

4Q13 Quality Improvement Report
EXECUTIVE SUMMARY
3/26/14

I. INTRODUCTION

This is the Executive Summary of the BSDC 4Q13 Quality Improvement (QI) Report. The Report is comprised of 8 sections of relevantly similar subject matter. Each section contains several *Indicators*—short reports that measure and evaluate the care, clinical support services, and organizational functions that affect individual outcomes. Indicators incorporate quantitative and qualitative methods to evaluate a number of key focuses developed and agreed upon by BSDC ICFs and several departments.

Quarterly, the Quality Improvement Committee reviews the Report for meaning and for relevance. The Executive Summary is a condensed, but several page, Report summation, identifying general conclusions among all indicators, recommendations for stakeholder departments, and Action Plans. *Recommendations* are areas of concern that should be reviewed by the stakeholders; they have not yet risen to the level of an Action Plan. *Action Plans* are discussed with the stakeholders prior to and during the quarterly Committee meeting and are finalized after the inter-disciplinary Committee discussion. Their status is tracked and reviewed at each Committee meeting. Follow-up is ongoing.

II. UPDATE FROM PREVIOUS QUARTERS

Indicator Action Plan Tracker (3Q13):

On 8/21/13, the QI Committee began utilizing an Excel-based Action Plan Tracker. The Tracker was fully implemented in 3Q13 and will continue to be used. Using the Tracker has resulted in an increase in more timely Action Item completion and enhanced accountability.

As of 2/26/14, all outstanding Action Items from 3Q13 Report were completed.

A12 - Medication Errors (2Q13)

The only material change made in 2Q13 to the Report was to Indicator A12 in 2Q13 – Medication Error Rates. In that quarter, A12 clearly defined the term *Medication Error*, using BSDC's Policy 6.14 Medication Treatment Incidents Policy: "A *Medication Error* is any error made in the process of prescribing, transcribing, dispensing, or providing a drug or treatment whether or not any adverse consequences occurred." Using this policy parameter will preclude any future confusion or inconsistency about what constitutes a medication error; however, *doing so resulted in a variance from previous Indicator quarters*. This change explains the variances between 1Q13 through 3Q13, which appear to be resolving in 4Q13.

In the near future, MARs and TARs will be entered into Therap (the ICF electronic case management system), which should dramatically reduce documentation errors. Moreover, should Therap interface directly with the pharmacy, a drastic reduction in pharmacy errors would be foreseeable.

As the baseline and targets were established under the previous processes, this indicator will be monitored to determine whether baseline and targets should be reevaluated, or whether employee performance can be improved to make the target reasonable with the new process changes.

A18B – General Anesthesia (3Q13)

The HLRC Chairperson met with the Qualified Developmental Disabilities Professionals (QDDPs) to coordinate a plan of reduction that included writing programs/plans to reduce the need for general anesthesia during dental procedures.

B9 – Rates of Pneumonia (3Q13)

All staff completed updated Urgent and Non-Urgent Trigger training. Increased staff vigilance of individuals experiencing triggers continues to contribute to a decrease in pneumonia rates.

D3 – Increased Employment Hours (3Q13)

Not only did the Active Treatment Manager meet with Active Treatment Facilitators and Liaisons regarding documentation using the daily tracker sheet, but weekly reports to ICF administrators and QDDPs were also initiated during 4Q13. Diligence in this area has led to continued increases in the percentage of individuals working and volunteering five hours or more per week.

D10 – Choice for Service Providers (3Q13)

The QDDP Coordinator met with three individuals living at 415 Sheridan to discuss alternative living environments.

D11 – Audit of Home Room (3Q13)

The number of observations completed by Home Room Liaisons increased this quarter, and a new Action Plan has been initiated to ensure that this level of observations continues.

D12 – 5 Hours Away from Home Skills Training

The Active Treatment Program Supervisor developed a spreadsheet and correlating graph to track this Indicator. This information is being submitted weekly to the QDDPs to enhance the emphasis on this indicator.

E5 – Restrictions Have Active Reduction Plan

The QDDP Coordinator and the HLRC Chairperson met with at least 2 of the QDDPs from each ICF to review the form regarding reduction of restrictions to ensure that the QDDPs understand the importance of having a reduction plan in place. This resulted in an increase towards meeting this target goal.

III. CURRENT QUARTER'S STATUS

Section A: Individuals Are Safe

The focus of this section is the safety of the individuals who live at BSDC. BSDC has a no tolerance policy for abuse and neglect and for failure to report abuse or neglect. BSDC also has a very broad definition of abuse that includes verbal abuse and exploitation. Comprehensive incident reporting and investigations are integral to preventing abuse and neglect and ensuring individuals' safety. It is also important that individuals are free from all unnecessary restraint, as restraints pose a significant risk to individuals both physically and emotionally.

BSDC is entrusted with some of the most vulnerable Nebraska citizens. Thus continued success and progress in all of these areas is core to the BSDC mission.

Abuse/Neglect (A1, A4 and A8):

The target of 0% for Physical and Non-Physical Abuse was met this quarter, and only 3 individuals in all of 2013 were subjected to substantiated abuse (compared to 5 in 2012). The 2013 quarterly average is 0.75%, which is below the baseline of 1.25%.

The target of 0% for neglect was not met this quarter, and 15 individuals in 2013 were subject to substantiated neglect (compared to 10 in 2012). In 2Q13, 1 case involving 8 individuals resulted in a spike in this indicator. While the suspected abuse relating to this incident was unsubstantiated, neglect was substantiated due to failure to recognize and report potential abuse.

The 100% target for Reporting Abuse/Neglect has been met every quarter since 2Q12. It is crucial that all individuals supported by BSDC feel safe to report abuse or neglect, so this is an important success.

With regard to Peer-to-Peer Incidents of Aggression, the target of 0% was not met for this quarter, but the results for this quarter (1.5%) and the 2013 average (2.53%) were both significantly below the baseline of 15% (from 3Q11). Significant efforts have been undertaken to reduce incidents of aggression between individuals supported by BSDC, and clear progress has been made. Efforts have included staff training, improved Behavioral Support Plans (BSPs) and implementation for individuals, and thorough review/root cause analysis when incidents occurred.

While no incidents of neglect or peer aggression resulted in significant physical harm to individuals, it is important that BSDC remain diligent in its efforts to prevent abuse, neglect and incidents of peer aggression. Although no new Action Plans are

recommended, BSDC will continue its emphasis on current efforts that have led to the progress achieved.

Incident and Review and Investigation of Incidents (A10, A11, A12, A13 and A14):

There was an overall reduction in total incidents from 808 in 2012 to 761 in 2013. Moreover, there was a reduction in quarterly averages: from 202 in 2012 down to 190 in 2013. Despite this improvement, during 2013, there were increases in the following areas: Falls with reportable injuries; serious reportable injuries; ingestion incidents; and airway obstructions.

Upon review, Action Plans related to incidents indicated that 52% were related to interdisciplinary supports for individuals, while only 24% were related to process issues. While human error may occur, it is imperative that BSDC have processes in place to address such error. This shows an improvement in process development.

With regard to medication administration, targets for medication errors were developed utilizing a policy interpretation that was changed in 2013. In 2Q13, BSDC revised its interpretation of medication errors so that each dose involved in an incident is counted as a separate medication error (so an individual incident of missed medication administration involving 8 doses of various medications would result in 8 medication errors being recorded instead of just 1 error being recorded.) This resulted in a spike in medication errors in 3Q13 and 4Q13 (which included an adjustment for errors in the previous quarters due to the new policy interpretation.) The medication error target of .025% was not met this quarter (as the 4Q13 rate was .4182%), but **no** medication errors resulted in harmful outcomes to individuals.

The revised policy interpretation may have affected the validity of the baseline and targets for medication error rates. However, proper medication administration is important to individuals supported by BSDC, and several initiatives are underway to improve medication administration, including a pilot implementation of an electronic case management system (Therap) that includes a medication administration module that is anticipated to address many of the documentation errors currently being experienced. So this indicator will be monitored to determine whether the baseline and targets should be evaluated, or whether current initiatives will result in improved processes and employee performance, making the current target reasonable.

With regard to falls, the current quarter results and 2013 annual average are both consistent with the baseline of 0.77, which is slightly above the target of 0.75 and the 2012 average of 0.70. Preventable falls have decreased 41% since 1Q13, and all individuals with falls that were determined to be preventable were referred by the Interdisciplinary Teams to supports (such as the Mechanical Gait and Ambulation Clinic) to prevent recurrence. The most common category of falls continues to be accidental falls; however, considering the increased activity of individuals and the extreme weather patterns experienced in 4Q13, it is a positive sign that falls did not increase significantly. While continued diligence is required related to falls, it is important not to sacrifice the independence and community inclusion of the individuals based upon numbers alone.

With increasing individual activity and community integration, the baseline and goal may need to be reevaluated in 2014.

Adopted Action Plans related to these Indicators:

- A10 - Incident Management Policies are to be reviewed to assess whether revisions are needed to differentiate between airway obstructions that an individual is able to clear on his/her own and airway obstructions that need emergency action by staff (A10);
- A11 - The Compliance Team will develop goals to measure identified outcomes within investigations by 3Q14 (A11); and
- A12 - Starting in January 2014, Medical QI will recommend Action Plans to reduce/eliminate future medication errors, as needed, and distribute to the Medical Director and the Director of Nursing on a monthly basis. Medical QI will distribute reports of medication errors by staff to their respective ICF Administrators, the Medical Director, the Director of Nursing, and to the Nurse Supervisors on a monthly basis. Medical QI will participate in the implementation of the Medication Administration module in Therap.

Restraints (A15, A16, A17, A18a, A18b, and A19):

BSDC continues to experience success in its reduction of restraints. No individuals at BSDC were subjected to mechanical or chemical restraints in 2013. No programmatic physical restraints are allowed at BSDC. Physical restraint may only be utilized for emergency safety interventions, and BSDC has a target of 0%. While this target was not met, the use of physical restraints have consistently continued to decline since 2011. The 4Q13 rate of individuals who were subject to physical restraint was 0.8% (compared to the baseline of 13% and the benchmark of 4%).

All individuals who utilized medical restraints this quarter have reduction plans in place (meeting the target of 100%).

The use of general anesthesia for dental work rose above the target of 4.0% to 4.97% this quarter; however, the annual result is a reduction from 4.04% to 3.96%, which meets the target.

Rates of medication used for individuals during Behavioral Crisis Intervention have continued to consistently decline since 2012. 4Q13 results were 0.79%, and the 2013 annual average was .78%. While BSDC maintains a target of 0%, current results are significantly below the baseline of 1.68% and show a continuing downward trend.

Staff training, improved BSPs and enhanced program monitoring and supervision have contributed towards improvement in all areas involving restraints. While there are no Action Plans related to restraints, BSDC will continue to diligently ensure that individuals are free from unnecessary restraint and that Interdisciplinary Team Processes continue to be both proactive and responsive to these concerns.

Sections B and C: Individuals Are Healthy

Being healthy is an important basis for individuals living at BSDC to be able to live the most independent lives possible and to participate in meaningful daily activities. While individuals living at BSDC may access community medical/clinical providers, their overall healthcare is monitored by BSDC Primary Care Providers (PCPs), and most of their healthcare needs are met by the BSDC Dental Clinic and Public Health Clinic (PHC), utilizing BSDC medical and clinical practitioners who specialize in supporting people with intellectual and developmental disabilities. Health indicators tracked by the QI Committee have experienced successes and challenges, as follows:

B3, Dental Exam and Oral Hygiene - There is a slight upward trend in oral hygiene checks, from a 2012 quarterly average of 65%, to a 2013 quarterly average of 66%.

B4, Hospitalizations/ER Transfer – There were fewer actual repeat transfers in 2013; however, due to a significant decrease in all hospital transfers, the rate increased from 7.48% in 2012 to 7.89% in 2013, and the target of 0% was not met.

B6, Pressure Ulcer Rates - There is an overall downward trend in pressure ulcers. The 2012 quarterly average was 1.29%, compared to 0.58% in 2013.

B7, BMI \leq 20 - In 2013, there were 0 individuals with BMIs less than or equal to 20.

B8, BMI \geq 30 - There was an overall downward trend of individuals with BMIs more than 30, from 12.4% in 1Q13 to 8.73% in 4Q13.

B9, Rates of Pneumonia - The last 3 quarters of 2013 met the target of \leq 0.4 and trending downward for rates of pneumonia. The 2013 quarterly average was 0.2594.

B10, Rates of Urinary Tract Infection - The 4Q13 Urinary Tract Infection rate was down to 0.79%, the lowest of all 4 quarters and lower than the 2012 average of 6.94%. The annual rate was up to 7.67% in 2013 from 6.94% in 2012. However, the quarterly and mean average beat both the baseline of 8.8% and the goal of 8%.

B11 through B15, Documentation - While the target for timely PCP progress notes has consistently been met, challenges still exist regarding laboratory and x-ray review, receipt and review of progress notes from outside consultants, and receipt and review of inpatient hospitalization documentation. Due to the importance of receipt and review of such documentation, the PHC has implemented a new tracking protocol, and the PHC Manager will oversee the new tracking protocol implementation and report results **monthly** until the target is met.

C3, Rates of Antipsychotic Polypharmacy - The 2013 goal was met at $<$ 14.3% and trending downward, with the rate for 4Q13 of 9.8% and the 2013 average of 12.25%.

C4, Rates of Antiepileptic Drug Polypharmacy – Significant effort has been made to evaluate the diagnosis and treatment of epilepsy in individuals in 2013, and this has resulted in fewer individuals being diagnosed with epilepsy. Thus, while there has only

been an increase of one individual receiving 2 or more antiepileptic drugs (AEDs), the rate increased to 59%, (which is above the target and baseline, but within the benchmark set by the AHRQ – Agency for Healthcare Research and Quality). Individuals will continue to be evaluated by neurology and psychiatry to review medications collaboratively.

C5a and b, Rates of Intractable Epilepsy and Methods of Treatment – The current annual rate of individuals with intractable epilepsy is 22%, which is up from the baseline of 12% and target of 0%, but less than the benchmark of 30%. Of the individuals with intractable epilepsy, the rate of individuals taking 2 or more antiepileptic drugs was 9%, down from 20% in 1Q13. 91% of individuals with intractable epilepsy who are taking more than 2 antiepileptic drugs have been considered for a neuro-ablative procedure or have a vagal nerve stimulator. In consultation with the BSDC neurologist, Medical QI recommends that the definition of intractable epilepsy be revised.

C7, Rates of Laxative and Prokinetic Polytherapy for Constipation – The rate of individuals on 2 or more laxatives and/or prokinetics for 4Q13 is 47%. The baseline and target will be developed for this indicator in 2014.

C9, Rates of Timely Completion of Internal Mortality Reviews – 100% of the Internal Mortality Reviews were completed within 30 days of an individual's death.

C11, Medical Peer Reviews - The 2013 target of 80% compliant charts was met with 95% compliance.

C12a, b, and c, Clinical Peer Reviews – OT/PT, SLP, RD - The 2013 target rates for compliant charts were met or exceeded in each of these areas.

C12d and e, Clinical Peer Reviews – BST-Behavioral Progress Notes and Psychological Evaluations – The 2013 target rates for compliant notes and evaluations was only partially met. However, the current scoring criteria assesses all elements in the same manner. The Behavior Support Team (BST) Director will develop weighted scoring criteria that more accurately measures quality by 2Q14, and the Medical QI will then apply that criteria to 2013 historical reviews so that a baseline can be determined for 2014 by 3Q14.

C12f, Clinical Peer Reviews – Nursing - At 76%, the 2013 target of 80% was unmet. The Director of Nursing will develop weighted scoring criteria that more accurately measures quality by 2Q14. Medical QI will then apply that criteria to 2013 historical reviews so that a baseline can be determined for 2014 by 3Q14.

Adopted Action Plans related to these Indicators:

- B11 – The PHC Manager, in consultation with the Medical Director, should develop and implement guidelines measuring the quality of PCP progress notes by 2Q14;
- B12, B13, and B14 – PHC has implemented a new tracking protocol. The PC Manager will oversee the new tracking protocol implementation and report results monthly until the target is met.
- C5a – The definition of Intractable Epilepsy will be revised, and Medical QI will work with the BSDC Neurologist and PCPs to determine the effects of this new definition on the QI data by 2Q14.
- C12d and e - The BST Director will develop weighted scoring criteria that more accurately measures quality by 2Q14; Medical QI will then apply that criteria to 2013 historical reviews so that a baseline can be determined for 2014 by 3Q14.
- C12f – The Director of Nursing will develop weighted scoring criteria that more accurately measures quality by 2Q14; Medical QI will then apply that criteria to 2013 historical reviews so that a baseline can be determined for 2014 by 3Q14.

Section D: Individuals are Supported in their personal goals to achieve independence

It is a primary goal of BSDC to support every individual in the most integrated setting possible, and this requires supporting individuals in their personal goals to achieve independence.

Working and volunteering, particularly in the community, is an important indicator towards achieving independence, and BSDC is experiencing continued success in these areas. Recreation Integration (D1), all individuals showing an average of at least 1 integrated activity per week) showed a steady, upward trend from 73% in 1Q13 to 92% in 4Q13. The percentage of people working off campus (D2) has increased significantly from 7% in 2010 to 62% in 2013. Moreover, there has been steady progress in the percentage of unretired individuals who work or volunteer ≥ 5 hours per week—from 44% in 3Q12 to 92% in 4Q13 (D3).

In order to promote independence, it is important to identify individual preferences and incorporate them into an individual's planned goals and activities. Campus-wide, 100% of individuals who had an annual IDT meeting within the quarter had a formal goal that reflected the individual's choices and preferences through a general connection (D6a). Campus-wide, 95% of individuals who had an annual IDT meeting within the quarter had a formal goal that reflected the individual's choices and preferences through a specific connection (D6b). 100% of individuals have a formal goal that reflects the individual's choices and preferences through specific plans (D6c), and this has been the case since 3Q12. To encourage exploration of alternative preferences, the 80% campus-wide goal of individuals experiencing an alternative living environment during the past IPP year was met at 84% (D10).

BSDC has a target of 100% for individuals to have 5 or more hours per day of skills training away from their residence (D12). This has been a challenge throughout 2013,

and the rate for 4Q13 is only 83%. The Active Treatment Supervisor will begin sending a weekly report listing hours off the home for each individual living at BSDC to the Area Administrators, the Liaisons, the Active Treatment Manager, the Indirect Services Administrator, and the Chief Executive Officer. The Liaisons will communicate with the QDDP for all individuals who have not met the 5 hour target for the week, then document the reason why and develop an Improvement Plan appropriate for the circumstances. With this added effort, it is anticipated that significant progress can be made towards this target.

In order for individuals to participate in integrated activities, they must have their support needs met. While 93% of individuals needing functional and/or language communication assistance are receiving such, this is insufficient to meet the 100% target and is below the 95% baseline. Efforts must continue in this area (D4). With regard to BSP competency, however, enhanced focus on training and monitoring has led to a competency rate of 99%, which is significantly higher than the baseline of 87% and the target of 90% (D8). This has likely contributed positively to behavioral management, leading to a reduction in psychoactive medications (D9).

In order to evaluate whether individuals are supported in their goals to achieve independence, BSDC does routine Home Room audits (D11) and measures progress towards goals through the IPP process (D5). Despite most 2013 Home Room audits indicating that activities in the Home Rooms were consistent with the likes and needs in individuals' IPPs, 4Q14 showed a deficiency in this area (with only a 90% rate of compliance). Noted below are Action Plans that address this challenge.

With regard to IPP evaluations, all BSDC areas are showing increased progress towards individuals' goals in 2013 (6% over 2012). Yet this progress is not reaching the target for this indicator. Reasons and actions taken to address progress inertia are included in the evaluation, and continued focus will remain on addressing these concerns. These are both areas that will benefit from the permanent internalization of the QDDP Coordinator team's efforts related to ongoing assessment and support of the QDDPs and the IPP process.

Adopted Action Plans related to these Indicators:

- D2 - Beginning February 2014, the Vocational Employment Supervisors will update job postings weekly, routing them to BSDC's CEO, Indirect Services Administrator, and all ICF Administrators. They will also work with outside consultants to address the challenges in continuing to expand employment opportunities.
- D9 – Medical QI will coordinate with the BST Director and Medical Director to determine a better way to measure the efforts and results involved with medication and behavioral management in 2Q14.
- D11 - By 1Q14, the Home Room supervisor will revise Indicator D11 to indicate the measurement of the 3 separate areas: likes, needs, and interests.
- D11 - By 1Q14, the Home Room supervisor will execute a S.M.A.R.T. plan to address whether discrepancies between individual IPPs and actual activities in

the Home Rooms and Activity Center are due to a) the IPP inaccurately relaying individuals' likes, needs, and/or skill level or b) Active Treatment is insufficiently accommodating the IPP specifications, or c) both.

- D12 - The Active Treatment Supervisor will begin sending a weekly report listing hours away from home for each individual living at BSDC to the Area Administrators, the Liaisons, the Active Treatment Manager, the Indirect Services Administrator, and the Chief Executive Officer. The Liaisons will communicate with the QDDP for all individuals who have not met the 5 hour target for the week, document the reason why, and develop an Improvement Plan appropriate for the circumstances. With this added effort, it is anticipated that significant progress can be made towards this target.

Section E: Individuals are treated with Dignity and Respect

Being treated with dignity and respect is a crucial element of a meaningful life, and BSDC has several processes and initiative to ensure this is occurring for individuals. This is achieved through Home Leader Observations of staff interactions with individuals, assessing individuals' access to active social support networks, and ensuring that individuals' rights are respected and that they are not being inappropriately restricted. BSDC sets a high standard for the respectful treatment of individuals, and while years of cultural initiatives have provided significant progress in these areas, BSDC will not be satisfied until the individuals it supports are treated with the same dignity and respect as other individuals living independently in the community.

With regard to BSPs and restrictions, the current rates of BSPs requiring HLRC review that contain restrictive procedures is 14% for 4Q13 and 7% annually for 2013 (with the target being 10%, E3). Only 76% of the restrictions reviewed by HLRC were accompanied by Plans for Reduction. While this is significantly higher than the baseline of 42%, it is well below the 100% target (E5). Each of the non-compliant situations was addressed by the HLRC Chairperson with the relevant ICF staff. BSDC now has a full-time HLRC chairperson who reviews BSPs and IPPs, and **all** HLRC decisions regarding individual restrictions were complied with during the 4Q13 (E4).

Many people have lived at BSDC for decades and many have little or no family or other natural social-support systems. For years BSDC operated with a culture of "taking care of" people instead of supporting them in the most independent manner possible. While the Home Leader Observations show that 94% of staff-to-individual interactions were positive, it is still concerning that issues remain relating to the dining atmosphere in some homes and with staff not supporting individuals in a respectful manner (for example, "Telling" an individual what do to instead of discussing options or not properly supporting an individual in addressing a hygiene issue). Additionally, while active social network rates have increased since 2012 (a 9% increase from 4Q12 to 4Q13), the 47% rate is still quite concerning. The interdisciplinary teams have been taking action to determine where barriers may exist for families (e.g., weather, transportation, health and age), and they will continue to work to develop solutions where feasible and where the family/guardian is willing to participate. Additionally, efforts at community inclusion

discussed in Section D herein should also result to the creation of new social relationships for individuals.

Adopted Action Plan related to these Indicators:

- E2 – The QDDP Coordinator will modify the target for Active Social Support Network to 70% on 1Q14.

Section F, G and H: Employees Matter

Much effort has gone into ensuring the quality of services provided by BSDC employees. BSDC has a comprehensive initial training and orientation for new employees, with supplemental and ongoing advanced training available for current employees. Healthcare Coordinators and Behavioral Support Specialists are also available in all ICFs for staff training and monitoring of more complicated issues (such as Points of Service plans and BSPs.) Frontline supervision is provided by Shift Supervisors and Home Managers 24 hours a day at all ICFs, and Home Leaders do routine observations and audits throughout campus to ensure that staff are providing quality services. BSDC values its employees and wants to ensure that they have a good working environment, they are free from fear of retaliation for reporting abuse/neglect, and they are respected, supported and recognized for their efforts. The following are Indicators that relate to these concerns:

- F1, Adherence to zero tolerance policy for substantiated abuse/neglect - The 100% goal has been met since 1Q13.
- F9, Emergency Restriction – For 4Q13, staff have been successful in obtaining timely written consents in 96% of all emergency restriction situations (with a 100% rate of obtaining witnessed verbal consents.)
- F10, Habilitation Record Audit – For all of 2013, staff have met the target of 100% relating to obtaining HLRC approval for restrictive practices within BSPs and Safety Plans.
- G1, Adherence to non-retaliatory practices - The 4Q13 goal of 100% was met, as it was for the last 7 quarters, ensuring that all staff reporting allegations of abuse/neglect were not subjected to retaliatory practices.
- G3, Staff Injuries – While overall numbers of injuries have been consistent over the past year, the number of injuries resulting from individual behaviors/aggression has reduced from 61% in 3Q12 to 43% in 4Q13 and the number of injuries resulting from Transfers/Repositioning has reduced from 14% to 3% during the same time period; both of these successes may be attributed to improved staff training, monitoring and support. The only category that increased was Catching Falling Individual, which is closely related to the increase in Falls addressed in Section C.
- G7, POS Training and Support - 97% of POS trainings were completed in 4Q13, exceeding the 95% quarterly goal.

While much progress has been achieved relating to employee work environment and quality of services provided by staff, significant challenges remain relating to recruitment and retention of employees (H1, H2, and H4). This impacts staffing levels and drives overtime (H5). While staff turnover remains at 7% (below both the baseline and target

ranges), staff vacancy rates remain consistently near 26-27%, with the most significant impact being to 2nd shift staffing. Although overtime is significantly less than when BSDC staffing initiatives began in 2008, overtime still remains above the target of 10% (with 4Q13 at 13.68%). The suburban location of BSDC, the challenging nature of direct support staff duties, and the significant stressors of continued, enhanced oversight make it very difficult to progress in these areas. To address these concerns, current recruitment and initiatives remain ongoing, and a few new initiatives related to supervisory training and 2nd shift incentives will begin.

Adopted Action Plans related to these Indicators:

- F9 – The HLRC Chairperson will change the indicator target for Emergency Restrictions in light of 2013's data and the ongoing written consent turnaround delays by 2Q14.
- F10 – The HLRC Chairperson will acquire and maintain lists of individuals' BSPs and Safety Plans with restrictive practices by 4/10/14.
- H2 – DHHS Staff Development is developing additional training specifically for supervisors.
- H2 – A 2nd Shift incentive plan is scheduled to begin 2/1/14.

IV. 2014 FORECAST

While continued progress has been made in all areas in 2013, and while BSDC is excited about the quality of services it provides to individuals supported, it is important to remain diligent in continuously seeking ways to maintain progress achieved and to further improve and or adapt to evolving industry/regulatory standards. Much effort has been invested by the QI Committee, from the Focus Groups organized in 3Q13 through the evolution of the QI Report finalized this 4Q13. Data collection and analysis processes are firmly in place, and now the Committee has added an Information Technology Analyst to the team, as well. It is anticipated that this position will contribute to automating some of the data collection and presentation tasks, allowing for even more focused effort toward important analytical challenges. The following are planned 2014 activities for the QI Committee:

A. Data Collection/QI Report Conversion

The IT Analyst will work with the QI Committee to convert current manual data collection and presentation processes into a more user-friendly, automated process, using technology to eliminate areas of duplicated effort and to reduce manual entry error risks.

Data Sections of the QI Reports will be automated to generate directly from source data, leaving more time for the QI Committee to focus on the analytical sections of the quarterly and annual reports.

B. Focus Groups/Annual Indicator and Process Review

In addition to the potential use of Focus Groups (similar to those convened in 3Q13), the QI Committee will convene an Annual Indicator and Process Review meeting this summer. With a new Indirect Services Administrator and structural changes to the QI Department taking place in 2013, the Committee was hesitant to make significant changes to the Indicators or to the Quarterly Report's format or process. It was important for the new Administrator and QI Manager to work through some data challenges in 2013 and for the entire QI Committee to have more detailed discussions with BSDC subject-matter experts about how the collected data relate to quality measurement for each Indicator (so that efforts are not being wasted collecting less meaningful data). In some sections of this Report, meaningful measurement tools, appropriate baselines and targets, and potential definition and process revisions are discussed. Consideration of timelines for existing Indicators also needs to be addressed to ensure that timely information is available when needed in a manner that also ensures that resources are properly allocated and prioritized to directly support individuals and programs at BSDC.