded due to the length of stay)
Bed Checks	100% of Bed Checks will be performed as required	2nd Shift=80% (170 out of 212) 3rd Shift= 98% (207 out of 212)	2nd Shift= 70% (127 out of 182) 3rd Shift= 93% (169 out of 182)	2nd Shift= 65% (111 out of 172) 3rd Shift= 92% (159 out of 172)	2nd Shift= 66% (285 out of 434) 3rd Shift= 93% (404 out of 434)	2nd Shift= 94% (840 out of 890) 3rd Shift= 99% (884 out of 890)
Supervision	Supervision checks - procedure being followed during supervision checks (100%)	92% 1st- 100% 2nd- 75% (staff not monitoring back hall appropriately) 3rd-100%	75% 1st -100% 2nd - 50% (4/8-supervision on playground and cottage back halls/bedrooms) 3rd - 75% (2/8-supervision on back hall)	89% 1st-100% 2nd- 67% (4/6-supervision on back hall) 3rd- 100%	95% 1st- 92% (bus stop) 2nd- 92% (back hall) 3rd-100%	94% 1st- 100% 2nd- 83% (both staff in cottage in the office instead of location of residents) 3rd- 100%
Ratio	Ratio will be maintained 100%	83% 1st-100% 2nd- 50% (one staff in cottage with 8 residents and new staff left with 7 residents) 3rd-100%	79% 1st- 88% (1/8) 2nd- 50% (4/8) 3rd- 100% (8/8)	92% 1st- 100% 2nd- 75% (1 staff left in cottage with 7 residents while supervisor distributed meds) 3rd- 100%	95% 1st- 92% (bus stop) 2nd- 92% (1 staff 8 residents Porterfield) 3rd- 100%	89% 1st- 83% (2 call outs leaving 1 cottage with 1 staff) 2nd- 83% (1 staff took 1 resident on an appt leaving other staff with 7 residents) 3rd- 100%
Supporter Stewardship	80% of first-time donors receive follow up communication in 5 business days	N/A	11% (4/35)	8% (10/118)	8% (3/38)	6% (5/80 – 5 others received personal emails follow up outside of the 5 days)
Orientation	Full orientation process is completed for 80% of all new teammates	N/A	50% (1/2)	75% (12/16)	100% (4/4)	33% (1/3)

Program Outcomes

This section provides expanded information on sustainable change that is being achieved across the organization. Specific goals in all areas of the organization are identified each year as opportunities for improvement. Data visualization, detailed information on these measurements, and notes for improvement are included in each section. Information for this section is updated on a quarterly or annual basis, depending on the nature of the measurement.

Critical Incidents

Goal Statement	Baseline	Q1	Q2	Q3	Q4
Reduction in behavioral critical incidents, runaways	14 per quarter (56 total for 2020-2021)	15 *(+6 out of school suspension)*	14 *(+8 out of school suspension)*	15 *(+6 out of school suspension, 4 medical, 2 mental health)*	2 (+5 out of school suspension, 2 medical, 2 mental health)



Plan: (1) Briefly describe opportunity for improvement, (2) What info and data that supports the need for this change, (3) Describe success indicators, how outcomes will be measured, and success will be determined.

1. Reduction of critical incidents is an expected outcome for all developing and current programs. Current population showed a need for new tools and resources for teammates.
2. It was identified that there were too many preventable incidents given the training and procedures currently in place.
3. The number of critical incidents will be measured by quarter and compared to last year's average as a baseline.

Do:

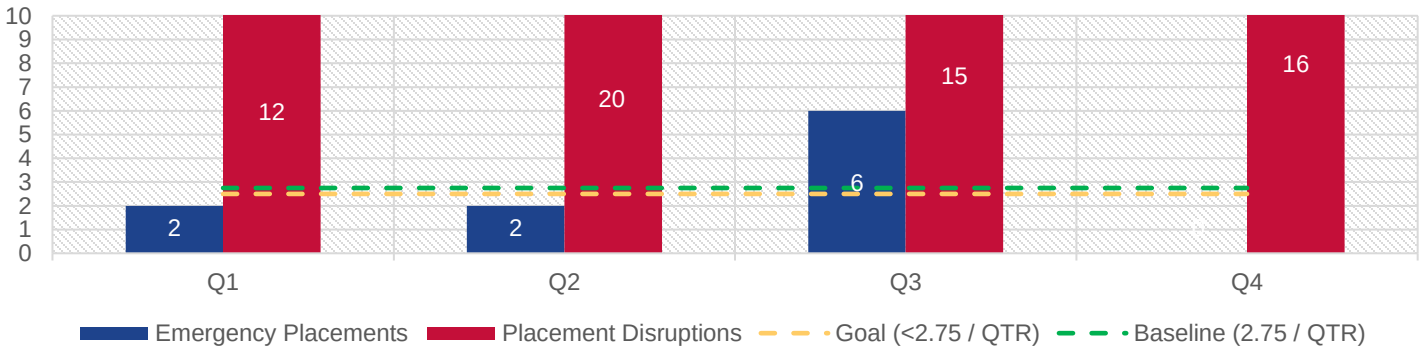
Action Item	Owner	Resources	Target Date	Actual Date	Progress Notes
CANS training for intake staff	Emily	Time	7/31/2021	7/31/2021	Completed; 7 teammates trained
Retraining residential staff with NVCI (mandatory for all staff)	Alicia	Trainers, time	9/30/2021	9/30/2021	Completed
Documenting and distributing individual resident safety plans	Alicia	Time	8/31/2021	8/31/2021	Completed and handled by Dr. Joshua as needed
Complete CARE Educator training	Emily	Time	8/31/2021	8/31/2021	Completed
Beginning CARE training with all staff	Emily	Trainers, time	8/31/2022		In progress; goal of 80% to be trained by 6/30/2022

Check & Act: (1) Describe results & observations of improvement plan, (2) Describe challenges encountered during plan implementation, (3) Describe how completed plan will be integrated into regular practice.

1. Foundational training is key to changing this metric. Impact of these steps is still in progress but improvement is already evident. Severity of critical incidents has been reduced.
2. Generally, medical critical incidents are not considered preventable in most cases. The main focus is on mental health and behavioral critical incidents. School suspensions are monitored and addressed but are less controllable by the Home, which is why these are noted separately.

Placement Disruption

Goal Statement	Baseline	Q1	Q2	Q3	Q4
Reduction in emergency placement disruptions	11 out of 50 for (2020-2021)	2 out of 12 discharges	2 out of 20 discharges	6 out of 15 discharges	0 out of 16 discharges



Plan: (1) Briefly describe opportunity for improvement, (2) What info and data that supports the need for this change, (3) Describe success indicators, how outcomes will be measured, and success will be determined.

1. Stable placements are one of the primary outcomes of focus for DSS and is best practices for the children to reduce trauma.
2. The number of emergency placement disruptions was identified as unsatisfactory when measured during last fiscal year.
3. Outcomes will be measured and compared to last fiscal year's ratio of emergency placement disruptions to planned discharges as compared to all discharges.

Do:

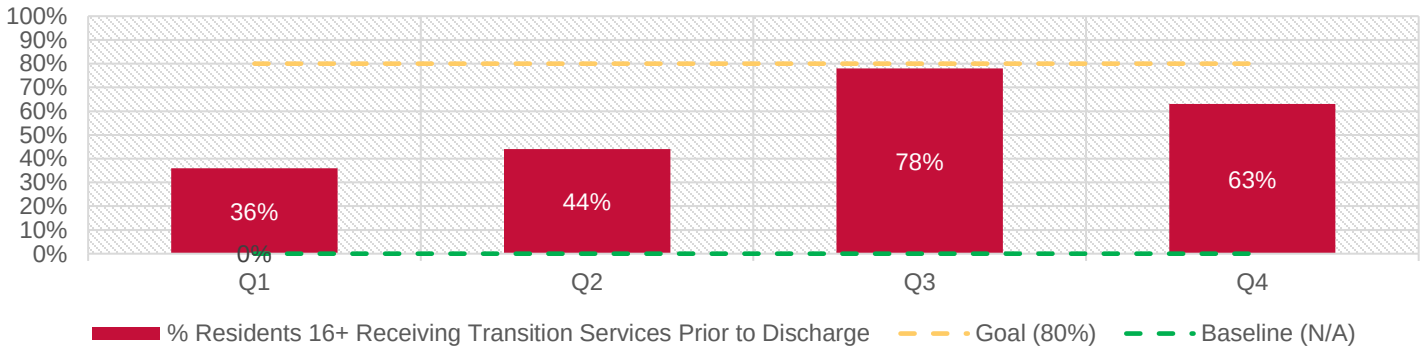
Action Item	Owner	Resources	Target Date	Actual Date	Progress Notes
Developed processes to increase placement stability through behavior contracts	Alicia		8/31/2021	8/31/2021	Process in place and ongoing
Increased staffing with caseworkers	Alicia	DSS Support	10/31/2021	10/31/2021	Consistent attendance from DSS at resident staffings and more responsiveness to individual meetings needed
Included plans within residents' comprehensive care plans to transition between cottages based on needs	Alicia	Level appropriate environments	7/31/2021	1/31/2021	Currently part of the residents' care planning; Sept-Dec this was limited due to Freeman-Norris closure due to staffing

Check & Act: (1) Describe results & observations of improvement plan, (2) Describe challenges encountered during plan implementation, (3) Describe how completed plan will be integrated into regular practice.

1. Getting cooperation from DSS to staff the residents at an appropriate level is a challenge. This need is being communicated regularly to DSS, including during residents staffings and individual meetings.
2. Residents have been able to avoid placement disruptions and increase stability of their placement with transitioning between the cottages.
3. It's been identified that educating the residents and staff about the purpose, structure, and services in each cottage would be helpful. Clear definitions of this also need to be developed for educational purposes.
4. To identify additional opportunities to maintain placement, CAH will request additional CFTM (child family team meetings) as needed for children in danger of placement disruption.
5. To identify opportunities for support for the child in danger of placement disruption, CAH will increase internal staffings to provide more support to keep the placement.

Transition Planning

Goal Statement	Baseline	Q1	Q2	Q3	Q4
80% of residents 16+ receive transition planning services prior to discharge	N/A	36% (4 out of 11 completed- started beginning of Sept.)	44% (4 out of 9 residents completed)	78% (7 out of 9 residents completed)	63% (5 out of 8 residents completed)



Plan: (1) Briefly describe opportunity for improvement, (2) What info and data that supports the need for this change, (3) Describe success indicators, how outcomes will be measured, and success will be determined.

1. Ensuring transition planning is happening for residents 16+ is one of the primary outcomes of focus for DSS and is best practices for youth to prepare them for a successful future.
2. Residents do not receive these services from DSS as they are supposed to.
3. This is measured separate from their comprehensive care plan and progress and planning is based on the Independent Living Tiers and goals identified by the residents themselves.

Do:

Action Item	Owner	Resources	Target Date	Actual Date	Progress Notes
Policy developed to set standards for this process	Alicia	DSS Support	6/30/2021	6/30/2021	Process implemented in September
Residents must identify a minimum of one support person; invited to the transition planning meetings	Alicia	Resident support system	9/30/2021	9/30/2021	Process implemented in September; getting participation from support system has been a challenge

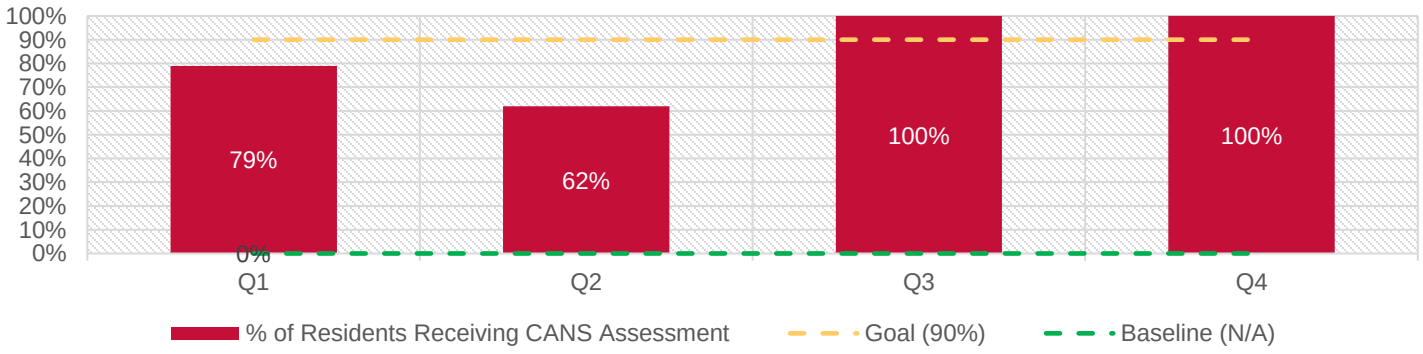
Transitional planning meetings with resident participation held every 90 days	Alicia	Resident participation	9/30/2021	9/30/2021	Process implemented in September; high engagement rate with residents in this process

Check & Act: (1) Describe results & observations of improvement plan, (2) Describe challenges encountered during plan implementation, (3) Describe how completed plan will be integrated into regular practice.

1. Getting participation from support system in transitional planning meetings can be a challenge. Regular and multiple communications with advanced notice are given to the identified support system individuals. This involvement is continuing to be reviewed.
2. Working with residents to develop attainable and realistic goals has been a challenge but this process has created space and opportunity for constructive conversation.
3. The process in place has increased teamwork among staff in helping residents with transition planning and increased knowledge for staff in how to work together in treatment planning organizationally with residents.
4. Designated Care Coordinator(s) have been assigned the transition age youth to streamline the process and increase participation from youth in transition planning.
5. The transition planning steps will be prioritized with the CANS assessment at the beginning and subsequent reviews. Additionally, checks need to be put in place for residents turning 16 but not currently placed in the transition age cottage.

Assessment Process

Goal Statement	Baseline	Q1	Q2	Q3	Q4
90% of residents receive a CANS assessment	N/A	79% (19 out of 24 completed-started mid-August)	62% (5 out of 8 residents that were admitted. 8 residents excluded due to the length of stay being less than 14 days)	100% (20 youth total-17 received, 3 excluded due to length of stay)	100% (5 out of 5 residents that were admitted. 8 excluded due to the length of stay)



Plan: (1) Briefly describe opportunity for improvement, (2) What info and data that supports the need for this change, (3) Describe success indicators, how outcomes will be measured, and success will be determined.

1. We identified that more effective practices during intake would provide a trauma-informed approach for new residents and help us identify better ways to support them during their stay at the Home.
2. There was no standardized assessment process for new residents that provided a consistent experience for successful planning.

3. CANS assessment with each resident will be done within 5 days of initial intake. This process helps better identify what their main goals should be. This process requires two people.

Do:

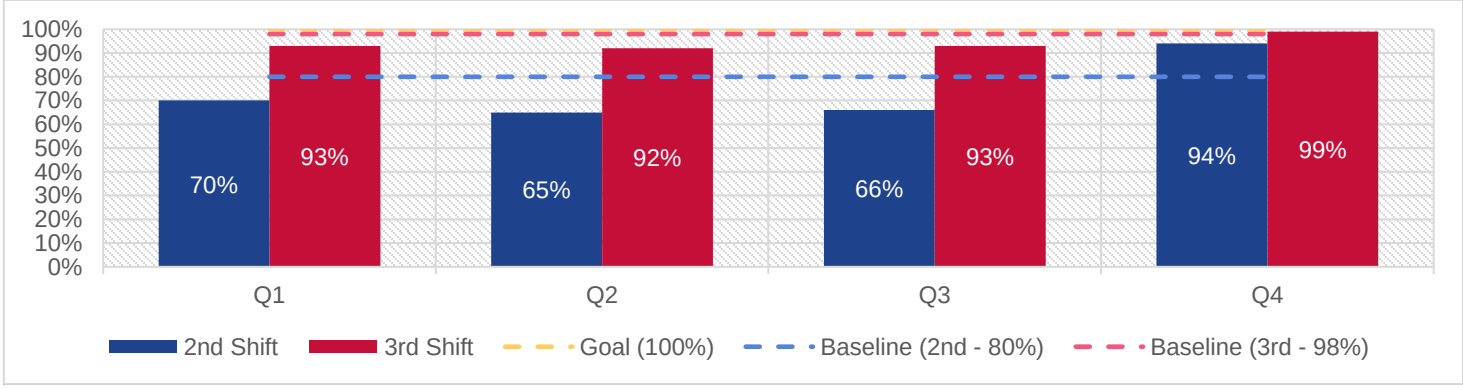
Action Item	Owner	Resources	Target Date	Actual Date	Progress Notes
CANS training for intake staff	Emily	Time	7/31/2021	7/31/2021	Completed; 7 teammates trained
Established as part of the intake procedure	Alicia	Staff	8/31/2021	8/31/2021	Began including in intake
Additional supervisor training to increase consistency of assessment being completed	Alicia	Staff/time	4/30/2022	Ongoing	Emphasis on CANS assessment included in ongoing supervisor training

Check & Act: (1) Describe results & observations of improvement plan, (2) Describe challenges encountered during plan implementation, (3) Describe how completed plan will be integrated into regular practice.

1. Residents who are currently at the Home were also given this assessment, and this is still in progress.
2. Assessments were difficult to complete during the time that we were down a Care Coordinator, as this process requires two people.
3. Inconsistency in assessments being completed have been identified. Additional staff training will be completed to address.
4. Additional supervisor trained to assess and currently in process for certification.
5. Ongoing training has been given to supervisors to highlight its importance and increase completion of this process for residents.
6. Going into next fiscal year, this goal will be updated to track the assessment review process to ensure this is happening consistently.

Resident Bed Checks

Goal Statement	Baseline	Q1	Q2	Q3	Q4
100% of Bed Checks will be performed as required	2nd Shift=80% (170 out of 212) 3rd Shift= 98% (207 out of 212)	2nd Shift= 70% (127 out of 182) 3rd Shift= 93% (169 out of 182)	2nd Shift= 65% (111 out of 172) 3rd Shift= 92% (159 out of 172)	2nd Shift= 66% (285 out of 434) 3rd Shift= 93% (404 out of 434)	2nd Shift= 94% (840 out of 890) 3rd Shift= 99% (884 out of 890)



Plan: (1) Briefly describe opportunity for improvement, (2) What info and data that supports the need for this change, (3) Describe success indicators, how outcomes will be measured, and success will be determined.

1. This goal is carried over from last fiscal year.
2. A formal process was created to track resident's supervision while they are sleep. By tracking resident's activity while sleeping, it will note any patterns in sleep disturbances. The process was being completed inconsistently.
3. Compliance and improvements in resident care support the need to monitor this area.
4. Success will be determined when all shifts are at 100%. Staff will document bed-checks in 15 min intervals and the overall compliance in completing bed-checks will calculated on a quarterly basis.

Do:

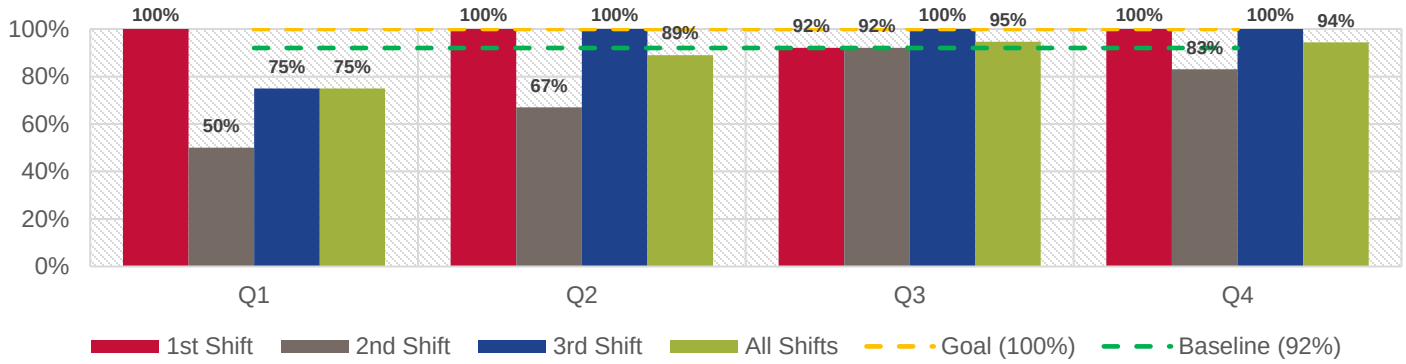
Action Item	Owner	Resources	Target Date	Actual Date	Progress Notes
Revise bed-check tracking sheet to reflect start time when all residents are asleep.	Alicia	Time	9/1/2021	7/1/2021	Change will happen in the upcoming fiscal year to keep tracking accurate.
Bed-checks documents are uploaded quarterly for residential teammates to complete	Alicia	Time	6/1/2020	6/1/2020	A bed-check folder is uploaded on the drive quarterly to allow staff to complete bed-checks daily and help ease the calculations for tracking.
For Freeman, bed-check process was changed to meet DSS requirements for serving Level 3 residents	Alicia	Training/ time	7/1/2021	7/1/2021	Incorporated into normal bed-check process
With extendedReach, custom forms for this process will be created to assist with consistency	Alicia	Updated software & support	5/31/2022		Waiting on extendedReach to complete their portion of software set up

Check & Act: (1) Describe results & observations of improvement plan, (2) Describe challenges encountered during plan implementation, (3) Describe how completed plan will be integrated into regular practice.

1. Due to requirement of staff being on the back hallway and troublesome technology, different processes need to be developed to ensure consistent tracking can be completed. This will be handled with extendedReach implementation.
2. With being short-staffed on second shift, ensuring this was completed was difficult. Training for new staff on entering bed check data was highlighted in orientation process.
3. Second shift staff was retrained on how to complete bed checks and 3rd shift staff were trained on how to create the forms to ensure completion.
4. Due to extended timelines with extendedReach implementation, Microsoft forms will be developed to improve this tracking process in the interim.

Direct Care Supervision

Goal Statement	Baseline	Q1	Q2	Q3	Q4
Supervision checks - procedure being followed during supervision checks (100%)	92% 1st- 100% 2nd- 75% 3rd-100%	75% 1st -100% 2nd - 50% (4/8-supervision on playground and cottage back halls/bedrooms) 3rd - 75% (2/8-supervision on back hall)	89% 1st-100% 2nd- 67% (4/6-supervision on back hall) 3rd- 100%	95% 1st- 92% (bus stop) 2nd- 92% (back hall) 3rd-100%	94% 1st- 100% 2nd- 83% (both staff in cottage in the office instead of location of residents) 3rd- 100%



Plan: (1) Briefly describe opportunity for improvement, (2) What info and data that supports the need for this change, (3) Describe success indicators, how outcomes will be measured, and success will be determined.

1. This goal is continued from last fiscal year. The organization needed a formal process to track the adequacy of supervision of the residents on shift.
2. During the occurrence of incidents, supervision was not maintained, which warranted the need to track compliance regarding supervision of residents.

Do:

Action Item	Owner	Resources	Target Date	Actual Date	Progress Notes
Increased frequency of tracked observations of supervision	Alicia		7/31/2021	7/31/2021	Being completed consistently
Improvements to camera system	Tara	Funding, community partnership	5/31/2021	5/31/2021	Completed in May 2021
Staff training specific to supervision	Alicia		7/31/2021	7/31/2021	Completed
Mobile access to view camera coverage given to supervisors	Tara	Mobile Phone	8/30/2021	7/31/2021	Limited camera viewing granted to supervisors.

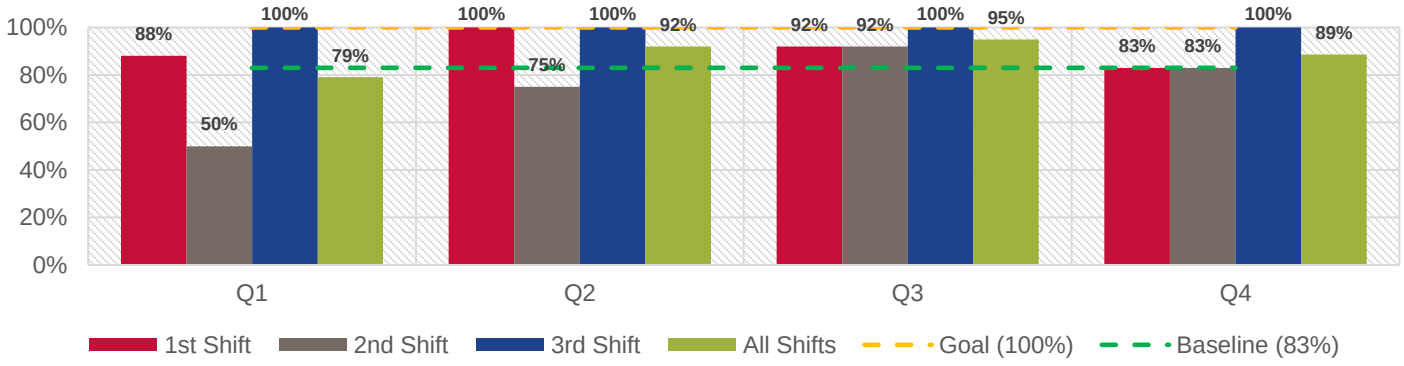
Check & Act: (1) Describe results & observations of improvement plan, (2) Describe challenges encountered during plan implementation, (3) Describe how completed plan will be integrated into regular practice.

1. There were challenges with supervision on second shift due to being short staffed and staff from other shifts filling in. Staff redirection was given to ensure this improved.

2. Resident expectations had to be adjusted and education given regarding procedure. This helped with cooperation between staff and residents to meet supervision requirements.
3. In response to quarter 3 results, teammates were retrained on supervision at the bus stop and on the back hall.
4. This goal will be moved to a supervisors scorecard and will continue to be tracked and closely monitored.

Direct Care Ratio

Goal Statement	Baseline	Q1	Q2	Q3	Q4
Ratio will be maintained 100%	83% 1st-100% 2nd- 50% 3rd-100%	79% 1st- 88% (1/8) 2nd- 50% (4/8) 3rd- 100% (8/8)	92% 1st- 100% 2nd- 75% (1 staff left in cottage with 7 residents while supervisor distributed meds) 3rd- 100%	95% 1st- 92% (bus stop) 2nd- 92% (1 staff 8 residents Porterfield) 3rd- 100%	89% 1st- 83% (2 call outs leaving 1 cottage with 1 staff) 2nd- 83% (1 staff took 1 resident on an appt leaving other staff with 7 residents) 3rd- 100%



Plan: (1) Briefly describe opportunity for improvement, (2) What info and data that supports the need for this change, (3) Describe success indicators, how outcomes will be measured, and success will be determined.

1. This goal is continued from previous fiscal year. Staff-to-resident ratio must be monitored to meet compliance requirements. A process was developed to monitor it 4 per times per shift over a quarterly period, and this was updated with increased frequency of monitoring for this fiscal year.
2. Success will be determined when all shifts are 100% all the time.

Do:

Action Item	Owner	Resources	Target Date	Actual Date	Progress Notes
Increase staffing or adjust schedules to help maintain ratio on 2nd shift.	Alicia	Time, additional staff	11/30/2021	11/30/2021	Schedules were adjusted for staff on opposite shifts to help aid in coverage until additional staff is hired.
Monthly supervisor meeting to review schedule	Alicia		7/31/2021	7/31/2021	Still happening; proven effective

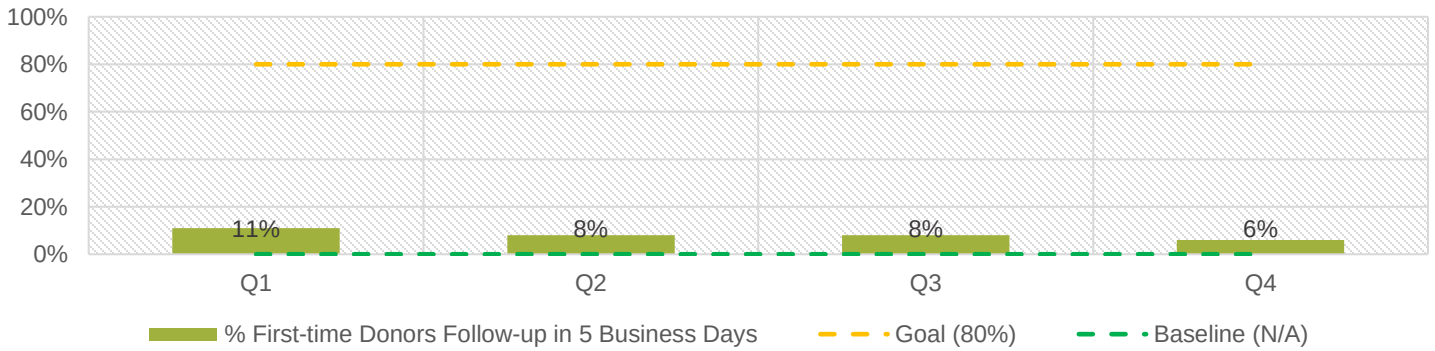
Salary range adjustments, other compensation, additional benefits, and flexible scheduling offered	Emily	Funding	10/31/2021	10/31/2021	All benefits put into effect
Teammate appreciation efforts evaluated and updated	Katy	Community support	2/28/2022	2/28/2022	Community sign-up still being filled

Check & Act: (1) Describe results & observations of improvement plan, (2) Describe challenges encountered during plan implementation, (3) Describe how completed plan will be integrated into regular practice.

1. Monthly supervisor meetings have increased communication and teamwork in ensuring scheduled are completed in advance and filled. This process will continue.
2. Retention has improved but recruitment for new staff proved challenging.
3. Additional evaluation around benefits and support for staff are ongoing to ensure employee engagement and satisfaction.
4. Additional teammates were hired to help fill in gaps and employment levels were maintained.
5. This goal will be moved to a supervisors scorecard and will continue to be tracked and closely monitored.

First-time Donor Stewardship

Goal Statement	Baseline	Q1	Q2	Q3	Q4
80% of first-time donors receive follow up communication in 5 business days	N/A	11% (4/35)	8% (10/118)	8% (3/38)	6% (5/80 – 5 others received personal emails follow up outside of the 5 days)



Plan: (1) Briefly describe opportunity for improvement, (2) What info and data that supports the need for this change, (3) Describe success indicators, how outcomes will be measured, and success will be determined.

1. First time donor communication has proven effective in building lasting relationships with current and future donors.
2. Qualitatively, a high percentage of first-time donors who received timely communication gave a second gift and became long term donors.
3. Using Bloomerang, first-time donors are identified and will be tracked regarding who is receiving personal phone or email follow up to their donation within 5 days of giving.

Do:

Action Item	Owner	Resources	Target Date	Actual Date	Progress Notes
Training reviewed for development	Katy		9/30/2021	9/30/2021	Methods for better utilizing task

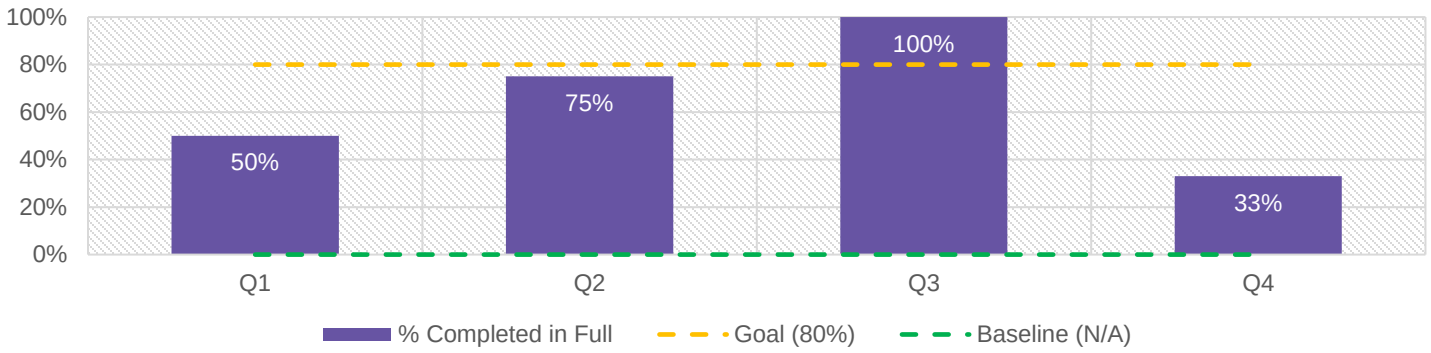
staff and first-time donor stewardship process					management in Bloomerang being implemented to improve consistency of communication
Aligning volunteer follow-up communications that happen in conjunction with financial giving	Tara		4/30/2022	4/30/2022	Collaboration with all community-facing areas taking place to collectively approach first-time supporter communication in all areas
Stewardship practices will be reviewed and streamlined	Katy		4/30/2022	4/30/2022	

Check & Act: (1) Describe results & observations of improvement plan, (2) Describe challenges encountered during plan implementation, (3) Describe how completed plan will be integrated into regular practice.

1. Inconsistency with first-time donor personalized follow up persists. Efforts to assist in this process have been identified with involving board members, Executive Director, and Development Support Specialist.
2. Current stewardship practices need to be evaluated to streamline all stewardship efforts and place processes around execution.
3. Streamline and coordinate efforts along the fundraising activity spectrum (awareness, asking, follow up) to simplify how people can help in fundraising process. More education will be part of the upcoming board meeting.
4. This metric will carry forward. Reporting processes and tracking needs to be reviewed to ensure all follow up is being captured accurately.

Orientation Process

Goal Statement	Baseline	Q1	Q2	Q3	Q4
Full orientation process is completed for 80% of all new teammates	N/A	50% (1/2)	75% (12/16)	100% (4/4)	33% (1/3)



Plan: (1) Briefly describe opportunity for improvement, (2) What info and data that supports the need for this change, (3) Describe success indicators, how outcomes will be measured, and success will be determined.

1. Inconsistencies were identified in orientation training for teammates, including position-specific training, organizational involvement, and ensuring all teammates received full training.
2. Staff retention beyond 90 days was challenging, and initial training was identified as a gap.
3. The number of staff who complete the newly-developed orientation schedule as compared to all newly-hired staff will be the metric for this goal.

Do:

Action Item	Owner	Resources	Target Date	Actual Date	Progress Notes
Building a schedule to meet with people across departments	Alicia		9/30/2021	9/30/2021	Implemented
Consolidating orientation times to include more people being trained at one time	Alicia		9/30/2021	9/30/2021	Implemented
Shadowing for all new residential teammates on 1st shift to help with training, including software	Alicia		9/30/2021	9/30/2021	Implemented
Regular check-ins at more frequent intervals during first 90 days	Alicia		9/30/2021	9/30/2021	Implemented

Check & Act: (1) Describe results & observations of improvement plan, (2) Describe challenges encountered during plan implementation, (3) Describe how completed plan will be integrated into regular practice.

1. Aligning schedules to consolidate orientations has been challenging for both new hires and meeting with teammates across departments.
2. Teammates have given feedback that the amount of information in the first two days is a lot, so information has been presented by more people. Some trainings must be done within the first 14 days, but some training has been identified as possibly moving to be within the first 30 days. Options for moving sections of training to be completed online will be evaluated.
3. The orientation checklist needs to be updated to ensure consistent training and communication is taking place.
4. 90-day retention rates will be evaluated during the third quarter to track impact of new processes. This metric will be built into outputs going forward.
5. Orientation training was spread out for the last quarter to be delivered by supervisors in conjunction with time spent in the cottages, and this seemed more effective for information retention.
6. Time for Relias new hire trainings to be completed in the first two weeks will be built in to time on site.