Performance and Quality Improvement

Annual Impact Plan & Report

Fiscal Year 2022-2023

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, the 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's 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.

	Jul	Aug	Sep	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)	2	0	0	1	0	2	0	0	1	0	1	1
# of New DSS Residents (Intakes)	27	7	8	8	3	6	7	8	7	12	3	8
# of New Residents by Age Group												
0-6 years (new)	0	0	0	0	0	0	0	0	0	0	0	0
7-12 years (new)	2	0	1	1	0	0	0	0	0	0	0	1
13+ years (new)	27	7	7	8	3	8	7	8	8	12	4	8
Gender of Residents												
New Male Residents	7	2	2	3	0	2	0	1	3	1	0	2
New Female Residents	22	5	6	5	2	3	6	5	3	6	4	6
New Transgender/Non-Conforming res.	0	0	0	1	1	0	1	1	1	3	0	0
# of Discharged Residents	4	7	13	7	5	6	5	7	10	2	1	3
Days of Service (Total)	752	772	721	708	692	754	661	720	792	660	713	760
Days of Service – DSS GC1	386	408	347	347	322	337	273	374	398	293	327	360
Days of Service – DSS GC2	149	141	138	167	153	174	110	53	56	60	49	65
Days of Service – DSS GC3	155	161	176	124	127	121	177	209	240	187	205	193
Days of service (Crossroads)	62	62	60	70	90	122	101	84	98	120	132	142
# of Sibling Groups	3	1	0	0	0	0	2	0	0	0	0	0
% of Youth in Sibling Groups	29	14	0%	0%	0%	0%	7%	0%	0%	0%	0%	0%
Development & Marketing	**Q1** *(Jul - Sept)*			**Q2** *(Oct - Dec)*			**Q3** *(Jan - Mar)*			**Q4** *(Apr - Jun)*		
# of Active Donors*	1147	1126	1092	1093	1035	1046	1033	1046	1053	1111	1024	1023
First-time Donor Retention Rate	1%	1%	3%	4%	6%	13%	13%	14%	15%	17%	17%	18%
Human Resources	**Q1** *(Jul - Sept)*			**Q2** *(Oct - Dec)*			**Q3** *(Jan - Mar)*			**Q4** *(Apr - Jun)*		
# of Teammates	61	61	59	60	60	58	60	60	61	63	60	61
Employee Turnover (# Separated)			5			6			6			11
Teammate Engagement Survey Results (85%)					90							
# of Trainings	21	17	32	27	32	35	38	28	37	23	18	23
# of Training Hours	232	143	187	122	213	335	474	420	280	120	221	451
Volunteers	**Q1** *(Jul - Sept)*			**Q2** *(Oct - Dec)*			**Q3** *(Jan - Mar)*			**Q4** *(Apr - Jun)*		
# of Individual Volunteers	44	26	14	23	25	27	18	19	48	36	34	35
# of Volunteers Hours**	110	80	57	84	80	75	58	48	128	109	126	109
# of Direct Hours	91	59	17	30	45	11	24	16	53	9	31	27
# of Indirect Hours	19	21	40	54	35	64	34	32	75	100	95	82

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

***Rounded*

Performance & Quality Improvement Scorecard

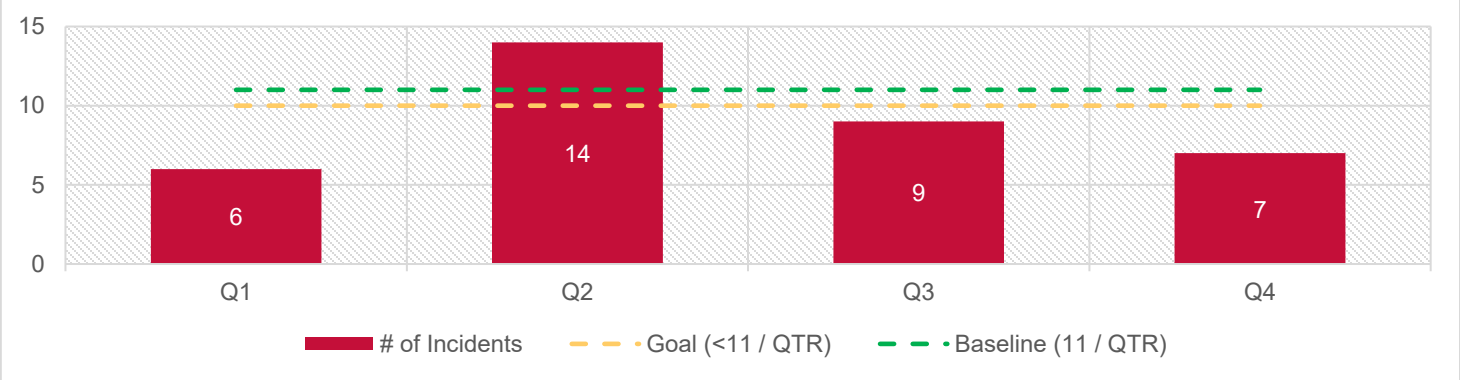
Quality Measure	Goal Statement	Baseline	Q1	Q2	Q3	Q4
Critical Incidents	Reduction in behavioral critical incidents, runaways	11 per quarter (46 total for FY22)	6 (3 runaways)	14 (8 runaways)	9 (5 runaways)	7 (3 runaways)
Behavior Report Reduction	20% reduction in behavioral reports that are documented correctly	400 per quarter (FY22)	51% (202/394)	40% (219/549)	81% (151/186)	73% (132/182)
Medication Errors	Medication errors will be reduced by 30% over the FY23	9 total for FY22	6 (4 same resident)	0	0	0
Transition Planning	80% of residents 16+ receive transition planning services prior to discharge	54% (20/37 for FY22; 63%)	43% (3/7)	92% (12/13)	87% (13/15)	90% (18/20)
Assessment Review Process	90% of eligible residents receive a CANS Assessment Review	N/A	60% (6/10)	64% (7/11)	80% (8/10)	75% (15/20)
Bed Checks	100% of bed checks will be performed as required.	2nd Shift = 94% (840/890) 3rd shift = 99% (884/890)	2nd shift=18% (52/286) 3rd Shift=73% (553/755)	2nd Shift=0% (0/235) 3rd Shift=6% (28/437)	2nd=0% (0/258) 3rd=91% (407/449) *20 was not completed prior to training 1/28 out of the 49	2nd=0% (0/190) 3rd=92% (500/541)
Orientation	Full orientation process is completed for 80% of all new teammates	65% (18/25 for FY22; 72%)	100% (2/2)	25% (1/4) due to holidays and part time employee schedule	75% (3/4) 3 excluded due to being hired at end of quarter.	71% (5/7)
Facility Maintenance	80% of inspection deficiencies are resolved within 30 days	N/A	97% (38/39)	99% (140/141)	100% 67/67	100% (63/63)
Supporter Stewardship	80% of first-time donors receive follow up communication in 5 business days	8% (22/271 for FY22; 8%)	29% (5/17)	Q2: 20% (13/66) Total: 22% (18/83)	Q3: 22% (14/63) Total: 21% (27/129)	Q4: 3% (2/62) Total: 16% (34/208)

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	11 per quarter (46 total for FY22)	6 (3 runaways)	14 (8 runaways)	9 (5 runaways)	7 (3 runaways)



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. There were too many behavioral critical incidents in the year prior, as seen and noted in previous PQI reports.
2. Success will be determined by a reduction in behavioral critical incidents, including runaways.

Do:

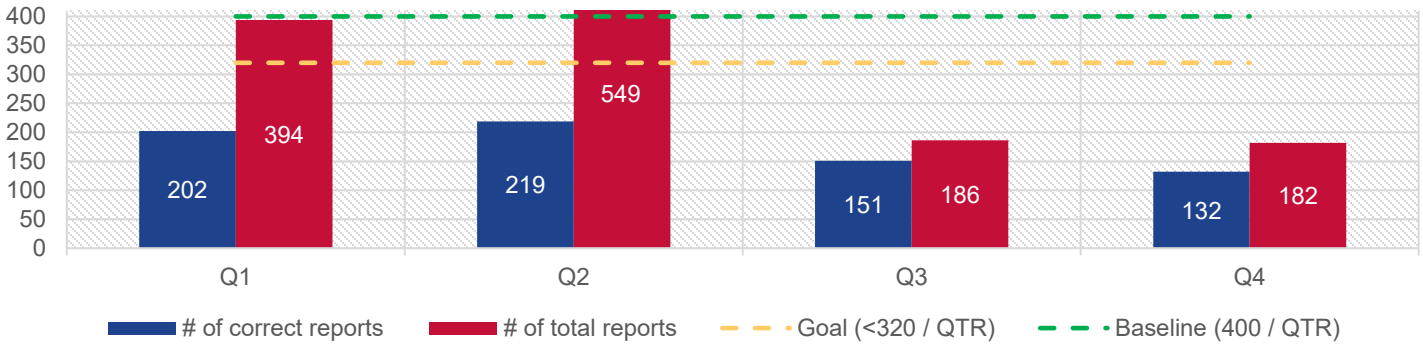
Action Item	Owner	Resources	Target Date	Actual Date	Progress Notes
Held de-escalation refresher trainings more frequently	Alicia	Staff	July 1 and ongoing	July 1 and ongoing	NVCI training module was updated to include trauma-informed care
Train additional staff trainer	Alicia	Staff; training budget	July 1	Jan 30, 2022	Current staff trained on updated NVCI module; additional staff member trained
Completed CARE training for all teammates	Emily	Staff	Dec 31	Feb 28	Approximately 90% of staff completed training by Dec 31, 2022 – newly hired staff completed in following year
Restructured organization to build in additional supervision and support	Emily	Staff; personnel budget	Feb 28	Jul 30, 2023	Took time to find candidates to fill additional supervisory positions
Increased staff on second shift	Alicia	Staff; personnel budget	Apr 30	Apr 30	

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. Relied on law enforcement to de-escalate the situation instead of relying on training. Additional training in de-escalation scheduled for staff.
2. Additional training is needed for staff to effectively de-escalate situations specific to the needs of the current population of residents.
3. Sending all teammates through CARE training aided in approaching situations through a trauma-informed lens and implementing a trauma-informed approach to prevent escalation.
4. In the following year, additional information describing the behavioral critical incidents will be explored.

Behavior Report Reduction

Goal Statement	Baseline	Q1	Q2	Q3	Q4
20% reduction in behavioral reports that are documented correctly	400 per quarter (FY22)	51% (202/394)	40% (219/549)	81% (151/186)	73% (132/182)



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. Staff were incorrectly using the reporting structure to make notes as opposed to accurately report behavioral critical incidents.
2. Information included in behavior reports was related to other areas of documentation, increasing the behavior reports as opposed to documenting alternative information in appropriate places.
3. Number of behavior reports reduced and behavior reports completed are actual behavior reports.

Do:

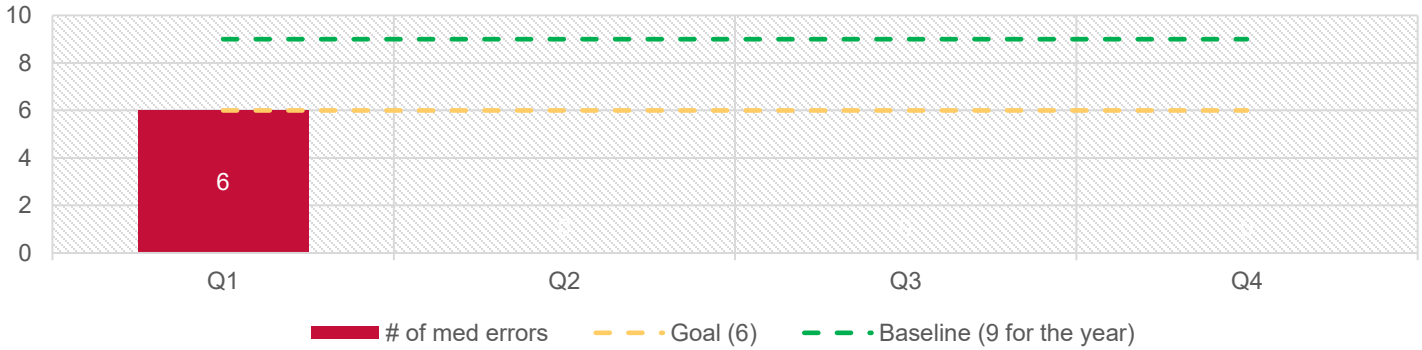
Action Item	Owner	Resources	Target Date	Actual Date	Progress Notes
Report audits done quarterly by area director	Alicia	Staff	Quarterly	Quarterly	Identified staff continuing to document incorrectly
Behavior reports went to supervisor; staff was retrained as needed	Alicia	Staff	Jan 30	Jan 30	All staff retrained on how/when to use and complete behavior reports
New software system provides notification to supervisor for approval	Alicia	IT budget	Aug 1	Aug 1	Increased timeliness of review and retraining

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. Number of reports decreased following staff training.
2. New software system provides notification to supervisor for review and retraining as needed. System access based on level of support are still being adjusted.
3. Supervisor approval process and retraining has been effective in ensuring report accuracy.

Medication Errors

Goal Statement	Baseline	Q1	Q2	Q3	Q4
Medication errors will be reduced by 30% over the FY23	9 total for FY22	6 (4 same resident)	0	0	0



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. It was identified that the number of medication errors was too high, based on PQI results from previous year.
2. Success will be measured by a reduction in medication errors.

Do:

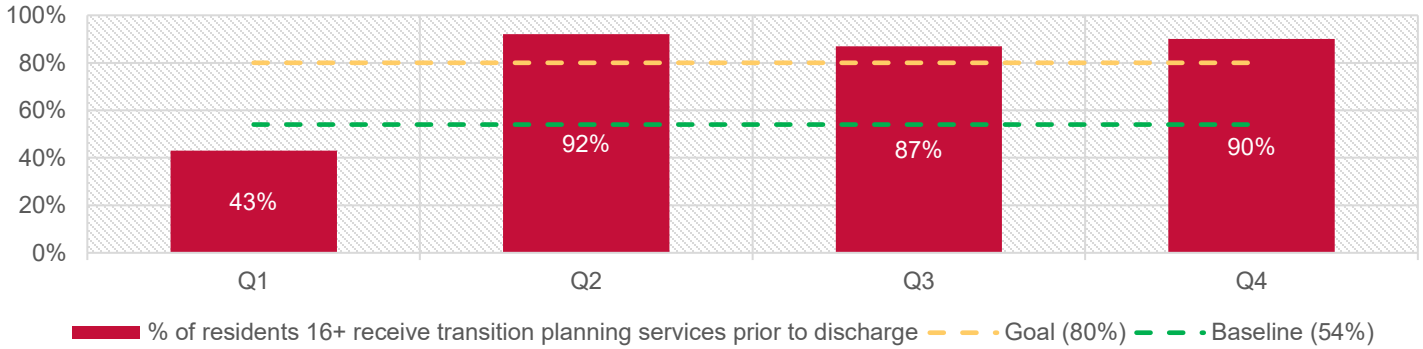
Action Item	Owner	Resources	Target Date	Actual Date	Progress Notes
Medication audits and training done by specific individual	Alicia	Staff	Sept 30	Sept 30	Staff member was previously trained in this area
Reorganized med cart to separate refills and controlled meds	Alicia	Staff	Sept 30	Sept 30	Saw a reduction in med errors
Implemented medication book to log refills and new meds	Alicia	Staff	Sept 30	Sept 30	Saw a reduction in med errors
YCII and up designated as responsible for medication distribution	Alicia	Staff	Jan 30	Feb 28	Change was made during organizational restructure

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. Changes made showed improvement with no medication errors had for the remaining three quarters.
2. Action steps provided allowed for consistent implementation of new processes.

Transition Planning

Goal Statement	Baseline	Q1	Q2	Q3	Q4
80% of residents 16+ receive transition planning services prior to discharge	54% (20/37 for FY22; 63%)	43% (3/7)	92% (12/13)	87% (13/15)	90% (18/20)



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. Too many residents were not having transition plans completed prior to discharge, per PQI results from the previous year.
2. Success will be measured with number of residents with completed transition plans.

Do:

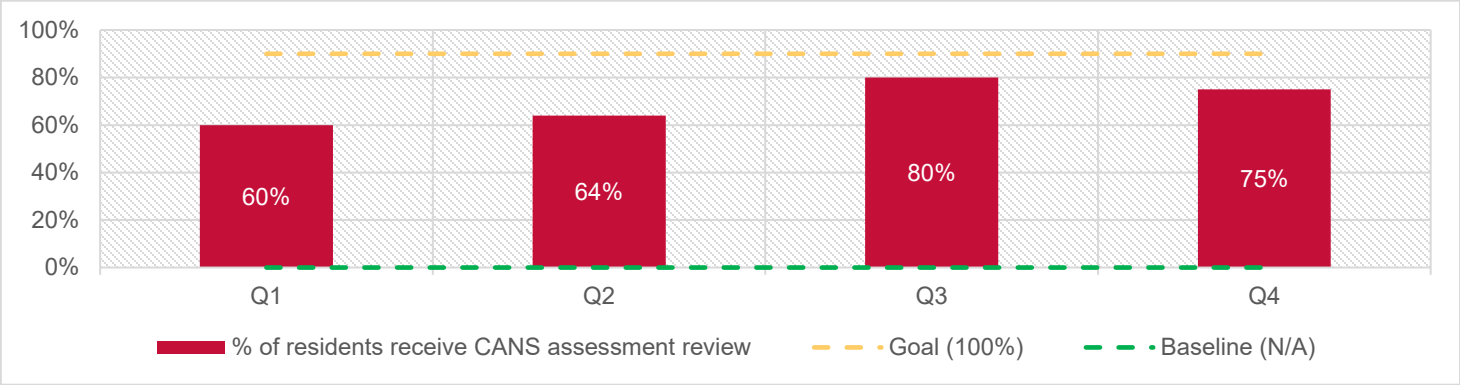
Action Item	Owner	Resources	Target Date	Actual Date	Progress Notes
Included in comprehensive care plan as opposed to making it a separate document	Care Coordinators	Staff; software	Sept 30	Oct 30	
Retrained Care Coordinators to implement as part of care plan	Alicia	Staff	Sept 30	Oct 30	

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. When Care Coordinator positions are vacant, completing this task proved more challenging.
2. Ensuring alignment of CAH plan and DSS plan will be critical for success in this area moving forward. CAH begins this process at 16 while DSS begins this process at 17.
3. With new software system, alerts for these tasks and items will be included.
4. Including programmatic staff members and other relevant teammates in future transition plans for residents will enhance the future success of this area.

Assessment Review Process

Goal Statement	Baseline	Q1	Q2	Q3	Q4
90% of eligible residents receive a CANS Assessment Review	N/A	60% (6/10)	64% (7/11)	80% (8/10)	75% (15/20)



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. It was determined that a review of the CANS assessment needed to be done for all eligible residents after 90 days of initial review.
2. It was recognized that changes were happening from initial assessment and progress needed to be identified so that care plans could be accurately adjusted.
3. It was determined that a CANS assessment needed to be completed every 90 days to ensure residents' care plans and goals accurately reflects and includes their progress.

Do:

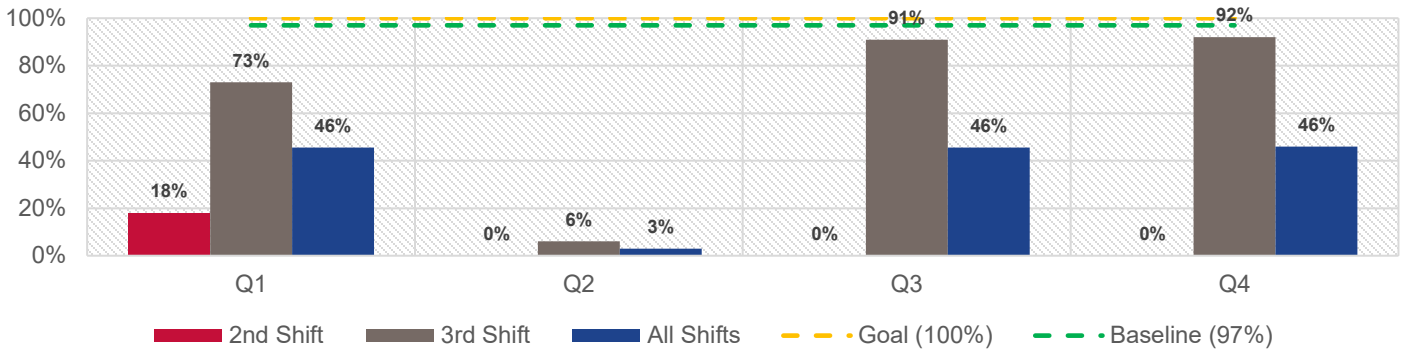
Action Item	Owner	Resources	Target Date	Actual Date	Progress Notes
Added into Kaleidacare care plan	Care Coordinators				Difficult to complete due to lack of trained staff to complete
Separated staffing meetings into regular meetings and emergency staffing meetings	Alicia	Staff	Dec 31	Dec 31	Increased effectiveness of emergency staffings
Trained staff on key principles of this assessment and alignment with CARE	Alicia	Staff	Dec 31	Dec 31	Staff and board were trained on key principles of different frameworks and how they align.
Planned certification training	Emily	Staff	Jun 30	Aug 30	Had newly hired staff trained
Filled key positions	Emily/Alicia	Staff	Mar 30	Aug 1, 2023	

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. Regular staffings allowed for more team-oriented approach to caring for residents versus small group.
2. Key roles were vacant longer than anticipated, so it was challenging to complete review assessment when also prioritizing initial assessments.
3. CANS assessment is being adjusted and fleshed out in the new extendedReach system.

Bed Checks

Goal Statement	Baseline	Q1	Q2	Q3	Q4
100% of bed checks will be performed as required.	2nd Shift = 94% (840/890) 3rd shift = 99% (884/890)	2nd shift=18% (52/286) 3rd Shift=73% (553/755)	2nd Shift=0% (0/235) 3rd Shift=6% (28/437)	2nd=0% (0/258) 3rd=91% (407/449) *20 was not completed prior to training 1/28 out of the 49	2nd=0% (0/190) 3rd=92% (500/541)



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. It was identified that staff did not fully understand when bed checks need to be completed, which is anytime a child is sleeping. This led to bed checks not being completed consistently.
2. Bed checks were not being completed on second shift and were not completed fully on third shift.
3. Bed check forms will be recreated into a more accurate and easy-to-use format. Success is when 100% of bed checks are completed.

Do:

Action Item	Owner	Resources	Target Date	Actual Date	Progress Notes
A new reporting system was implemented to create more accuracy of bed checks.	Alicia/Tara	Staff; IT resources	Jul 30, 2022	Jul 26, 2022	New forms were created and staff was trained on how to use
Staff was retrained on the importance and necessity of bed checks and when they need to be done.	Alicia	Staff	Jan 30	Jan 28	
New bed check forms will be integrated into new extendedReach system	Alicia	Staff; IT resources	Aug 1, 2023	TBD	System still being implemented and then training for staff will be completed
Supervisors were trained on how to pull reports	Alicia/shift supervisors	Staff	Mar 30	Feb 28	

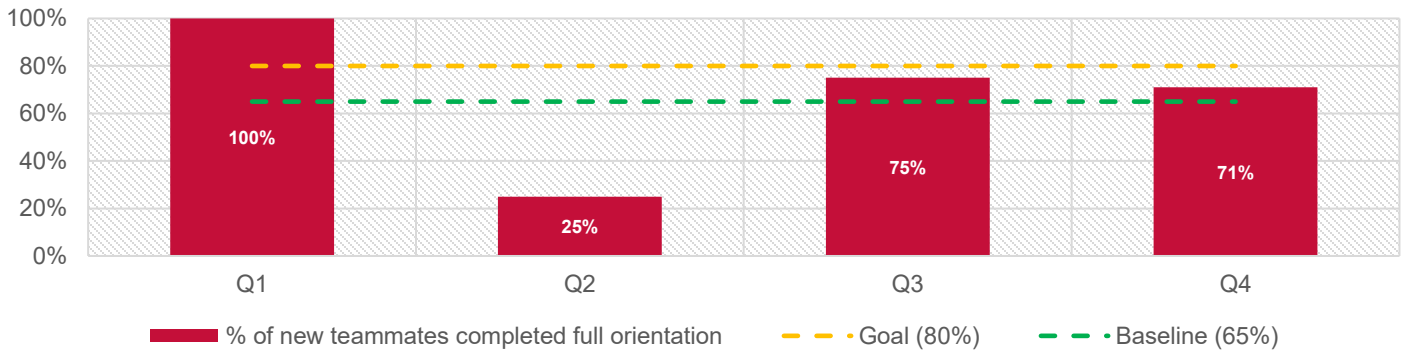
Check & Act: (1) Describe results & observations of improvement plan, (2) Describe challenges encountered during plan implementation, (3) Describe how completed plan will be integrated into regular practice.

1. Retraining in third quarter improved this area on third shift. Second shift continued to be a problem.
2. Ensuring staff used the correct reporting system was a challenge, as well as ensuring they were being completed in the correct timeframe.

3. It was discussed that this area should be added to evaluations for second and third shift staff.
4. It was identified that the motion detectors were being compromised and/or not activated. This issue is being addressed currently with supervisors.
5. Follow up discussion with shift supervisors is needed to ensure all staff are trained on this expectation and how to ensure completion.

Orientation

Goal Statement	Baseline	Q1	Q2	Q3	Q4
Full orientation process is completed for 80% of all new teammates	65% (18/25 for FY22; 72%)	100% (2/2)	25% (1/4) due to holidays and part time employee schedule	75% (3/4) 3 excluded due to being hired at end of quarter.	71% (5/7)



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. It was identified that the delivery of orientation and the necessary sections needed to be streamlined and extended to ensure staff were more thoroughly trained and effectively receiving information.
2. New teammates were inundated with information too quickly, some were not returning, and information was being delivered inconsistently.
3. Success would include full training schedule completed for orientation for every teammate hired.

Do:

Action Item	Owner	Resources	Target Date	Actual Date	Progress Notes
Orientation was extended to a week	Emily	Staff	Aug 30	Sept 30	Teammates are more fully informed with full organization
Additional shadowing time added	Alicia	Staff	Aug 30	Sept 30	Continued to be a challenge for part time teammates
Hired a training coordinator as part of organizational restructure	Tara	Staff; personnel budget	Jan 30	Apr 10	Additional virtual training being added to orientation
Added virtual training elements to orientation	Alicia	Staff	Jan 30	In progress	
Residential policy/procedure presentation developed	Residential leadership	Staff	Jan 30	Jan 30	Improved consistent delivery of information for new teammates

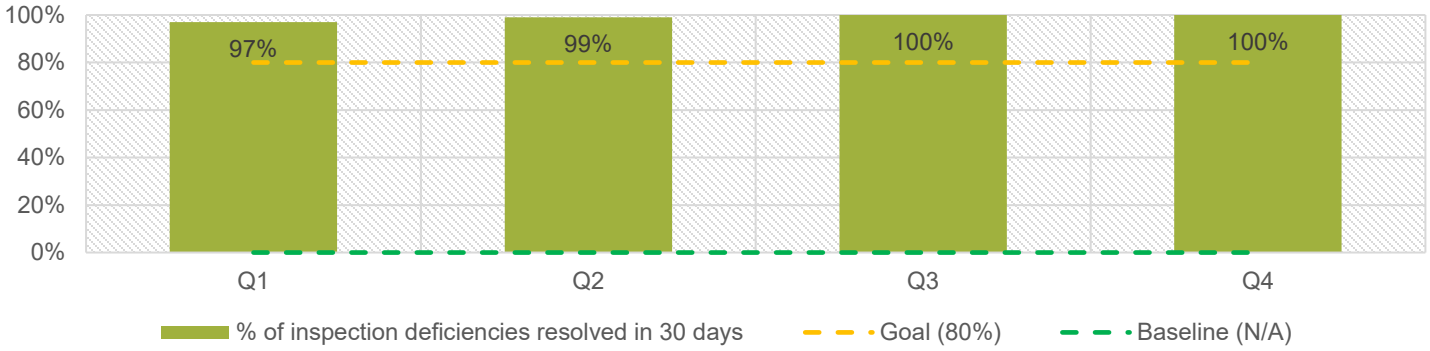
Check & Act: (1) Describe results & observations of improvement plan, (2) Describe challenges encountered during plan implementation, (3) Describe how completed plan will be integrated into regular practice.

1. During streamlining process, it was identified that a training coordinator would be helpful in consolidating the training program for all teammates, including orientation.
2. Orientation for part-time teammates continues to be a challenge due to their other commitments.

3. The increased information has proven to still be a lot for new teammates to adjust well, so the pacing of information is still being evaluated for effective training going forward.
4. It was also identified that we need to tailor orientation based on different programs.

Facility Maintenance

Goal Statement	Baseline	Q1	Q2	Q3	Q4
80% of inspection deficiencies are resolved within 30 days	N/A	97% (38/39)	99% (140/141)	100% 67/67	100% (63/63)



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. There was not a formalized tracking process for preventative maintenance. It was identified that this needed to happen.
2. High repair and maintenance costs pointed to a need for a formalized process to prevent emergency costs in the future.
3. Issues identified in inspection process are fixed and addressed within 30 days.

Do:

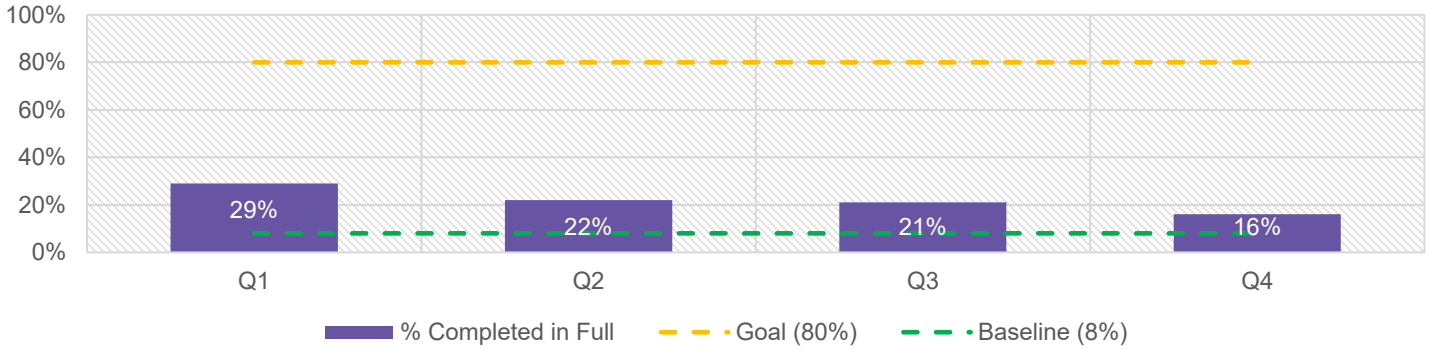
Action Item	Owner	Resources	Target Date	Actual Date	Progress Notes
Inspection plan and documentation process developed	Tara	Staff	Jul 30	Sept 30	

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. After the process was developed, the completion of the process and correction of deficiencies were completed consistency.
2. There remains an issue with staff reporting needs through appropriate channels (using the maintenance@attentionhome.org email for issue submission). This communication channel will continue to be reinforced through leadership.
3. While it is helpful to have one person consistently completing the inspection process, it was identified that areas developed blind spots. Rotating the person doing the inspections was identified as a helpful practice for moving forward.

Supporter Stewardship

Goal Statement	Baseline	Q1	Q2	Q3	Q4
80% of first-time donors receive follow up communication in 5 business days	8% (22/271 for FY22; 8%)	29% (5/17)	Q2: 20% (13/66) Total: 22% (18/83)	Q3: 22% (14/63) Total: 21% (27/129)	Q4: 3% (2/62) Total: 16% (34/208)



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. The completion of phone calls to donors within 5 days was not being done consistently versus later.
2. This was identified through the reporting in Bloomerang of tasks completed for first time donor calls, research shows that this increases likelihood of second.

Do:

Action Item	Owner	Resources	Target Date	Actual Date	Progress Notes
Integrating this task into the weekly donation review	Development Specialist	Staff	Jul 30	Jul 30	This process was done inconsistently; additional training completed
Incorporate weekly time for completing calls	Katy	Staff	Jul 30	Jul 30	This process was done inconsistently within 5 days and happened in an extended timeline
Hire development specialist	Katy	Staff	Apr 30	May 30	

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. This process was incorporated into the weekly donation process but was being assigned inconsistently. This was corrected when the position was filled later in the year.
2. Completing calls within the designated timeframe is a process that needs to be shared more widely and completed consistently in a timely manner.
3. Midway through the year, the development specialist position was vacant. This process was picked back up during the end of the fourth quarter when a new development specialist was hired.
4. It was identified that tribute gifts require a more specific approach tailored to the reason for giving.
5. It was discussed that this may need to be adjusted for realistic processes and expectations going forward in alignment with all stewardship processes.