Quality Assurance Plan
January-December 2016

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Executive Summary

Center for Social Change is a private, non-profit organization providing a variety of services for adults and children with developmental disabilities throughout the State of Maryland. Center for Social Change's main office is located in Elkridge, Maryland and services are provided throughout Baltimore, Howard, and Prince George's Counties. Currently, Center for Social Change offers residential services for adults and children in CSLA homes, ALUs and group homes. CSC also operates Adult Medical Daycare program Employment Services and Vocational day habilitation programs.

2016 Highlights

Program Expansion:

At the end of calendar year 2016, 106 individuals were supported in CSC's Residential Program. During 2016, an additional 8 individuals began receiving supports at the Employment & Vocational Services for a total of 88 individuals served. CSC's Adult medical Daycare opened its doors to provide quality medical care and is now serving 55 individuals.

Staff Expansion:

CSC has demonstrated its continued commitment to the development of a strong, skilled workforce to provide highest standards of quality. During the past year, 102 new direct support staff have been hired to help CSC best serve the individuals who have chosen CSC as their provider of choice.

In addition to these new hires, an additional 13 Administrative staff were hired, in several departments, during 2016. These included the hiring of two individuals who are supported in CSC's Residential Program to work in the main administrative office; additional new-hires in HR, Finance, Operations; increased staff in both the Medical Day Care and Day Programs; increased staff in the Residential Program. At this time CSC's has 281 direct care staff, 45 admin staff 1 RN and 5 LPN's.

Community Education, Involvement and Outreach:

As part of Center for Social Change's community involvement and outreach efforts we have developed relationship with the following:

CSC has provided internship experiences to multiple higher education institutes. One intern from University of Maryland Baltimore County completed required hours for her Health Administration and Policy Program degree.

Community Integration is a vital goal for CSC. CSC has continued and expanded participations (or membership) with:

- Maryland Chamber of Commerce
- Baltimore County Chamber of Commerce
- Maryland Council of Directors of Volunteer services
- Maryland Association of Nonprofits (MANO)
- Maryland Works
- Disability Sports USA
- Liberty Road Business Association (LRBA)
- Liberty Road Community Council (LRCC)
- Fieldstone Community Association
- Howard County Commission on Disability Issues (CDI)

CSC actively participates in quarterly and annual meetings of LRBA and LRCC. CSC is an annual Sponsor for the Liberty Road Tree Lighting Ceremony at Randallstown Gateway Park.

CSC in partnership with the Governor's Office and Department of Social Services provided needed items to those within our community. In 2016, CSC continued assisting the homeless population in Baltimore City to provide essential care items. CSC also provided Thanksgiving dinner assistance to multiple Shelter homes.

Continued Expansion of Information Technology Capabilities:

In March 1 2016, CSC introduced STEDS (Staff Training & Electronic Documentation System) a full-fledged online training and electronic documentation software developed by CSC. STEDS helps CSC Management to track and monitor staff's training, ALU management, and also to gain monetary benefits from paying recurring third party software license fees. STEDS helps staff to fulfil their responsibilities for receiving all the DDA mandated adult and children's trainings and other CSC Mandated trainings. The training module on STEDS has three separate sections for Adults Trainings, Children's Training & Mandated Trainings. The dash board of the system gives a complete tracking record of all the trainings of every staff in a single glance.

The administrative staff (training Managers and supervisors) will be able to see all staff's trainings from this dash board and also enable them to print the training certificates as well. The online documentation section (Friday Packet) of the system has the following menus:

1. Weekly Check List – to track & monitor the overall quality checks of the Homes
2. Change of Shift - to check how the staff is maintaining their ALUs (medication/cabinet, medication, other, individuals, home/environment & vehicles during their assigned shift)
3. Maintenance – to report any maintenance requests by the staff
4. Communication – to report any information to Program team members
5. Awake Overnight - to monitor individual's activity during night hours
6. House Meeting Notes – to report each week's house meeting notes to the Program Team.

Since STEDS is an in-house software CSC has the flexibility of expanding this system according to CSC's future requirements.

CSC is utilizing Therap for all its medical and clinical documentation which includes all medical and psychological appointments and follow ups, nursing reviews, plan of care, labs and nutritional assessments. Averages of 475 appointments are entered onto Therap on a monthly basis. Three clinical assistants are responsible to create, update and follow up on all these appointments. In 2016, CSC began to utilize Therap to pilot for a few individual's outcomes and goals documentation. The Individual Plan consists of all interim and annual meetings, consents and progress reports.

In addition to STEDS, CSC is maintaining in house software to manage the areas of HR, Quality Assurance, Field Staff Monitoring, Adult Medical Day Care Management and Home Supplies Monitoring.

1. CSCHRM

CSCHRM, emerging in line with the new generation of web HR systems, will assist in managing CSC's most important asset - human resource. CSCHRM, which is applicable to diverse business industries, is a perfect platform for re-engineering our HR processes, paving the way to a new level of HR Management.

2. Quality Assurance

This software is developed for monitoring quality checks on ALUs, IP/BP, Medical and CSC Vehicle Management

3. Adult Medical Day Care Management System

This software manages keeping up to date information about New Admissions, individual information, contact information, physician's details, follow ups and various agency required reports

4. Home Supplies Monitoring System

This software is developed to track the allocation of daily needed supplies to CSC units. The system can generate reports for items supplied to each unit on a monthly basis and also a yearend analysis at the end of a fiscal year.

5. Field Login System

To track the employees field presence on a day to day basis.

Quality Assurance Objectives for Calendar Year 2017

CSC has identified the following as the objectives for 2017. These objectives are based on the recent review from OHCQ, and suggestions from the Quality Assurance Committee.

Medical /Clinical:

1. Maintain at least a 95% rate of compliance to completion of scheduled and referred appointments.
2. Maintain the low rate of errors for "medications not given" at a level not to exceed 3% in any given quarter.
3. Achieve a rate of occurrence of MAR charting/ procedural errors (e.g.- Weight not documented, BP not documented missing Start Dates, , circles on the front not being explained on the back, medications discontinued appropriately with a reason on back of MAR) so as not to exceed 3% for any given quarter.
4. Maintain 100% rate of MAR's being printed with all the required information (including individual's name, gender, Allergies, DOB and delegating Nurse's name).
5. Achieve a rate of 100% of the completed consult forms to be uploaded in the Therap on line documentation system.

Person Centered Plans and Care Plans (Adult Medical Day, Residential & Employment Services):

- Achieve 100% of all IP's being up-to-date in both Residential, Employment & Vocational Day Habilitation Services.
- Achieve 100% of IP implementation Within 20 days of annual IP.
- Achieve 100% of all the care plans completed and implemented at Adult Medical Daycare.

Human Resources:

- Achieve a turnover rate of no more than 23% throughout the calendar year 2017.
- Achieve completion rate 100% DDA-mandated/Core trainings for all staff hired during calendar year 2017.
- Achieve and maintain a completion rate of 100 % performance evaluations completed on time.

Community Relation and Advocacy:

- Increase family member satisfaction to at least 95%.
- Increase Stakeholder satisfaction to at least 95%
- Increase Employee Satisfaction to at least 85%

Operations/ Maintenance:

- Maintain at least a 100% rate of compliance to completion of fire and disaster drills.
- Maintain 100% turnaround of addressing maintenance request within 24-48 hours.

Technology

- Utilizing STED 100% for all mandated trainings throughout the calendar year 2017.

Report on Quality Assurance Plan 2016

CSC's Quality Assurance Plan covers the calendar year 2016, and focuses on those Objectives which were identified in the previous year's QA Plan. In many cases, 100% of a given sample set was analyzed. However, due to the large number of program participants and available data, data for some analyses were collected utilizing randomly defined samples.

Using information available in agency databases, written reports, individual's files, stakeholder surveys, etc., objective data was collected and analyzed for selected program areas.

Quality Assurance Objectives for Calendar Year 2016:

Medical /Clinical:

1. Maintain 100% rate of MAR's being printed with all the required information (including individual's sex, DOB and delegating Nurse's name)
2. Maintain at least a 95% rate of compliance to completion of scheduled and referred appointments.
3. Maintain the low rate of errors for "medications not given" at a level not to exceed 3% in any given quarter.
4. Achieve a rate of occurrence of MAR charting/ procedural errors (e.g.- Weight not documented, BP not documented missing Start Dates, , circles on the front not being explained on the back, medications discontinued appropriately with a reason on back of MAR) so as not to exceed 3% for any given quarter.
5. Achieve a rate of 100% of the completed consult forms to be uploaded in the Therap on line documentation system.

Person Centered Plans and Care Plans (Adult Medical Day, Residential & Employment Services):

1. Achieve 100% of all IP's being up-to-date in both Residential and Employment Services.
2. Achieve 100% of IP implementation Within 20 days of annual IP.
3. Achieve 100% of all the care plans completed and implemented at Adult Medical Daycare.

Human Resources

1. Achieve a turnover rate of no more than 25% throughout the calendar year 2016.
2. Achieve a completion rate for DDA-mandated/Core trainings 100% for all staff hired during calendar year 2016.
3. Achieve and maintain a completion rate of 95 % performance evaluations completed on time.

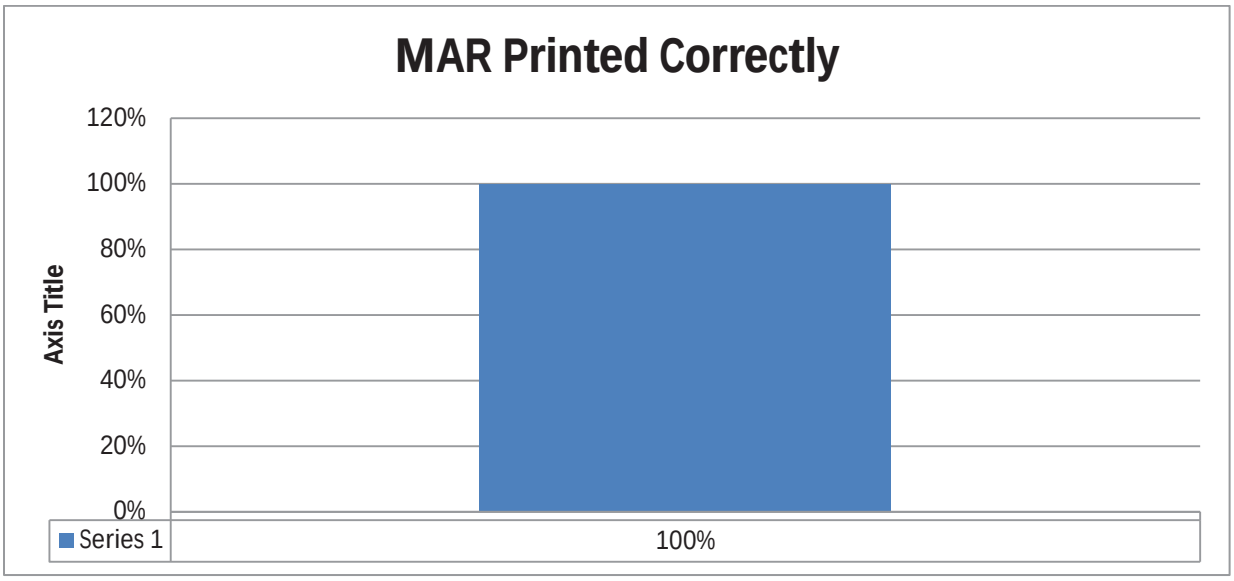
Community Relation and Advocacy

1. Increase family member satisfaction to at least 90%.
2. Increase Stakeholder satisfaction to at least 90%
3. Increase Employee Satisfaction to at least 80%

Operations

1. Maintain at least a 100% rate of compliance to completion of fire and disaster drills

Objective #1: Maintain 100% rate of MAR's being printed with all the required information (including individual's sex, DOB and delegating Nurse's name)

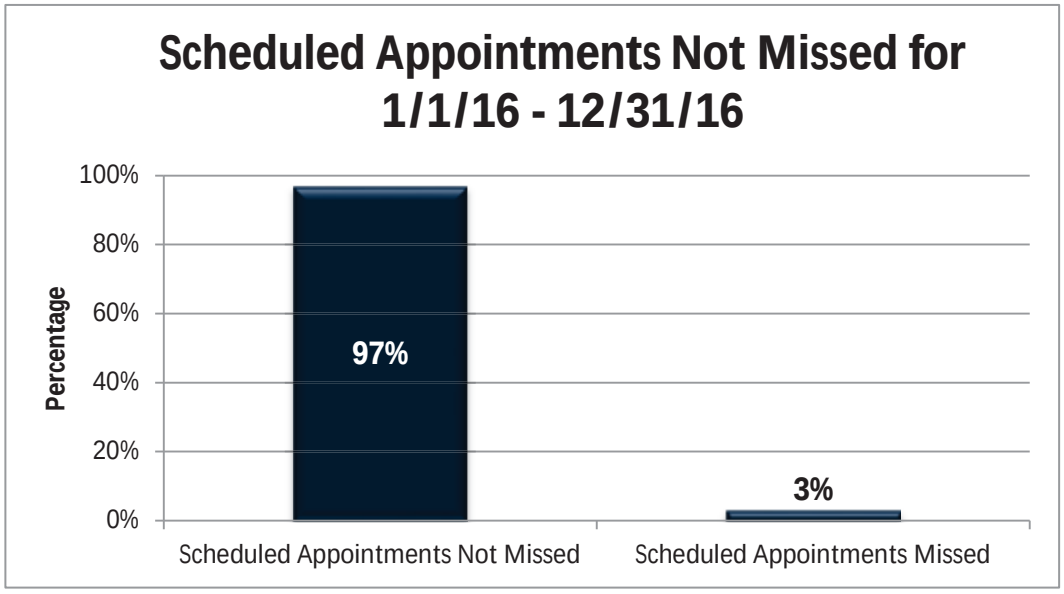


Results/Discussion:
CSC is partnered with Care one Pharmacy to serve the needs of the individuals. During 2016 four quarterly audits were completed on random individual medical binders. It was noted that 100 % MAR printed without any errors, and with the required information present. All four audits completed were on different information such as person served correct Name, DOB, Gender, Physicians name, Delegating Nurses name, or allergies etc.

Plan of Action:
The Coordinators and Clinical Department will continue to work with Care one Pharmacy to monitor new printed MARs each month to ensure all required information continues to be reflected. Quality assurance audits will be completed planned or randomly and an analysis report will be submitted to Quality Assurance committee.

Objective #2: Maintain a 95% rate of compliance to completion of scheduled appointments. (No more than 5% will be missed)

Data was collected for each individual throughout the year by the Quality Assurance Specialist. In total, 5239 appointments were performed throughout calendar year 2016, which averages to approximately 52 audits completed during the year for each individual served. Graph below, reveals that 97% of all scheduled medical appointments were successfully completed as scheduled.



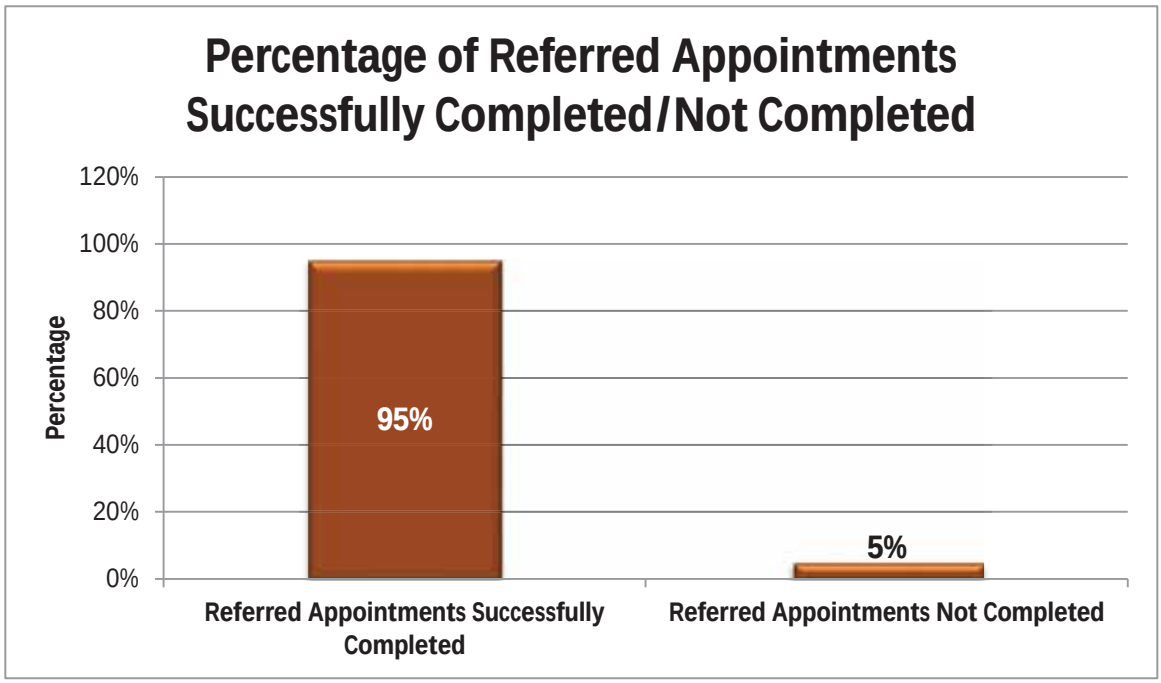
Summary Results/Discussion:
The results indicate that the goal of a 95% rate of compliance to completion of scheduled medical appointments was met, and exceeded, in calendar 2016. A total of 5239 were scheduled from Jan – Dec 2016. 5072 appointments were completed on time and 20 were missed.
Such assessment of the primary causes for which appointments were missed was completed. For those missed appointments for which a reason was identified, there were three primary reasons that they were missed:

1. Arriving late at the Dr. Office
2. Staff forgot about the appointment
3. Transportation issues

Plan of Action:
The Coordinators who provide status reports concerning whether or not medical appointments were kept as scheduled have been informed that it is their responsibility to provide a valid reason for any appointments missed. Also, the Clinical Specialist, who records the outcomes for all medical appointments, has been directed not to accept any status reports from Coordinators that fail to provide such a valid reason.
As to the reasons for appointments being missed, the most frequently occurring reason is that staff and the individual arrived late at the appointment. Therefore, the time for all appointments will be entered into Therap, the medical scheduling database, as ½ hour prior to the actual appointment time.

Objective #2: Maintain at least a compliance rate of completion of follow-up/referral appointments of 95%

For each individual, all medical appointment reports were read, and any referrals were identified. It was then further determined whether or not these referred appointments were completed. Based on a review of Therap from Jan to Dec 2016, a total of 347 follow up appointments were scheduled. These appointments include post –ER, dentist, endocrinology, vision and other PCP follow up. The results are demonstrated in Graph 2, below.



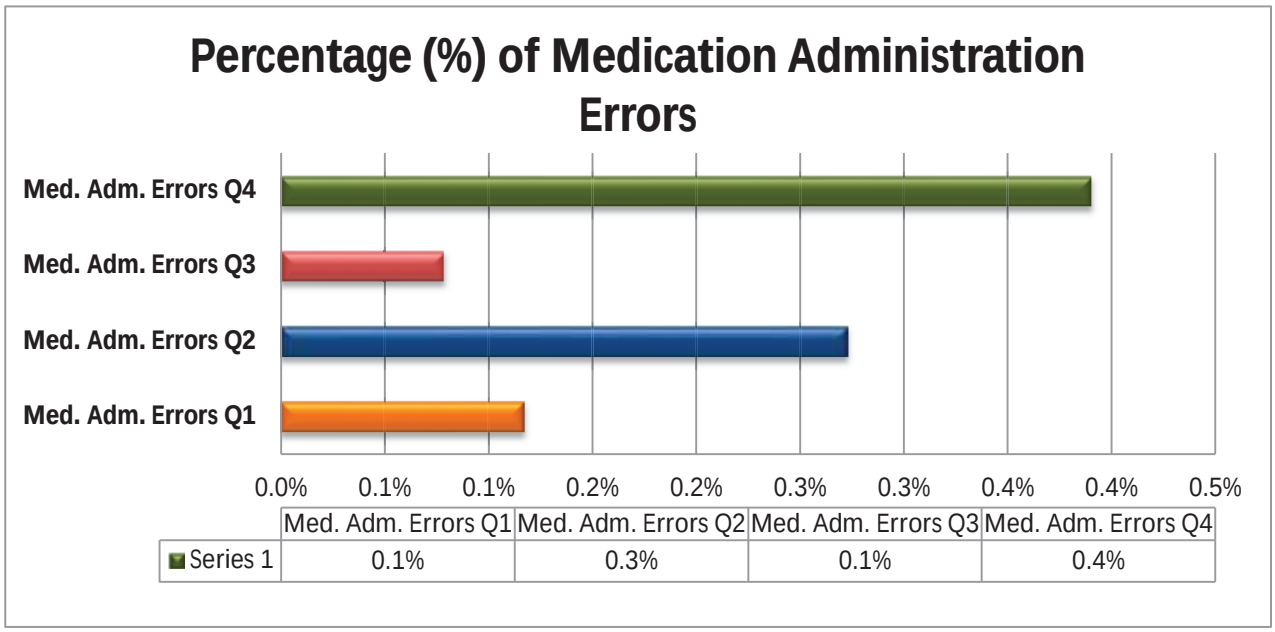
Graph 2

Results/Discussion:
The results indicate that the goal of a 95% rate of compliance to completion of scheduled medical appointments was met and exceeded through calendar 2016. Specifically the audits reveal that 5% of all referred appointments were not completed as prescribed. The remaining 95% of referred appointments were completed. Out of 322 follow up appointments 16 were refused by the individuals, and none were canceled. All the refused appointments were rescheduled and completed.
The reasons that a small percentage of referred appointments were not completed are the same reasons that any given appointment might not be kept- problems with transportation at the time of the appointment, referral issues required by insurances that needed to be sorted out, staff arriving late, etc. Some appointments noted as not completed were due to not having availability by the referred doctor's office until after the noted time due.

Plan of Action:
Many referred appointments are in unfamiliar areas. Staff will be given written copies of directions for such appointments and calls will be made by the Clinical Specialists to inquire about parking situations and requirements to alert staff and Coordinators of available parking and any associated costs. This will be communicated with staff prior and funds will be made available to ensure staff has all resources required.

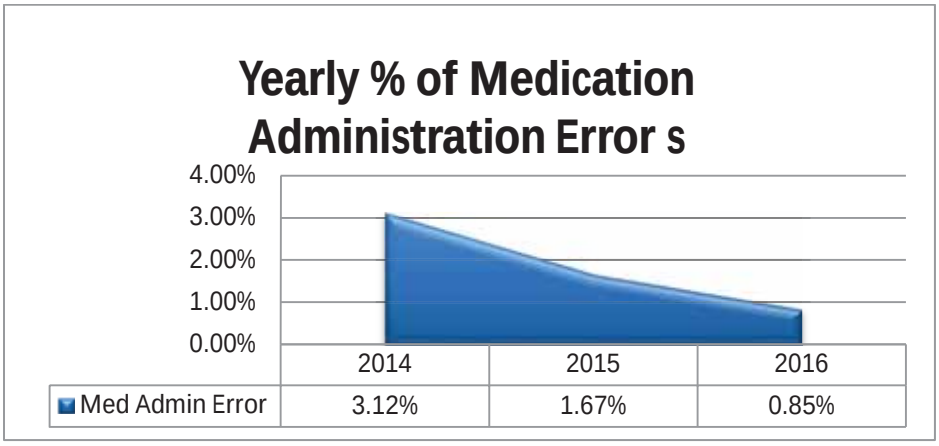
Objective #3: Improve the low rate of errors for "medications not given" at a level not to exceed 3% in any given quarter

The graph indicates the error rate for the error category "Medication Administration Errors"; for the most part, this error category is made of up failures by staff to give medications as prescribed. Data was collected throughout calendar year 2016; more than 2564 separate audits were performed during the year.



Results/Discussion:

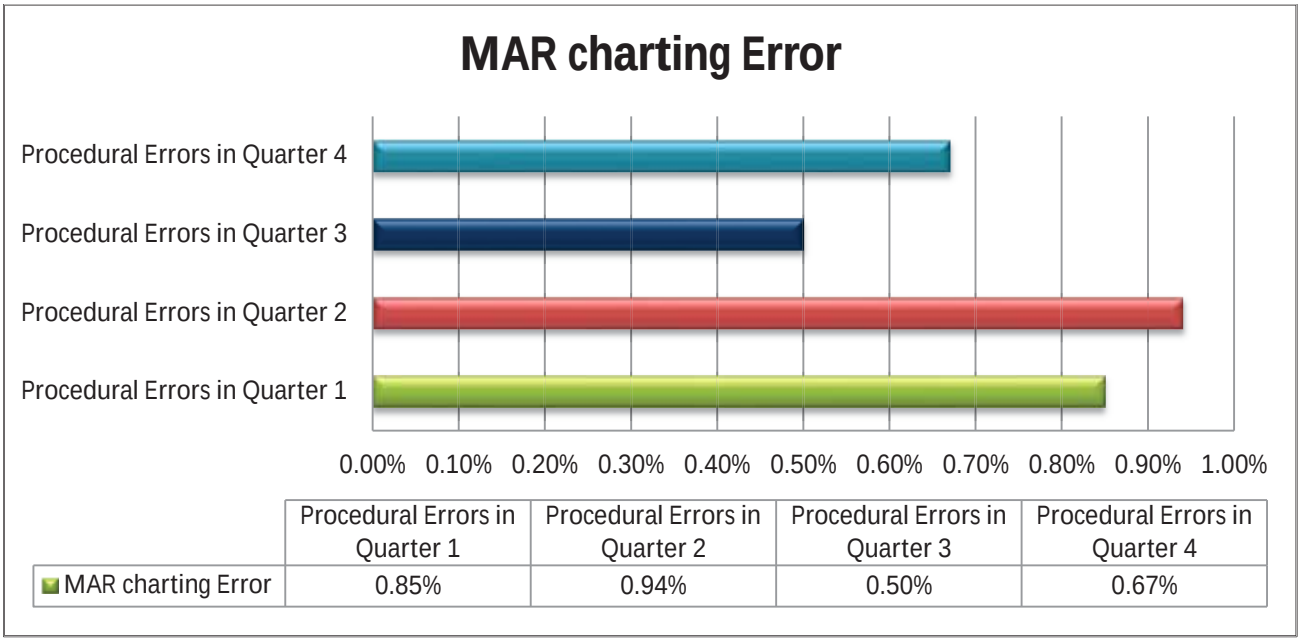
The results indicate that the goal of a less than 3% error per quarter rate was achieved, and exceeded, in all quarters of calendar year 2016. A yearly comparison shows that the procedures put in place are assisting in Improving in reducing medication administration errors under a certain level .



Plan of Action:

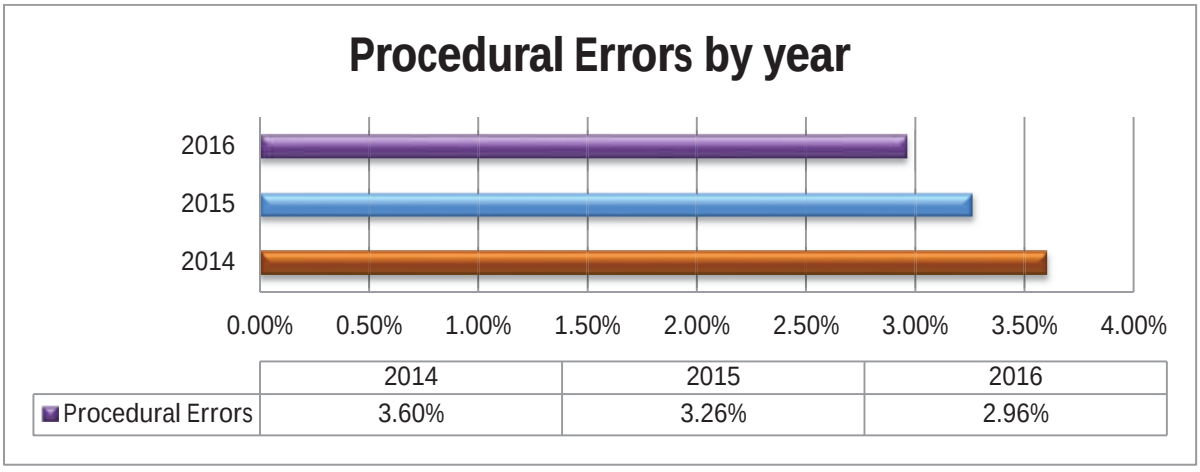
Coordinators will continue to be required to monitor medication administration at each of their daily house visits. The Quality Assurance team will continue to perform ongoing audits at a frequency of visiting each house approximately 4-5 times a month. Delegating nurses will visit the homes every 45 days. Also Med Rite performs their reviews 4 times a month.

Objective #4: Maintain a rate of occurrence of MAR charting errors (e.g.- missing Start Dates, medications not charted, circles on the front not being explained on the back, and "Medications Given, but Not Charted") so as not to exceed 3% for any given quarter



	Procedural Errors in Quarter 1	Procedural Errors in Quarter 2	Procedural Errors in Quarter 3	Procedural Errors in Quarter 4
MAR charting Error	0.85%	0.94%	0.50%	0.67%

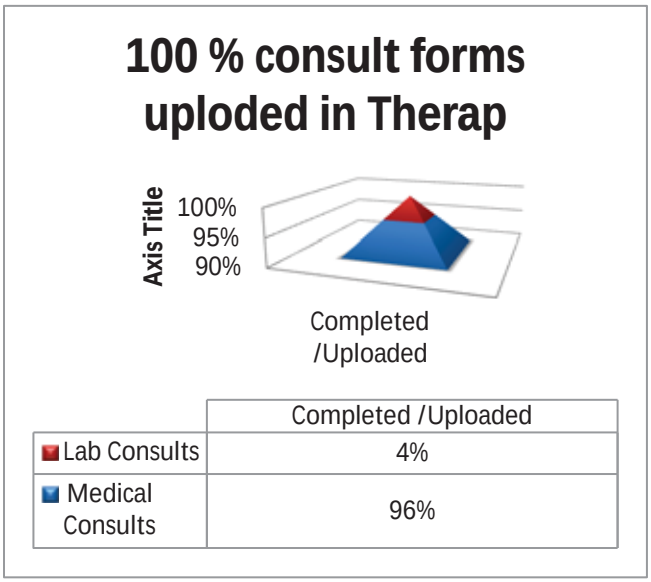
Results/Discussion:
The graph indicates that the goal of a less than 3% rate of occurrence of MAR Charting Errors was met, and exceeded, in all quarters of calendar year 2016. In fact, this is an improvement compared to (3.26%) for calendar year 2015 and (3.60%) in calendar year 2014.



	2014	2015	2016
Procedural Errors	3.60%	3.26%	2.96%

Plan of Action:
As the goal was met, and as significant improvements were made when compared to the previous calendar year, no changes are planned in the process of maintaining MAR accuracy.

Objective #5: Achieve a rate of 100% of the completed consult forms to be uploaded in the Therap on line documentation system

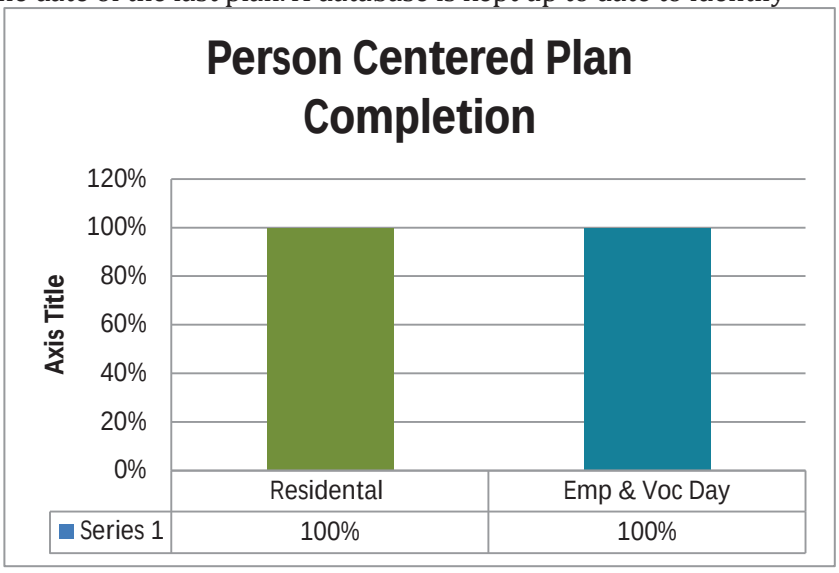


Results/Discussion:
Excluding Phlebotomy when there is a delay in receiving results, a total of 6345 completed consult forms were successfully uploaded in Therap. Lab consults were total 280. Total number of consults uploaded in Therap was 6625.

Plan of Action:
Clinical specialists will continue to process and upload consultation forms within 48 business hours of completion of each appointment. Quality assurance team will continue to monitor the completion-upload of the consultation form in the Therap online documentation system.

Objective #6: Achieve 100% of all person centered plan's being up-to-date in both Residential, Employment Vocational Day Habilitation Services.

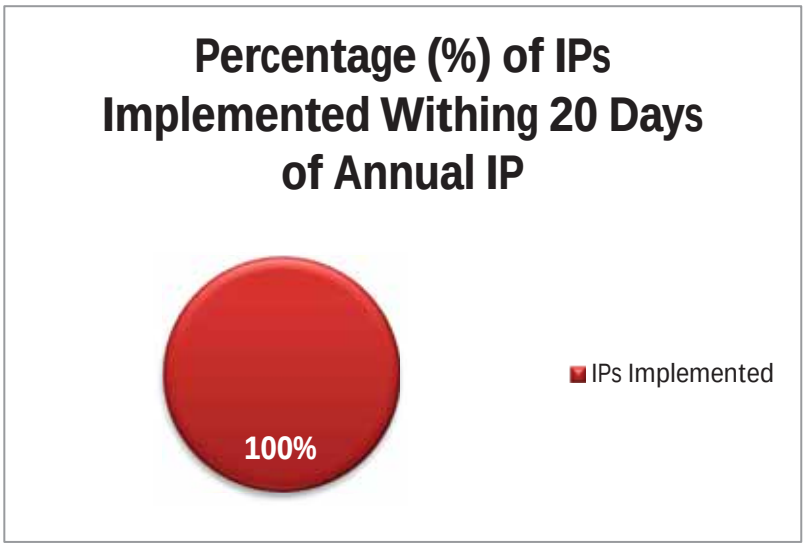
For this year the entire 194 Person center plans were audited to determine if the current had been put in place within the required one year from the date of the last plan. A database is kept up to date to identify when the last planning meeting was held and when the next one is due. Program Specialist, update once the planning meeting is occurred for the person served. Graph below, shows the results of that audit:



Results/Discussion:
During this year there were 194 Individual Plan completed within 365 days. 6 individuals were new admissions and their plans were completed within the 30 day admission/annual IP meeting.

Plan of Action:
The dates for all IP's (Residential or Vocational) have been entered into a database which calculates the "next IP due date". IP meetings are scheduled based on this database, thereby ensuring that no IP meeting, with a resulting IP, will go beyond the required 365 days. The IP data base is updated every time an IP meeting is completed and IP is implemented within the 20 days for each individual.

Objective #7: Achieve 100% of IP implementation Within 20 days of annual IP



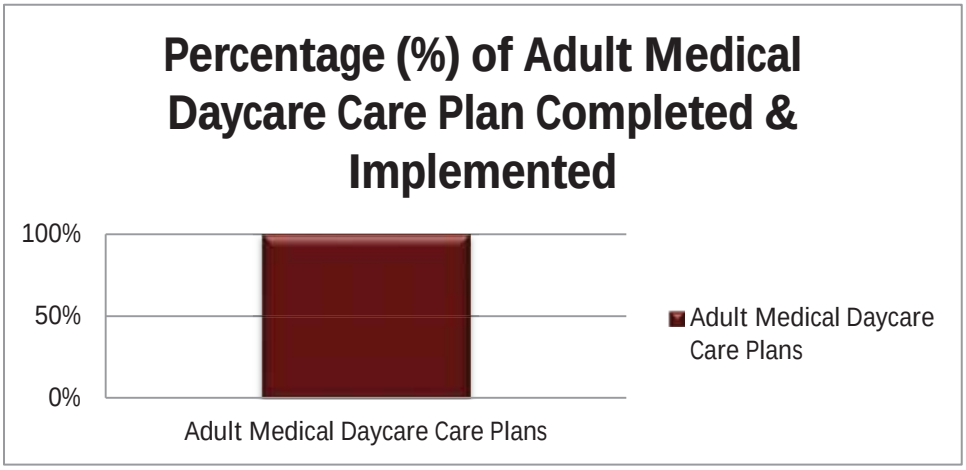
Results/Discussion:
From a total of 188 individuals, 184 annual IPs were implemented within 20 days of the annual IP, with only 4 IP outstanding.

Plan of Action:
Program Specialist will continue to schedule the implementation date as soon as the IP date is confirmed with teams. They will continue to follow up via use of emails and phone calls to ensure they receive the final IP from the Resource Coordinator within the required time for implementation.

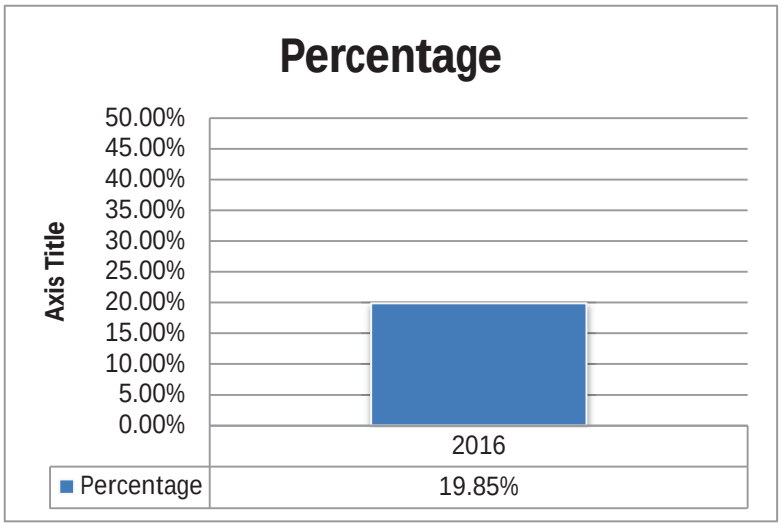
Objective #8: Achieve 100% of all the care plans completed and implemented at Adult Medical Daycare

Results/Discussion:
All Adult Medical Day participants have a care plan completed upon admission and reviewed and updated as necessary every six months. The audit completed of all participants displayed 100% were completed and up to date.

Plan of Action:
As the goal was met, no changes are planned in the process of maintaining care plans at Adult Medical Day.



Objective #9: Maintain a turnover rate of no more than 25% throughout the calendar year 2016

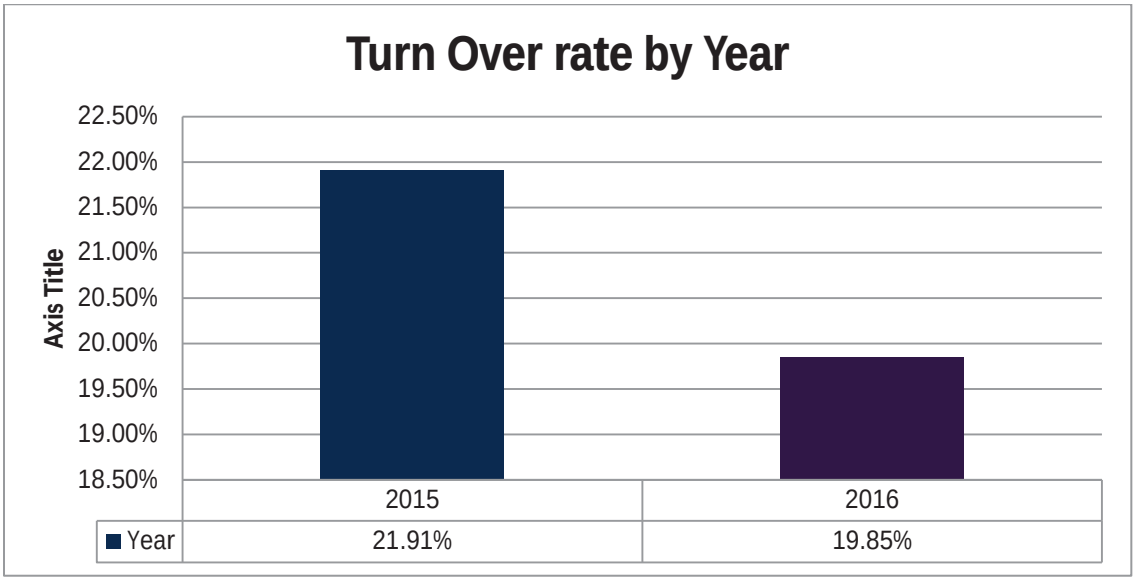


Turnover was, for the purposes of this (and previous) Quality Assurance Plans, defined as anyone leaving the job for any reason, regardless of that staff person's tenure. The rate of turnover was determined by identifying the average number of staff that were active (ie- received a paycheck) during 2016, how many staff left employment during 2016, and finally calculating the percentage of staff who left employment.

The average number of employees who were paid during 2016 was identified as being 519; the number of staff leaving employment during the calendar year was 103.

Results/Discussion:

The goal of maintaining a turnover rate of no more than 25% was met, and exceeded, for the calendar year 2016. Furthermore, the turnover rate has been steadily decreasing over the past several years.

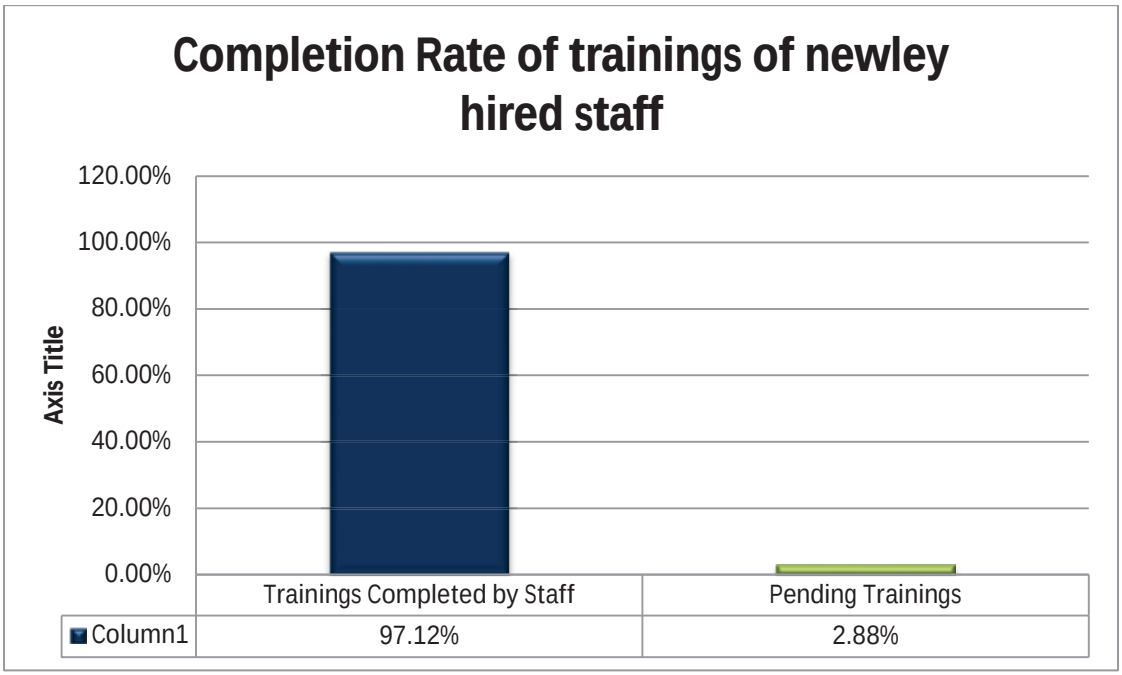


Plan of Action:

A number of incentives for staff have been developed during the previous and past year, and it is the belief of CSC's leadership that these incentives have helped to improve morale, resulting in a decrease in turnover. These include Special Recognition Programs with cash bonuses or other rewards; promotion from within the ranks of direct support staff; other special programs. All of these programs will be continued into the next calendar year, and new programs will be designed and implemented.

Objective # 10: Achieve a completion rate for DDA-mandated/Core trainings 100% for all staff hired during calendar year 2016

Newly hired staffs are required to complete a set of DDA-mandated trainings within 3 months of their hire date. In order to determine the percentage of such trainings which were completed within the required time frame, an audit of HR files was completed to identify those staff who were: a) hired during 2016 and b) who would have been required to complete DDA-mandated trainings by 12/31/16 As each staff member is required to complete 17 DDA-mandated trainings



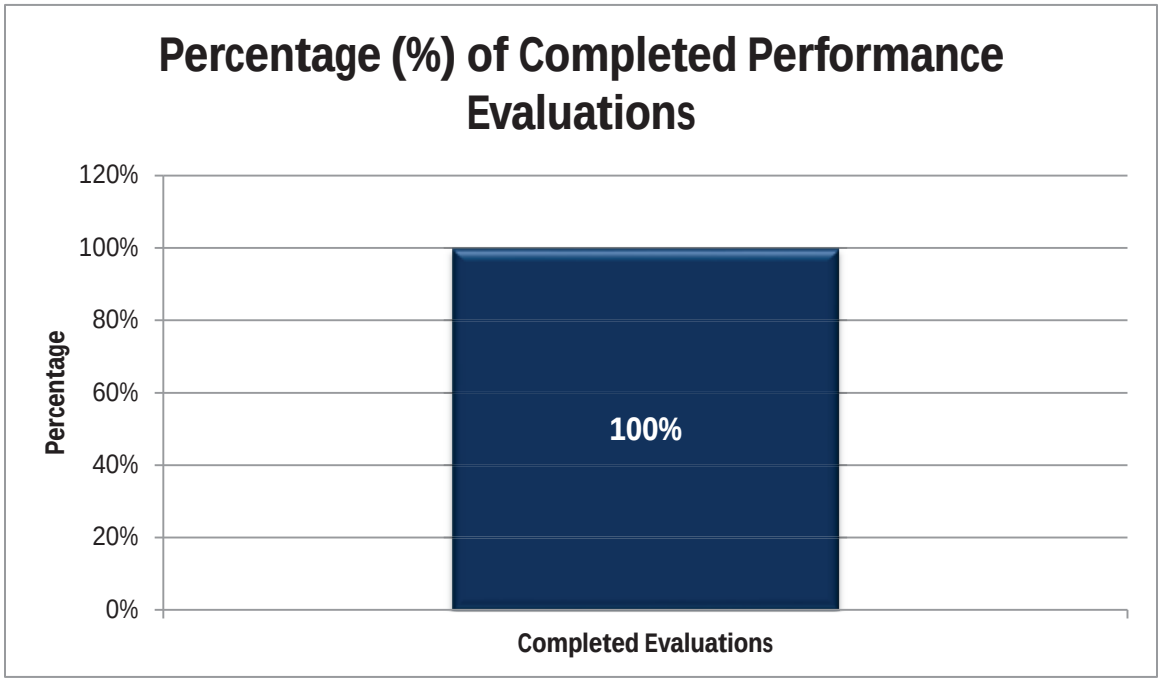
A subsequent audit of calendar year 2016 Training files for these newly hired staff members revealed that out of the 17 DDA required trainings, 7 staff did not complete as required;

Results/Discussion:
The 97.12% success rate fell below the stated Objective of 100%. The primary difficulty in getting all staff trained within a 30 day period is that many staff has multiple jobs, and scheduling a several-day training can be difficult. Also comparing to the last year when 14 trainings were required, now the staff have to complete 17 trainings. 3 of the newly hired staff are a person served who cannot complete the trainings due to limitations.

Plan of Action:
At the end of 2016, CSC had Dimensional Healthcare as their contracted nursing service to resolve any CMT training issues. HR and Training Coordinator staff will continue to offer newly hired staff different options to complete the mandated trainings on time such as web based availability from the workplace or home to allow flexibility with staff's schedules.

Objective #11: Achieve and maintain a completion rate of 95 % performance evaluations completed on time

A monthly audit of employee records is conducted to ensure that annual employee performance evaluations are completed on time. Graph, below, shows the results of this audit:

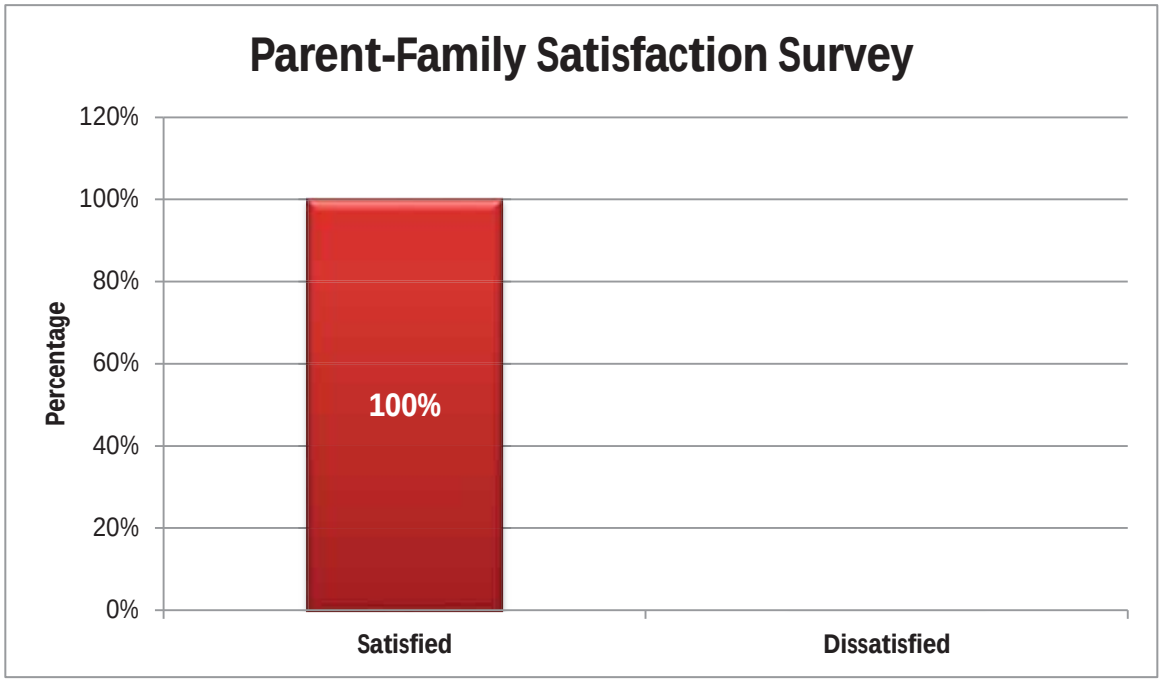


Results/Discussion:
The 95% success rate met the stated Objective. Out of 281 staff, 103 were new hires and their evaluation is due next year. An audit was completed on quarterly performance evaluations. It is noted that even though staff hire date might be different then there actual direct work date . For that reason, 30 + or – days are given for the performance evaluation as the staff are getting their trainings completed after they are hired.

Plan of Action:
An list of evaluations due will be provided to all supervisors at the beginning of each month. Completion of such evaluations will be monitored weekly throughout the month to ensure timelines are continued to be maintained and met. HR staff meets the coordinators during programs meetings.

Objective # 12: Increase family member satisfaction to at least 90%

We are gathering input for the purpose of Continuous Quality Improvement (CQI). Doing so will enable us to identify areas of satisfaction (or dis-satisfaction), allowing us to target these specific areas that need improvements. For this year we track the level of satisfaction of Individuals served and their family members (parents, legal guardians, siblings who are actively involved in the treatment planning of the individual). It was decided to employ the same survey that was used in previous years for each group so that a comparison could be made between groups. Distribution of family member surveys was done at the Annual IP meeting and during the visits with the individuals.



Results/Discussion:
One appropriate way to look at all of this data is to determine an "average satisfaction level" among all respondents for all questions.

Total # of Families Surveyed	**11**
Total # of Satisfied Responses	38
Total # of Dissatisfied Responses	11

Plan of Action:
CSC will reach out to the families and will make sure to work on the dissatisfied responses. Program specialist and Coordinators are responsible to maintain contact with the family member on weekly basis. This survey will be repeated in year 2017 to compare the averages of 2016. The survey had been mailed to families and a much smaller number of responses were received this year (7 versus 82). Program Specialists will provide copies of this survey to family members at annual IP meetings to increase participation.

Objective #13: Increase Stakeholder satisfaction to at least 90%

We are gathering stakeholder input for the purpose of Continuous Quality Improvement (CQI). Doing so will enable us to identify areas of satisfaction (or dis-satisfaction), allowing us to target these specific areas that need improvements. For this year we track the level of satisfaction of community members and stakeholders. It was decided to employ the same survey that was used in previous years for each group so that a comparison could be made between groups. Surveys to measure stakeholder satisfaction were prepared and disseminated to the stakeholders in July 2016.

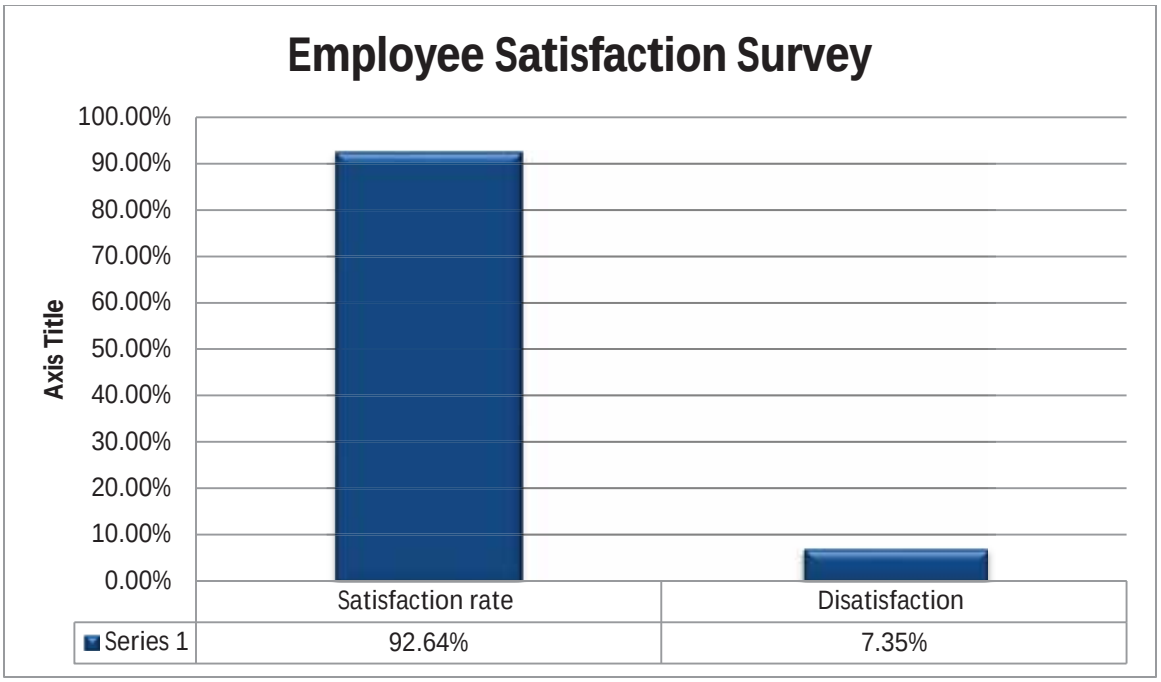
Results/Discussion:
One appropriate way to look at all of this data is to determine an "average satisfaction level" among all respondents for all questions.

Total # of Stakeholders Surveyed	**14**
Total # of Satisfied Responses	70
Total # of Dissatisfied Responses	0

Plan of Action:
The highly positive results indicate that no specific Plan of Action is needed. Therefore, the Plan will be to continue the processes that are already in place. CSC will attempt to reach out to more community members including stakeholders, neighbors and member organizations to gather feedback and to increase the number of responses and feedback.

Objective #14: Increase Employee satisfaction to at least 80%

We are gathering stakeholder input for the purpose of Continuous Quality Improvement (CQI). Doing so will enable us to identify areas of satisfaction (or dis-satisfaction), allowing us to target these specific areas that need improvements. For this year we track the level of satisfaction of employees. It was decided to employ the same survey that was used in previous years for each group so that a comparison could be made between groups. Surveys to measure employee satisfaction were prepared and disseminated to the employees in July 2016.



Results/Discussion:
One appropriate way to look at all of this data is to determine an "average satisfaction level" among all respondents for all questions.

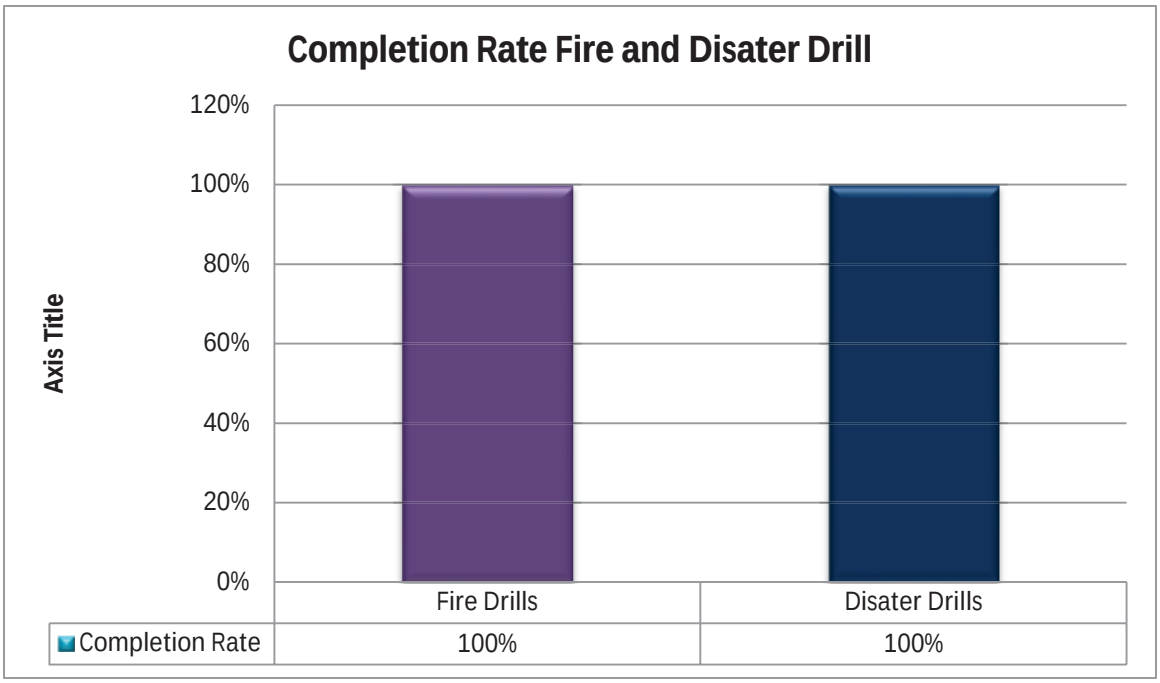
Total # of Employees Survey Received	**117**
Total # of Satisfied Responses	1084
Total # of Dissatisfied Responses	86

Plan of Action:
The results looking at all responses, only 7.35% of all responses were displayed dissatisfaction. Most of these were a result of part time staff not satisfied with benefits provided. Many part time staff are now offered health insurance. HR will continue to reach out to part time staff to offer full time positions to such staff prior to employing outside applicants to provide positions were all benefits can be deliverable to these employees.

Objective #14: Maintain at least a 100% rate of compliance to completion of fire and disaster drills

Results/Discussion:
All fire and disaster drills are completed appropriately as required.

Plan of Action:
A schedule of fire drills will continue to be maintained, ensuring each shift completes such drills throughout the year. Disaster drills will continue to occur every January, April, July, and October.



Incident Reporting

Reportable/Non-Reportable Incidents
January, 2016 – December 31, 2016

Overview
Between January 1, 2016 and December 31, 2016, incidents reportable with an A7 have been reported .The incidents occur with the frequency noted below for the following categories:
Reportable Incidents:

Abuse	7
Death	0
Hospital/ER	26
Hospital/Psychiatric	9
Inhumane Treatment	0
Injury	37
Other	3
Police	27
Restraint	1
Sexual Abuse	0
AWOL	2
Theft of Individual's Property or Funds	0
Total	82

- There were 7 incidents of alleged abuse. 3 of the abuse incidents were false allegations from the individuals. 2 were allegations of abuse by an individual from another individual, 1 allegation was substantiated, and 1 was unsubstantiated, but CSC sided on the side of safety for the individual involved and terminated all staff on duty.
- Essentially all hospital/ER visits were due to unexpected illness of individuals.

Internally Investigated incidents

A total of 100 internally investigated incidents occurred during calendar year 2016; these were reported on the A5 form. A breakdown of the types, and frequency of occurrences, is shown below:

Hospital/ER	81
Injury	4
Police	10
AWOL	0
Other	5
Total	**100**

Generally, the distribution pattern of internally investigated incident types is quite similar to that found in the Reportable Incident list- that is, Hospital visits and "Police" visits occur with the greatest frequency in both the Reportable Incident list and the internally investigated incident list. This is, perhaps, not unexpected.

The majority of the largest incident category, Hospital Visits is visits due to medical issues expected for the individuals involved. Examples include ER visits for: seizures; wound care, g-tube care, behavioral etc .

The Standing Committee *(see Appendix B for Standing Committee details*) reviews all incidents to determine whether the responses made by staff and the agency were appropriate, and whether any systemic changes need to be made to avoid such incidents in the future.

Appendices

Appendix A - Resources Used for Data Collection and Analysis

Analysis of Medical/Nursing Services

Therap Online Documentation which contains all information regarding:

- Medical appointments (PCP and specialty)
- Annual physical examinations
- Laboratory workups done
- Hospital/ER visits
- Nutritional evaluations
- Initial nursing assessments
- Nursing Plan of Care
- 45 Day Reviews
- Interim nursing visits (in follow-up to hospital visits)
- The scheduled date for all medical appointments (day/time)
- Whether or not the appointment was successfully kept
- If not kept, reasons why appointments were not kept
- Staff member responsible for ensuring the appointment is kept

Medication Administration Books which contain:

- Current MARs
- Current PMOFs
- Various log sheets (e.g. - blood pressure logs, blood sugar logs, weight logs, seizure logs, etc.)
- Nursing Plan of Care

Analysis of Individual Plans

- Individual Plan/Behavior Plan Database- contains information regarding:
- Start date for IP/BP and for each individual
- Expiration date for IP/BP for each individual
- Required meeting sign-in sheets
- Required individual permission/consent forms
- Copies of IP's and BP's, including goals and Progress Notes
- Implementation dates for IPs

Analysis of staff training

HR Database- contains information regarding:

- Start date for all individual staff
- Documentation of all required personnel information
- Documentation of all required trainings
- Evaluation due dates

Training Database- contains information regarding:

- Schedule for all required pending training for all individual staff
- Documentation of completion of all required trainings for all individual staff
- Expiration dates for all required trainings, certification, etc. for all individual staff

Analysis of Incident Reporting

Incident Reporting Database- containing information regarding:

- Type of incident
- Place of incident
- Date of incident
- Staff involved
- Nature of incident
- Status of A-5/A-7 reporting
- Investigator
- A5 and A7 reports

Analysis of Stakeholder, family, employee Satisfaction

- Stakeholder Survey
- Parent/Family member Survey
- Employee Survey

Appendix B - Members of Standing Committee

Members of the Standing Committee at CSC are:

Review of BPs
Licensee staff:

- Dana Dimas, Chief of Programs - Chair (dana@centerforsocialchange.org)
  6600 Amberton Drive, Elkridge, MD 21075
  410-579-6789

- Amy Fletcher, Programs Manager (amy@centerforsocialchange.org)

Community members:

- John Senyard jsenyard@verizon.net

- Patricia Graham patgraham50@yahoo.com

Review of reportable incidents:
Licensee staff:

- Amy Fletcher, Programs Manager (amy@centerforsocialchange.org)

- Thomas Alexander
  Operations Manager, CSC (thomas@centerforsocialchange.org)

Community members:

John Senyard jsenyard@verizon.net

Patricia Graham patgraham50@yahoo.com

Alternate member: Sajid Tarar.

The Standing Committee meets at least quarterly.