



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Boys Town

on 05/18/2016

CINS/FINS Rating Profile

Standard 1: Management Accountability

1.01 Background Screening	Satisfactory
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Satisfactory
1.05 Analyzing and Reporting Information	Satisfactory
1.06 Client Transportation	Limited
1.07 Outreach Services	No rating

Percent of indicators rated Satisfactory: 83.33%
 Percent of indicators rated Limited: 16.67%
 Percent of indicators rated Failed: 0.00%

Standard 3: Shelter Care

3.01 Shelter Environment	Satisfactory
3.02 Program Orientation	Satisfactory
3.03 Youth Room Assignment	Satisfactory
3.04 Log Books	Satisfactory
3.05 Behavior Management Strategies	Satisfactory
3.06 Staffing and Youth Supervision	Satisfactory
3.07 Special Populations	Satisfactory

Percent of indicators rated Satisfactory: 100.00%
 Percent of indicators rated Limited: 0.00%
 Percent of indicators rated Failed: 0.00%

Standard 2: Intervention and Case Management

2.01 Screening and Intake	Satisfactory
2.02 Needs Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management and Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petition Process	Satisfactory
2.07 Youth Records	Satisfactory

Percent of indicators rated Satisfactory: 100.00%
 Percent of indicators rated Limited: 0.00%
 Percent of indicators rated Failed: 0.00%

Standard 4: Mental Health/Health Services

4.01 Healthcare Admission Screening	Satisfactory
4.02 Suicide Prevention	Satisfactory
4.03 Medications	Satisfactory
4.04 Medical/Mental Health Alert Process	Satisfactory
4.05 Episodic/Emergency Care	Satisfactory

Percent of indicators rated Satisfactory: 100.00%
 Percent of indicators rated Limited: 0.00%
 Percent of indicators rated Failed: 0.00%

Overall Rating Summary

Percent of indicators rated Satisfactory: 96.00%
 Percent of indicators rated Limited: 4.00%
 Percent of indicators rated Failed: 0.00%

Rating Definitions

Ratings were assigned to each indicator by the review team using the following definitions:

Satisfactory Compliance	No exceptions to the requirements of the indicator; limited, unintentional, and/or non-systemic exceptions that do not result in reduced or substandard service delivery; or exceptions with corrective action already applied and demonstrated.
Limited Compliance	Exceptions to the requirements of the indicator that result in the interruption of service delivery, and typically require oversight by management to address the issues systemically.
Failed Compliance	The absence of a component(s) essential to the requirements of the indicator that typically requires immediate follow-up and response to remediate the issue and ensure service delivery.

Review Team

Members

Ashley Davies, Lead Reviewer and Consultant, Forefront LLC

Bonita Williams, Regional Monitor, Department of Juvenile Justice

Angela Patton, Program Manager/Case Manager, Thaise Educational

David Caldas, Director of Non-Residential Services, Youth and Family Alternatives

Tanesha Strickland, Non-Residential Counselor, Stewart Marchman

Persons Interviewed

- | | | |
|--|--------------------------|-------------------------|
| <input checked="" type="checkbox"/> Program Director | 1 Case Managers | 0 Maintenance Personnel |
| <input type="checkbox"/> DJJ Monitor | 2 Clinical Staff | 3 Program Supervisors |
| <input type="checkbox"/> DHA or designee | 0 Food Service Personnel | 0 Other |
| <input type="checkbox"/> DMHA or designee | 1 Health Care Staff | |

Documents Reviewed

- | | | |
|---|--|--|
| <input type="checkbox"/> Accreditation Reports | <input checked="" type="checkbox"/> Fire Prevention Plan | <input checked="" type="checkbox"/> Vehicle Inspection Reports |
| <input checked="" type="checkbox"/> Affidavit of Good Moral Character | <input checked="" type="checkbox"/> Grievance Process/Records | <input type="checkbox"/> Visitation Logs |
| <input checked="" type="checkbox"/> CCC Reports | <input type="checkbox"/> Key Control Log | <input checked="" type="checkbox"/> Youth Handbook |
| <input type="checkbox"/> Confinement Reports | <input checked="" type="checkbox"/> Logbooks | 5 Health Records |
| <input type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 5 MH/SA Records |
| <input type="checkbox"/> Contract Monitoring Reports | <input type="checkbox"/> PAR Reports | 30 Personnel Records |
| <input type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 10 Training Records/CORE |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 5 Youth Records (Closed) |
| <input type="checkbox"/> Escape Notification/Logs | <input type="checkbox"/> Sick Call Logs | 5 Youth Records (Open) |
| <input checked="" type="checkbox"/> Exposure Control Plan | <input type="checkbox"/> Supplemental Contracts | 0 Other |
| <input checked="" type="checkbox"/> Fire Drill Log | <input checked="" type="checkbox"/> Table of Organization | |
| <input checked="" type="checkbox"/> Fire Inspection Report | <input type="checkbox"/> Telephone Logs | |

Surveys

- | | | |
|---------|---------------------|---------|
| 9 Youth | 5 Direct Care Staff | 0 Other |
|---------|---------------------|---------|

Observations During Review

- | | | |
|---|--|--|
| <input type="checkbox"/> Intake | <input checked="" type="checkbox"/> Posting of Abuse Hotline | <input checked="" type="checkbox"/> Staff Supervision of Youth |
| <input checked="" type="checkbox"/> Program Activities | <input checked="" type="checkbox"/> Tool Inventory and Storage | <input checked="" type="checkbox"/> Facility and Grounds |
| <input type="checkbox"/> Recreation | <input checked="" type="checkbox"/> Toxic Item Inventory and Storage | <input checked="" type="checkbox"/> First Aid Kit(s) |
| <input type="checkbox"/> Searches | <input type="checkbox"/> Discharge | <input type="checkbox"/> Group |
| <input type="checkbox"/> Security Video Tapes | <input type="checkbox"/> Treatment Team Meetings | <input type="checkbox"/> Meals |
| <input checked="" type="checkbox"/> Medical Clinic | <input checked="" type="checkbox"/> Social Skill Modeling by Staff | <input type="checkbox"/> Youth Movement and Counts |
| <input checked="" type="checkbox"/> Medication Administration | <input checked="" type="checkbox"/> Staff Interactions with Youth | |

Comments

Items not marked were either not applicable or not available for review.

[Rating Narrative](#)

Strengths and Innovative Approaches

Rating Narrative

Since the last Quality Improvement review, the agency has had several promotions: Erica Vagle was promoted to In-home Supervisor, Justin Colson was promoted to CSP Supervisor, Camille Campbell was promoted to CSP Trainer, and Dr. Jason Gallant was promoted to Director of Behavioral Health.

New positions that were added since the last review include: Jackie Nitti as the Outreach Coordinator, Dr. Joe Clemens as the Behavioral Health Psychologist, and three Diversion Consultants.

The agency opened its new office in Metro West in Orange County.

The agency served 1,933 youth in 2015 and exceeded the Development goal of \$501,000.

The agency was a Disney Grant recipient for 2016.

The agency has had a 90% combined occupancy through April 2016.

The agency has served 848 youth through March 2016 and is on track to serve over 3,000 for 2016.

This year (2016) was the agency's 30th anniversary in Central Florida.

The agency over-hired an extra position to make up for their low served numbers in the non-residential program.

The non-residential program increased outreach families and now have a waiting list again.

The Director of the non-residential program was voted in as vice chair of the Juvenile Justice Advisory Board.

Standard 1: Management Accountability

Overview

Narrative

The Boys Town of Central Florida program located in Oviedo, Florida is an affiliated local program of Father Flanagan's Boys Home; which has their corporate office in Omaha, Nebraska. Boys Town of America is a national non-profit agency that provides a broad range of services to youth and families. Boys Town has numerous locations throughout the country. The agency has multiple contracts that it manages that include funding from the Department of Juvenile Justice, Department of Children and Families, Community Based Care of Central Florida, Seminole County School Board, and more.

Boys Town of Central Florida, Inc. provides both residential and non-residential services to dependency, status offenders and other youth and families in need of services in Seminole County. Boys Town of Central Florida is managed by an Executive Director, who oversees program operations and services. The agency's leadership and management teams consist of one Executive Director, one Senior Director of Program Operations, one Program Support Coordinator, one Psychiatrist, one Clinical Support Coordinator, one Clinical Support Specialist, one Program Director, one Compliance Specialist, and one Non-Residential IHFS Director. The Intervention and Assessment Center, also known as the youth shelter, employs twenty-six staff members, including: one Program Director, two Supervisors, one Shelter Teacher, one Administrative Assistant, and twenty-one Youth Care Workers. There was one vacant Youth Care Worker position at the time of the review. The Program Director is also accountable for the daily financial accounting at the site, as well as, the annual program budgets and expenditures. The Program Support Coordinator, the Youth Shelter Program Director, and IHFS Supervisor conduct supervisory meetings as needed with staff members to review programs, staff issues and development, quality improvement/quality assurance, and individual youth treatment planning.

Training for the staff is provided through the Florida Network of Youth and Family Services, through online computer-based trainings. In addition, the agency provides live instructor-led sessions to managers and staff members on various job-specific and professional development offerings. An individual training file is maintained for each staff member.

The agency also utilizes several teams to oversee monthly reports delivered by the National and local level offices. The agency reviews the results of these reports and assigns responsibilities to address program operations, work performance and general risk management issues accordingly.

1.01 Background Screening

Satisfactory

Limited

Failed

Rating Narrative

The program has a written policy in place for background screening. The program conducts a background screening for all department employees, contracted provider and grant recipient employees, volunteers, mentors and interns. In addition, employees and volunteers are re-screened every five years of employment.

There were twelve new employees hired since the last on-site Quality Improvement review. All twelve employees received an eligible background screening prior to their hire date. There were eighteen employees eligible for a five-year rescreening during the review period. All eighteen employees documented re-screening was completed within the appropriate time frames.

The program had a signed and notarized Annual Affidavit of Compliance with Level 2 Screening Standards completed and sent to the Background Screening Unit on January 4, 2016, prior to the January 31st deadline.

There were no exceptions to this indicator.

1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

Rating Narrative

The program has a written policy for an abuse free environment. The program provides an environment in which youth, staff and others feel safe, secure, and not threatened by any form of abuse or harassment.

In all ten of the staff files reviewed, the staff signed a code of conduct form. The program had one grievance during the review period. The form was filled out completely. The youth and staff addressed the grievance and signed the form. Out of the nine youth surveyed, all reported they are aware of the abuse hotline and their ability to call the abuse hotline if wanted. All youth reported they have not called the abuse hotline and reported they have never been stopped from calling the abuse hotline. All of the youth reported they have never heard a staff member use profanity and they have never heard a staff member threaten another youth and that they feel safe in the shelter. All five staff surveyed knew the process for allowing a youth to call the abuse hotline. None of the staff have ever heard a co-worker telling a youth they could not call the abuse hotline. None of the staff have ever heard another co-worker using profanity, threats, or intimidation when speaking with the youth.

Program satisfaction surveys provided to the youth and parents were reviewed for the last six months. The youth reported being safe while in the program. In addition, the youth reported that staff did not yell, curse, threaten, or make fun of them. The youth reported no sexual abuse or ever being hurt, bullied, or threatened. Parent satisfaction surveys were reviewed for the past six months. All but one parent reported being satisfied with the services received while in the program. One parent reported no but did not provide a detailed explanation of why. There were a lot of positive comments from the parents about the staff communication in regard to services.

There were no exceptions to this indicator.

1.03 Incident Reporting

Satisfactory

Limited

Failed

Rating Narrative

The program has a written policy for incident reporting. When an incident occurs, the program will notify the Department's Central Communications Center (CCC) within two hours of the incident or within two hours of becoming aware of the incident.

The program had four CCC incident reports during the review period. All four incident reports were called into the CCC within the two hour timeframe. The program maintains a CCC report containing monthly calls to CCC. The document includes date, youth initials, incident time, time of call to CCC, incident, and whether accepted or not. The program maintains a binder with all the incident reports and results.

There were no exceptions to this indicator.

1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

The program has a written protocol for training requirements. First year employees will have eighty hours of training related to the job. After the first year, staff are required to have forty hours of training annually.

There were five staff training files reviewed for first year training requirements. Four of the five files reviewed had at least eighty hours or more of training in the first year. One file had documentation of completing 77.75 training hours; however, this staff has until December 2016 to complete the remaining training requirements. The training included Program Orientation, Crisis Intervention, Suicide Prevention, CINS/FINS Core Training, Title IV-E Procedures, Fire Safety Equipment, CPR, First Aid, Signs/Symptoms of Mental Health and Substance Abuse,

Medication Distribution, Professional Ethics, and Behavior Management. All five files reviewed had documentation of completing an in-service component training. The staff also completed additional trainings that were not required but recommended.

There were five staff training files reviewed for in-service training requirements following the first year of employment. All five files had over forty hours of training for the year. All files had documentation of completing Fire Safety, CPR, First Aid, and Crisis Intervention Skills. In addition, the files had documentation of completing the recommended training for Signs/Symptoms of Mental Health and Substance Abuse. Three of the five files had no documentation of completing Suicide Prevention Training.

Exception:

Three of the five staff training files reviewed had no documentation of completing Suicide Prevention Training.

1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

The agency does have structured guidelines that address the requirements of the Analyzing and Reporting Indicator. Boys Town is a large nonprofit agency that provides services for children and families nationwide. Boys Town assists in reuniting children with their families, locating foster homes, and providing a broad range of services for children and families with few or no other alternatives. The Boys Town organization has sophisticated data collection, management and reporting. The agency also produces numerous data management reports on a national level to assess its programs for quality improvement purposes. In addition, the Boys Town national office has a Marketing and Research Department that develops the company's national programs.

The local office utilizes professional research reports and findings to assist them in developing locally driven initiatives. At the local service level there are several processes which assess program operation, performance and risk manager issues, and trends.

Internal reports generated include the Program Assessment Tool (PAT), Corporate Performance Management Report and monthly Risk Management reports. The agency also utilizes a Score Card system. The Score Card addresses several areas including Serving More Youth and Families, Improving Program Quality and Improving Economics and Site Promotions. The PAT addresses several agency performance areas including Model Implementation, Youth Behavior, Family Engagement, Staff Engagement, Consumerism, Safety Permanency and Well Being, Family Behavior, and Youth Behavior. These areas are reviewed for the agency's multiple programs and also include CINS/FINS and In Home Family Services and Treatment Family Homes Intervention and Assessment Center.

The agency generates several formal monthly and quarterly reports. The agency has five (5) committees that aid in generating these reports: Youth and Family Records, Service Review, Health and Safety, Staff and Program Requirements, and Quality Management Councils. The YFR, SR and QMC meet on a monthly basis. The remaining 2 committees meet bi-monthly. Each committee has a chairperson that reports on red flag issues related program operations and risk management issues monthly.

The youth and family records committee ensure the quality and timeliness of youth and family records documentation across the continuum. This committee meets monthly to peer review files. Evidence of the agency's case record review reports were studied. Examples of indicators that are regularly assessed are: is the word confidential fixed on each file; is there a thoroughly completed medical alert form in the front of the file; is there evidence the youth meets admission criteria; is there a DJJ domestic violence referral for screening; is there a CINS/FINS intake assessment form with signature from staff and supervisor on file; has the 30, 60, 90 day review been completed. Documentation notes if follow up is needed for a particular file, it is reviewed at a following meeting.

The service review committee reviews the files in a more in-depth manner by reviewing the quality and efficiency of

service delivery systems and processes. Documentation provided proves that things such as screening form information, treatment plans, progress notes, and discharge summary notes are reviewed. This not only looks at if service was rendered but if the quality of service and if the services rendered were appropriate. This helps to improve on systems and processes when needed.

The Quality Management Council also conducts monthly reviews of incidents, accidents, and grievances. Incidents such as abuse registry calls, client grievances, youth and safety ethics calls, safety holds and manual guidance, staff injuries are noted. Incidents are differentiated by many categories such as missing child, medication error, illegal substance, AWOL, police involvement, sexual assault of client and serious illness/injury. After a client grievance is made, there is administrative response/action that is noted. This process allows for staff to be informed and improvements to be implemented.

Annual review of client satisfaction are conducted. Parent/guardians and youths have opportunity to complete surveys to express their satisfaction or dissatisfaction with the service. The actual surveys reviewed for the quarter appear to have very high remarks for the program. This detailed process allows for the program to evaluate needed improvements and also verifies that client and guardian remarks are taken into consideration through a review. Overall, findings are regularly reviewed by management and communicated to staff. These processes assists in the assessment of the services being rendered. It allows for the agency to build on strengths. This contributes to the overall ratings of occupancy for the agency and the growth of youth and families in the community.

Last year, Boys Town served 1,875 children. This was the highest number served in Boys Town Central Florida history. This year's goal is to serve 2,265 youth and families.

Additionally, annual outcome data was reviewed. In comparison from last year, there was a decline in medication errors, injuries, manual guidance, and safety holds. And on average, at discharge there has been more clients placed at the same or less restrictive placement. Improvement indeed is realized.

There were no exceptions to this indicator.

1.06 Client Transportation

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy and procedure for transportation. All drivers have a driver's license check and are covered under the agency's insurance. Human Resources approves all drivers prior to being hired. The agency does allow transportation of a single passenger without a third person in the van, but requires supervisory approval. The agency has a list of approved drivers.

The agency has a log that documents the date, time, driver, youth, other staff, starting mileage, ending mileage, number of passengers, purpose, location, and supervisory approval for single client transports. However, the log was not consistently filled out. Some of the youth were not listed, starting mileage was occasionally missing, and ending mileage was often missing.

Also, there were inconsistencies in the way staff are documenting the number of people in the van. Some staff include the driver in the count and some staff include only the passengers in the van and not the driver. This made it difficult at times to determine which transports were single client transports as the number of passengers would state "2"; however, when cross referenced with other documents it was discovered that only one client was in the van with the driver, and there were in fact not two passengers but one driver and one passenger. This occurred on several occasions throughout the last six months reviewed.

Supervisory approval was missing in the majority of the single client transports. On at least nine of the twelve single client transports the supervisory approval box on the log was left blank. During the months of October and November 2015 the single client transports were being approved by a Supervisor. However, from December 2015 to the present there was no documentation of the single client transports being approved.

The agency's two vans are equipped with the required fire extinguisher, first aid kit, knife-for-life, and window punch.

Exceptions:

During the months of October and November 2015 the single client transports were being approved by a Supervisor. However, from December 2015 to the present there was no documentation of the single client transports being approved.

Transportation logs were not consistently filled out. Some of the youth were not listed, starting mileage was occasionally missing, and ending mileage was often missing.

Also, there was inconsistencies in the way staff were documenting the number of people in the van.

1.07 Outreach Services

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that addresses the major elements of this indicator; however, it does not specifically mention attending DJJ council meetings. The agency has over thirty outreach events each month. An agency staff is the vice-chair of the DJJ council. Documentation of DJJ council meetings was provided including attendance and minutes.

There were no exceptions to this indicator.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

The agency is contracted to provide residential and non-residential CINS/FINS services to youth and families residing mainly in Seminole County and surrounding counties. The non-residential program consists of an In Home Family Services (IHFS) Director, an IHFS Supervisor, and three IHFS CINS/FINS Consultants.

These non-residential services are delivered through the agency's non-residential component and are provided twenty-four hours a day, seven days a week. The program participants receive program orientation materials upon their initial entry to the program. Program information provided to youth and parent/guardians includes confidentiality notices, release of information, service options, and other orientation materials.

The non-residential component of the program has access to Licensed Clinicians. All counselors have a minimum of a Bachelors' or Masters' level degree. Non-residential services are provided at the agency's office, in the client's homes with families, local schools, and other community based organizations.

The non-residential program also offers Case Staffing Committee meetings as needed to address nonproductive outcomes for the youth and their family. The youth along with their family, a representative from the local school board, Department of Juvenile Justice attorney and other social services agencies gather together to address the services that are being provided by the program or entities that are not doing their part or taking part in the services. The result of the meeting is that another service plan is developed to meet the needs of the youth and family members. The Case Staffing Committee can also recommend a CINS Petition to be filed in court to order participation with treatment services.

2.01 Screening and Intake

Satisfactory

Limited

Failed

Rating Narrative

A total of ten files were reviewed (five non-residential files and five shelter files). All files indicated that contact was made with the family within seven calendar days from the date of the referral. The parents and youth were given the CINS/FINS services brochure; which describes the case staffing committee, CINS petition process, and CINS adjudication at the time of intake. Consent to treatment, client rights and responsibilities, and notice to privacy practices were also given to the youth and parents. The youth and parents received the services that were available to them in writing and they were given an Intervention & Assessment Center Guide and an In-Home Family Services brochure. The parents and youth signed forms acknowledging they received this information. All ten files that were reviewed had signed documentation from the youth and parent that they received the information at intake.

There were no exceptions to this indicator.

2.02 Needs Assessment

Satisfactory

Limited

Failed

Rating Narrative

According to policy, a needs assessment must be initiated within 72 hours of admission for shelter youth and completed within two to three face-to-face contacts for non-residential youth.

A total of ten files were reviewed (five non-residential files and five shelter files). The needs assessment was completed within the appropriate time frame in all the files reviewed. All ten needs assessments were completed by Bachelor's or Master's level staff and signed by a supervisor. Out of the ten files reviewed, four indicated an elevated suicide risk as the result of the screening. Those files were referred for an Assessment of Suicide Risk by

a licensed clinical supervisor.

There were no exceptions to this indicator.

2.03 Case/Service Plan

Satisfactory

Limited

Failed

Rating Narrative

A total of ten files were reviewed (five non-residential files and five shelter files). The case/service plan was developed with the youth and family within seven working days following the completion of the needs assessment for all ten files. Each service plan was individualized and identified the needs and goals for the youth and family. The service plans included: the type, frequency and location of services, person responsible, target dates, and actual completion dates. All five non-residential files included all information. Agency staff reports that they print out a final service plan upon closure, which indicates if progress is made and the date it was achieved (actual completion date), if applicable.

The five shelter files do not reflect an actual completion date; however, it was noted that youth often stay in the shelter for less than thirty days and are discharged prior to completing goals. All files were signed by the youth, except one non-residential file. However, it was documented in the file that the youth refused to cooperate with services. All ten files were signed by the parent/guardian, counselor, and supervisor. The files were reviewed with the youth and family every thirty days for the first three months and signatures from the parent and youth were obtained at the time of that review. The reason was noted if a review was late.

There were no exceptions to this indicator.

2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

Rating Narrative

A total of ten files were reviewed (five non-residential files and five shelter files). All files were assigned a counselor/case manager to follow the youth's case. Referrals are identified for each youth as needed and worker coordinates service plan implementation. Shelter files indicate that referrals were provided to the family at discharge. Progress notes in the files indicates the family's progress in services and case monitoring. Families are being referred for additional services as needed. Shelter files indicate that staff monitors out-of-home placement. Two cases were referred for case staffing as needed to address the problems and needs of the families. No cases required accompanying a youth to a court hearing or appointment. Case termination follow-up was completed and placed in closed files as appropriate. The thirty and sixty day follow ups after exit from the program were completed as applicable and placed in a binder for non-residential files and placed in shelter files.

There were no exceptions to this indicator.

2.05 Counseling Services

Satisfactory

Limited

Failed

Rating Narrative

A total of ten files were reviewed (five non-residential files and five shelter files). All ten files document providing counseling services in accordance with the Case/Service Plan to the youth and families as needed. All files documented that the youth were receiving individual/family counseling and group counseling (shelter care) per standard.

Daily meeting logs were reviewed for shelter files. These logs indicated that in the five shelter files, the youth

received group counseling at least five days a week. The youths' presenting problems are identified in the needs assessment and on the service plan in each of the files. Case notes are maintained for all counseling services provided and documents the progress of the youth. Each file documented that it was reviewed by a supervisor.

There were no exceptions to this indicator.

2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy and procedure in place for Case Staffing Committee. The program has an established case staffing committee and has regular communication with committee members via emails. The program has a schedule for committee meetings for the entire year. There were two files reviewed (one closed file and one open file) of a staffing in progress. Both staffings were initiated by agency staff. Notification to the family were sent via certified mail no less than five working days prior to the staffing. Committee members were also notified of the staffing within the appropriate time frame.

The case staffing that was previously held included a local representative from the school, DJJ representative, agency staff, mental health representative, representative from the Seminole County Sheriff's Office, and others requested by the youth/family. The file contained signatures from the above mentioned people and emails requesting their attendance. Reminder notifications were also sent to the families. The service plan for the case was updated to include the goals and recommendations from the case staffing committee and provided to the family. The youth and family was also provided a copy of the recommendations at the time of the case staffing. The case staffing in the second file had not yet occurred at the time of the review.

There were no exceptions to this indicator.

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

A total of ten files were reviewed (five non-residential files and five shelter files). All of the files reviewed were marked "confidential" on both sides of the folder. The files are kept in a secure room that remains locked and is only accessible to program staff. The records are neat and in order. Staff can easily access the information in the file. Program staff indicated that they do not transport files. However, the agency has a locked opaque container that is marked confidential in the event they have to transport a file to court.

There were no exceptions to this indicator.

Standard 3: Shelter Care

Overview

Rating Narrative

The Boys Town shelter is located on a large, attractive campus in Oviedo, FL which is located Northeast of Orlando in Seminole County, Central Florida. The shelter facility is licensed by DCF for eighteen beds. The shelter has two separate wings for males and females. These areas are separated by a large dining area, conference room, kitchen, and classroom. There is also a "boy's lounge" and a girl's "dream room" for activities, social interaction, and relaxation.

Each youth admitted to the Boys town shelter receives a comprehensive new client orientation upon admission to the facility. Youth and parents also are provided a copy of the Boys Town Intake and Assessment Handbook during the orientation process. Youth rights, emergency procedures, and grievance process are reviewed with each youth at intake. During the intake/assessment and new client orientation process youth are evaluated by the staff member doing the intake and are assigned to a room and bed based on various criteria, behaviors, and/or characteristics. The agency uses the nationally recognized "Boys Town Model" behavior management system consistent with all Boys Town programs across the Country. The Agency does provide Domestic Violence Respite (DVR), Probation Respite, Domestic Minor Sex Trafficking (DMST), and Staff Secure shelter services.

3.01 Shelter Environment

Satisfactory

Limited

Failed

Rating Narrative

A walk-through of the shelter environment with the program director was conducted. Facility grounds were clean and well-maintained. All fire drills were completed and up-to-date with a completion time of two minutes or less. One mock emergency drill was completed per shift per quarter. Food menus were posted and visible to youth that coincided with a healthy nutritious menu. The agency has a current DCF license displayed in the building. Evacuation maps were located throughout the facility. No contraband was found in rooms, bathrooms, or common areas. All doors and cabinets were locked and secured. All community areas and bathrooms were clean and free of debris. Grievance forms were posted and accessible to all youth. Daily activities schedules were posted in more than one area.

There were no exceptions to this indicator.

3.02 Program Orientation

Satisfactory

Limited

Failed

Rating Narrative

There were five files reviewed for program orientation procedures. All files documented an orientation handbook was provided to the youth within twenty-four hours of admission. Additionally, there was documentation of grievance procedures and disciplinary actions explained to all youth. All youth received a contraband list and the physical layout was posted throughout the facility. The alert board was up-to-date. All intake documents reviewed were signed by parent/legal guardian.

There were no exceptions to this indicator.

3.03 Youth Room Assignment

Satisfactory

Limited

Failed

Rating Narrative

There were five youth files reviewed for youth room assignment procedures. All youth appeared to be classified by age, gender, history, status, and exposure to trauma. All youth were appropriately assigned to a room. All alerts were documented throughout the charts.

There were no exceptions to this indicator.

3.04 Log Books

Satisfactory

Limited

Failed

Rating Narrative

Log books were reviewed for the last six months. Safety and security incidents were documented appropriately. Entries in the log book were detailed and included: medication counts, shift reviews, intakes, and potential intakes. Errors observed in the log books were crossed out, initialed, and dated. There was no evidence of white-out used in the log books. Supervisors reviewed logbooks within the appropriate time frame. Staff on duty were reviewing the log book as well. Supervision and youth counts were documented appropriately in the log book.

There were no exceptions to this indicator.

3.05 Behavior Management Strategies

Satisfactory

Limited

Failed

Rating Narrative

The Behavior Management System is well aligned with the promotion of positive youth behaviors. Youth are always provided an opportunity to develop new coping skills through therapeutic practices used by Boys Town. The system promotes pro-social behaviors as a way of youth getting needs met and coping with challenges. Youth earn points based on positive behaviors, then points are used to redeem rewards for special privileges. Consequences and sanctions are part of the Behavior Management System as well and are clearly outlined in the Client Handbook and Program Manual.

There are no exceptions to this indicator.

3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that addresses the major elements of this indicator. The agency has three shifts: 7am to 3pm, 3pm to 10pm, and 9:30pm to 7:30am. Staff work schedules were reviewed for the last six months. A minimum of three staff were on duty during waking hours and a minimum of two staff were on duty overnight. The agency does an exceptional job in ensuring at least one staff from each gender is scheduled for each shift. Staff ratios were consistently met.

The overnight bed checks are done between five and ten minutes exceeding the fifteen minute requirement. Times are staggered and are not at equal intervals every time demonstrating they are entering time as they do the checks and not prefilling the box. On a few occasions one staff only initialed the top box and then drew a line through the rest of the form, instead of initialing each individual box. The supervisor noted this was due to a training issue with a new staff.

There were no exceptions to this indicator.

3.07 Special Populations

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of this indicator. The policy addresses the following special populations: Domestic Violence (DV) Respite, Probation Respite, Domestic Minor Sex Trafficking (DMST), and Staff Secure. The files are clearly labeled denoting the specific special population.

Two DV files were reviewed and both were closed files. Both DV files reviewed met the criteria for placement (DV arrest) and each youth stayed a period that did not exceed the twenty-one day time frame. Both youth had a case plan that focused on one of the following areas: aggression management, family coping skills, or other interventions designed to reduce re-occurrence of violence in the home. All of the other services were consistent with the general CINS/FINS program requirements as evidenced by the documents in the file.

Two Probation Respite files were reviewed and both were closed files. Both files reviewed met the criteria for placement (approved by the Florida Network and the Chief Probation Officer) and each youth stayed a period that did not exceed the fourteen to thirty day time frame. All youth had case management and counseling needs met. All of the other services were consistent with the general CINS/FINS program requirements as evidenced by the documents in the file. There was no evidence that the length of stay had been determined at admission.

The agency did not have any Staff Secure or DMST youth in the past 12 months.

There were no exceptions to this indicator.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The Boys Town of Central Florida have screening systems and processes to detect general health and mental health risks presented by prospective youth. This process requires that each youth that meets CINS/FINS eligibility requirements be screened by staff members for the severity of potential health and mental health issues. Designated trained Youth Care Worker residential and non-residential staff members utilize agency screening forms that include the general screening forms, CINS Intake form, and psycho-social assessment. The CINS intake form includes a mental health and health screening section that is required to be completed by staff members. The agency also utilizes a Suicide Risk Assessment instrument that is conducted on youth that indicate a positive on the CINS Intake form.

All Boys Town direct care staff members employed at the Intervention and Assessment Center are trained on the suicide risk screening process and utilize the CINS Intake form to screen for potential risks prior to placing all youth on sight and sound supervision status. Further, the agency's staff members have access to two (2) licensed clinicians and a contracted psychiatrist on an as needed basis.

At the time of this review, the agency's Clinical Support Coordinator or other designated clinical staff were primarily responsible for reviewing and consulting on assessments completed to determine if the youth were required to stay on elevated supervision status or have this level of supervision reduced. The agency utilizes an effective general alert system that informs direct care staff of the youth's health, behavior, or mental health status. The agency also documents any youth that have received onsite or offsite first aid or medical care.

4.01 Healthcare Admission Screening

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy for Physical Health Screening that was last reviewed and updated on January 28, 2016. The policy states that at the time of admission the youth will be provided a preliminary physical health screening by the Registered Nurse, if on duty, or designated staff. Follow-up will be provided as indicated.

The agency completes two different forms at intake to assess the youth's physical health. The first form used is the CINS/FINS Intake Assessment (physical health section) and the second form used in the Initial Health Screen Form. The Initial Health Screen Form is divided into three sections: Medication/Medical Allergy, Weight/Allergy/Nutrition Information, and Health Screening. A body chart is also completed to document observations of pain, injury, scars, skin markings, etc.

There were five youth files reviewed (four open and one closed). All five files documented all applicable forms were completed on the day of admission. Four of the five youth were on medications and the medication, as well as, the reasons for it were documented. One file documented the youth had numerous allergies and all were appropriately documented on all forms. Four of the five youth documented mental health and/or substance abuse concerns. All five youth's body charts were completed.

None of the files reviewed required any type of follow-up medical care; however, the agency has a system in place to ensure the youth will receive follow-up medical care if needed. The Intervention and Assessment Placement Agreement is reviewed with the parent at intake. This agreement states that the parent/guardian is responsible for any type of follow-up medical care the youth may need during their placement in the shelter. The parent/guardian must sign and date the agreement, as well as, initial next to each bullet in the agreement stating they understand their responsibility. This agreement was found, signed and dated by the parent, in all five files reviewed.

In addition to the above documentation staff also document a detailed intake entry in the shelter log book for each youth admitted. The entry documents any physical health concerns the youth may have, any medications the youth is taking, and any allergies the youth may have.

There were no exceptions to this indicator.

4.02 Suicide Prevention

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy that addresses the requirements of this indicator. The current policy is called At Risk Screening and Assessment and effectively describes the process of evaluating youth with risk of suicidal behaviors with the least restrictive means possible. This policy was last updated January 28, 2016. The agency has additional related policies that include the Risk and Self-Harm Screening and the Qualified Risk Screener. The plan addresses all elements of the indicator and complies with the procedures outlined in the Florida Network's Policy and Procedure Manual for CINS/FINS.

The agency's Clinical Support Coordinator and Clinical Support Specialist are both Licensed Mental Health Counselors (LMHC). The agency also recently hired a Behavior Health Psychologist.

The agency's suicide prevention process requires that all youth be screened for suicidal risk by using the six (6) suicide risk questions on the CINS/FINS Intake form. If the youth answers "yes" to any of the 6 questions, that is considered a "red flag" indicating self-harm risk. Next the Supervisor, Program Director, or clinical support staff will administer the Suicide Probability Scale (SPS) or Child Suicide Risk Assessment (CSRA), depending on the youth's age. A CSRA is used if the youth is thirteen years old or younger or if the youth shows some type of developmental delay or impairment precluding the use of the SPS. The youth can be placed on elevated supervision by meeting a minimum SPS T score of 70 or above or a CSRA score of 8 or above. Youth are then placed on the appropriate level of supervision until a Suicide Assessment is completed by a qualified professional. The agency uses four different levels of supervision: High risk, which is one-to-one supervision; moderate risk, which is constant sight and sound supervision; low risk, which is elevated supervision (five-minute watch); and no risk, which is normal supervision (fifteen-minute watch).

There were three files available for review of youth who had been placed on suicide precautions. All three files documented the youth were placed on at intake. All three files documented the youth was seen and assessed by a staff member working under the supervision of a licensed professional, within twenty-four hours or seventy-two hours if it was a weekend. The three files documented consultation with the LMHC. All three files documented thirty minute observations of the youth in the logbook. Entries in the logbook documented what the youth was doing and the name of the staff with the youth. All three files documented the youth was assessed by a staff member (who consulted with the LMHC) prior to removing the youth from constant sight and sound supervision. If youth are on constant sight and sound supervision during the overnight hours, the youth sleep in the room next to the staff work station so that staff have constant supervision of the youth.

Any youth on elevated supervision levels are documented during the transition meetings between each shift and document a staff member responsible for watching that youth each shift. A review of transition meetings revealed this is a consistent practice. In addition, all youth on elevated supervision levels and any changes in the supervision levels are documented in the logbook and highlighted in pink. A review of logbooks revealed this is also a consistent practice.

There were no exceptions to this indicator.

4.03 Medications

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place that addresses the requirements of this indicator. The current policy is called Medication Administration. The policy was last reviewed on August 3, 2015. The policy covers Medication

Administration, Disposal of Medications, Over-the-Counter Medication, Prescription Medication, Medication Recall, Accountability of Controlled Substances, Storage of Medications, Medical Neglect Referrals, Investigational Medications, and Placement of a Youth with a High-Risk Medical Condition.

The shelter provided a list of thirteen staff who are trained to supervise the self-administration of medications. There were six staff on that list who were listed as "Super Users" for the Pyxis Med-Station, with one of those staff being the Registered Nurse (RN).

The current RN has been employed at the shelter for approximately six months. The RN is on-site four days a week, Monday through Thursday from 5pm to 10pm, totaling approximately twenty hours a week. The RN will distribute evening medications on those days and all other times trained staff dispense the medications. The RN does complete various different trainings with the staff, including Medication Administration and training on using the Pyxis Med-Station.

The shelter began using the Pyxis Med-Station in April 2015. The RN reported most discrepancies produced by the Pyxis Med-Station were of staff inputting incorrect beginning counts due to being confused on the process. These discrepancies were easily fixed by the RN and at the time of the review the shelter had no open discrepancies. Staff have been trained on how to correctly input the counts and the RN reported there have been no discrepancies at all in the past couple months.

The shelter has a system in place for refrigeration of medication if needed; however, there was no medication that required refrigeration during the time of review.

All medications are inventoried at admission, when given, by maintaining a perpetual inventory with running balances, and at discharge. All controlled medications are also inventoried each shift by two staff members. The RN also completes a weekly inventory (every Monday) of all medications in the shelter, including over-the-counter medications, controlled and non-controlled medications. The RN will print out the inventory sheet from the Pyxis Med-Station and then document the actual inventories next to each medication to ensure the inventories are accurate.

There were five youth files reviewed for the medication administration process (three open and two closed). The agency still maintains hard copies of all documents relating to the medication process, as well as, enters all information into the medication cart system. All Prescription Medication Logs (PMLs) reviewed documented the youth's name, medication strength, instructions, allergies, medication side effects, reason for use, prescribing doctor, route, and staff initials, youth initials, and full printed name and signature of each staff member who initials a dose.

A cover sheet was located for each youth that documented the youth's date of birth, arrival date, current medications, and a picture of the youth. There were also additional print-outs located for each prescribed medication, with additional side effects and precautions. There was no documentation of the youth's full printed name and signature on the PMLs. The second page of the PML documents any medication communication, including that date, name, relationship to youth, reason for contact, and instructions/follow-up. There is also a section to document Transfer of Medication for Disposal. All PML's reviewed documented that all medication were given at prescribed times. If medications were not given, reasons why were documented. There is also a Prescribed Medication Count Sheet for each medication the youth is on. This form also documents when a medication was given and the count. All counts were completed appropriately for all medications reviewed. A perpetual inventory was also maintained for all medications reviewed, when given, and documented on the Prescription Medication Count Sheet.

A worksheet is printed out each day from the medication cart that lists each youth who is to receive medication for the day. This sheet is placed in the front of the Medication Log Book and staff check off each youth as the medication is given. In addition, youth on medication are also documented on the alert board in the staff office, along with the times to be given.

The shelter has had three CCC reports relating to medication errors in the last six months. All three reports were due to missed doses of medication. The errors occurred in December 2015, and January and February 2016. In one of the cases the youth missed a medication due to the parent not refilling the medication when asked. There

was documentation the parent was contacted and was given ample amount of time to bring in a refill; however, failed to do so in a timely manner. This resulted in the youth missing a dosage of medication. The remaining two incidents were due to staff error. In both cases the pharmacist was contacted and instructed staff to proceed with the next scheduled dose and that there would be no ill effects from the youth missing a dose of the medication. The staff in the two incidents did receive a verbal warning and re-training. There have been no further medication errors since February 2016.

Exceptions:

The shelter has had three CCC reports relating to medication errors in the last six months.

4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy for the Medical Alert Process and Mental Health and Medical Follow-up that was last reviewed and updated on January 28, 2016. The shelter uses an alert board located in the staff office, a Medical and Mental Health Alert form located in the front of each youth's file, and the shelter log book to document all youth alerts.

There were five youth files reviewed (three open and two closed). All five files documented applicable alerts identified during the admission screening process and were appropriately documented on the Medical and Mental Health Alert form located in the front of each file. The alert board in the staff office was reviewed for the three open files and all alerts identified on the alert form in the file were also documented on the alert board.

In addition, any applicable alerts were also documented in the shelter log book in the initial entry made by staff on the day the youth entered the shelter.

There were no exceptions to this indicator.

4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy for First Aid and Episodic/Emergency Care that was last reviewed and updated on January 28, 2016.

There have been no off-site emergency care events in the last six months. However, the shelter has completed at least one Medical Emergency Drill each month for the last six months on different shifts. The drills consisted of a sunburn, heat exhaustion, a blister, an insect bite, poison, suffocation, a human bite, and a corneal abrasion.

The shelter has a knife-for-life and wire cutters located in three different places throughout the shelter: in the staff office, in the boy's wing, and in the girl's wing. There are two first aid kits located in the staff office and also one in each of the two vehicles used to transport the youth. All the first aid kits are checked weekly by the overnight shift. The two vehicles also have a seat belt cutter and window punch located in them.

There were no exceptions to this indicator.