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Private Organization Maintenance of Accreditation (MOA) Report

This report is to be submitted annually on the anniversary date of an organization's accreditation in each of the first three years following a four-year accreditation award.

ORGANIZATIONAL INFORMATION:

Organization Name: Roy Maas' Youth Alternatives, Inc.
Organization ID#: 2604
CEO: Gloria B. Kelly
Address: 3103 West Ave.
Address:
City: San Antonio
State/Province: Texas
Zip Code: 78213
Phone Number: 210-340-8077

Your Organization's MOA or Accreditation Contact Person: Dona Suing
Title: CQI Coordinator
E-mail Address: dsuing@rmya.org

There is no finish line with quality/performance improvement. The Council on Accreditation wants to know how the organizations we accredit are deploying and actualizing quality/performance improvement in the years between site visits. We hope that this will be useful to your organization as well.

How has quality/performance improvement taken root in your organization? How is your organization moving forward with quality/performance improvement? Tell us how your organization is doing by completing the Quality Improvement Window on the next page.

If the information requested by the Quality Improvement Window is in another, already existing format completed by your organization, you may elect to submit that information with the MOA Report.

A. Our organization has attached/provided documentation of its own demonstrating a quality/performance improvement initiative: Yes No

B. As per the MOA request letter received from COA, our organization is exempt from completing the Quality Improvement Window: Yes

Checkbox for COA's use only:

QWNN



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(MOA Revised: 12.09)

QUALITY IMPROVEMENT WINDOW

1. Our organization’s quality/performance improvement opportunity was identified from the following source(s):

- 1. Long-term plan/Short-term plan
- 2. Regulatory/licensing environment
- 3. Consumer satisfaction survey data
- 4. Human resources/staff survey data
- 5. COA Final Accreditation Report
- 6. Annual Q/PI Plan
- 7. Risk management data
- 8. Outcome management data
- 9. Fiscal/financial information
- 10. Consumer complaint/grievance information
- 11. Consumer advisory group input
- 12. Feedback from governing body/other Q/PI process stakeholders
- 13. Organizational performance information
- 14. Other source(s) *(describe briefly):* Quarterly Case Review

2. Our organization’s identified quality/performance improvement opportunity was *(describe briefly):*

During quarterly Risk Management and Case Review Committee meetings, our agency identified improvements needed to reduce the risk of prescription medication errors agency-wide. Also identified was an on-going lack of consistency in how staff were filling out prescription drug logs and where the documentation of contacts made to caseworkers and pharmacists regarding medication issues were being filed.

3. The goal/objective of our organization’s quality/performance improvement initiative/action was *(if applicable, include performance targets, metrics, or benchmarks):* 1. Reduce the number of medication errors made at the programs, 2. Make improvements to prescription medication log forms, 3. Ensure accuracy when filing out prescription medication forms, and 4. Improve training in administering prescription medication.

4. The following work groups or individuals in our organization were involved with implementing the quality improvement initiative/action *(only list job titles of individual(s) or names of work groups/committees):*

RMYA’s Case Review Committee meetings were focused on the review of prescription drug logs of randomly selected case files. The Case Review Committee determined which issues needed to be addressed and put corrective actions into place agency-wide. RMYA’s nurse worked closely with each program providing additional training and implemented a change in how medication changes are documented on prescription drug forms. Program Directors were in charge of communicating all changes and corrective actions to their program staff, implementing those corrective actions, and overseeing that their programs were in compliance. RMYA’s Risk Management Committee was in charge of reviewing all medication errors agency-wide and ensuring corrective action was implemented when needed.

5. Our organization involved consumers or external stakeholders with the quality/performance improvement initiative/action:

2 No 1 Yes *(if yes, describe briefly):*

6. From the quality improvement initiative/action that we implemented, our organization obtained the following results/outcomes:

Specific to case reviews, there has been a noticeable improvement in medication logs in general and in completion of necessary documentation when a medication error occurs. The prescription medication form was updated last year to meet all minimum standards and to include the addition of space for a “double count” signature (a second staff must “double count”, or double check, medications before they are administered). Additional file training on prescription med logs taught staff how to carefully review these logs before they are filed in the child’s



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record. Procedures were put into place campus-wide to aid in prevention of medication errors, such as: providing support staff at programs during medication times; installing half doors in all cabin offices for better supervision; engaging telephone “Do Not Disturb” functions during medication times so staff won’t be interrupted. In addition, RMYA’s nurse has become very active in correction of medication errors. She meets with staff individually to discuss medication errors and meets with the entire cabin staff when a trend points in that direction. Additionally, she implemented a change in how medication changes are documented on prescription drug forms. We have also focused on medication standards in staff meetings over the past several months.

7. **Our organization’s evaluation of the effects of the quality/performance improvement initiative/action, or what was learned, is** *(describe briefly)*: Medication errors have decreased, and prescription drug logs are being completed correctly. As an incentive to maintain this progress, when campus-wide goals have been accomplished (such as having no medication errors for one month), staff rewards will be given. We have learned that on-going training with staff in this area is essential, having RMYA’s nurse directly involved in helping with all aspects of medication issues is essential, and administrative follow-up on all medication issues is imperative.
8. **We communicated the results of our quality/performance improvement initiative/action by** *(describe briefly)*: Reporting, on a quarterly basis throughout the year, at each of the following meetings: Risk Management, Case Review and CQI Committee. Strategies for improvements, corrective actions taken and results were also communicated on a regular basis at weekly administrative meetings and staff meetings.
- 9.
10. **Our results were communicated to the following stakeholders** *(check all that apply)*:
 - Governance Consumers
 - Staff Community
 - Other *(please describe briefly)*:



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COA ACCREDITATION STANDARDS

- G1. Ethical Practice, Rights, and Responsibilities.** The organization respects the rights and dignity of the individuals, families, and groups it serves.
- G2. Continuous Quality Improvement.** The organization demonstrates a commitment to continuous quality improvement (CQI) through implementation of a comprehensive CQI system.
- G3. Organizational Integrity.** The organization promotes the public interest through sound governance and administration, in accordance with applicable legal requirements, principles of effective management, and ethical practice.
- G4. Management of Human Resources.** The organization ensures that human resource planning and deployment fosters efficient and effective service delivery and promotes the attainment of desired outcomes.
- G5. Quality of the Service Environment.** The organization provides programs and services in an environment that is safe, accessible, and appropriate for the needs of personnel and persons served.
- G6. Financial Management.** The organization manages its financial affairs according to sound practices and applicable statutory and professional requirements.
- G7. Training and Supervision.** The organization promotes competence in personnel by providing regular supervision and training on topics relevant to service delivery.
- G8. Intake, Assessment, and Service Planning.** Intake, assessment, and service planning processes engage persons and families in evaluating their request for service and build on identified strengths to achieve desired outcomes.
- G9. Service Delivery.** The organization provides coordinated and carefully monitored services.
- G10. Behavior Management.** The organization protects the rights of persons served in its restrictive behavior management practices and complies with the standards of this section.
- G11. Administration and Risk Management.** The organization conducts its administrative affairs and manages its operations prudently and effectively to meet the needs of persons served, personnel, and the organization.

I, the undersigned and President/CEO, hereby acknowledge and affirm to the Council on Accreditation that our organization is and has at all times during the last year been in substantial compliance with COA Standards, G1–G11, and continues to strengthen organizational capacity and improve quality to meet the needs of persons served.

In addition, I attest to the truth and accuracy made in this document and/or attached material about our organization.

Signature:
Title: CEO

Date Signed:

Print or Enter President/CEO Name: Gloria B. Kelly