



# **Florida Network of Youth and Family Services Quality Improvement Program Report**

Review of Boys Town

on 01/11/2017

## CINS/FINS Rating Profile

### Standard 1: Management Accountability

1.01 Background Screening of Employees/Volunteers	Satisfactory
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Limited
1.05 Analyzing and Reporting Information	Satisfactory
1.06 Client Transportation	Satisfactory
1.07 Outreach Services	Satisfactory

Percent of indicators rated Satisfactory: 85.71%  
 Percent of indicators rated Limited: 14.29%  
 Percent of indicators rated Failed: 0.00%

### Standard 2: Intervention and Case Management

2.01 Screening and Intake	Satisfactory
2.02 Needs Assessment	Limited
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: 85.71%  
 Percent of indicators rated Limited: 14.29%  
 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
3.08 Video Surveillance System	No Rating

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	Limited
4.02 Suicide Prevention	Limited
4.03 Medications	Satisfactory
4.04 Medical/Mental Health Alert Process	Satisfactory
4.05 Episodic/Emergency Care	Satisfactory

Percent of indicators rated Satisfactory: 60.00%  
 Percent of indicators rated Limited: 40.00%  
 Percent of indicators rated Failed: 0.00%

Percent of indicators rated Satisfactory: 84.62%  
 Percent of indicators rated Limited: 15.38%  
 Percent of indicators rated Failed: 0.00%

## Rating Definitions

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

Satisfactory Compliance	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.
Not Applicable	Does not apply.

## Review Team

### Members

**Marcia Tavares, Lead Reviewer, Consultant-Forefront LLC**

**Toni DelRegno, Regional Monitor, Department of Juvenile Justice**

**Cecelia Stalnaker-Cauwenberghs, LMHC; Director of Programs; Youth Crisis Center**

**Solange Solis, Quality Management Specialist, CHS West Palm Beach**

**Mandy Kumrits, North Residential Supervisor, Family Resources Clearwater**

**Persons Interviewed**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Chief Executive Officer      | <input checked="" type="checkbox"/> Executive Director | <input type="checkbox"/> Chief Operating Officer            |
| <input type="checkbox"/> Chief Financial Officer      | <input checked="" type="checkbox"/> Program Director   | <input checked="" type="checkbox"/> Program Manager         |
| <input type="checkbox"/> Program Coordinator          | <input type="checkbox"/> Direct- Care Full time        | <input type="checkbox"/> Direct-Care Part Time              |
| <input type="checkbox"/> Direct-Care On- Call         | <input type="checkbox"/> Volunteer                     | <input type="checkbox"/> Intern                             |
| <input checked="" type="checkbox"/> Clinical Director | <input type="checkbox"/> Counselor Licensed            | <input checked="" type="checkbox"/> Counselor Non- Licensed |
| <input type="checkbox"/> Case Manager                 | <input type="checkbox"/> Advocate                      | <input checked="" type="checkbox"/> Human Resources         |
| <input type="checkbox"/> Nurse                        |  |   |
| 0 Case Managers                                       | 0 Maintenance Personnel                                | 2 Clinical Staff  |
| 1 Program Supervisors                                 | 0 Food Service Personnel                               | 0 Other   |
| 0 Health Care Staff                                   |  |   |

**Documents Reviewed**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Accreditation Reports                        | <input checked="" type="checkbox"/> Fire Prevention Plan             | <input 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 checked="" type="checkbox"/> Logbooks                          | <input checked="" type="checkbox"/> Fire Drill Log                   | 3 # Health Records                                  |
| <input checked="" type="checkbox"/> Continuity of Operation Plan      | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 4 # MH/SA Records                                   |
| <input type="checkbox"/> Contract Monitoring Reports                  | <input checked="" type="checkbox"/> Table of Organization            | 10 # Personnel Records                              |
| <input checked="" type="checkbox"/> Contract Scope of Services        | <input checked="" type="checkbox"/> Precautionary Observation Logs   | 6 # Training Records                                |
| <input checked="" type="checkbox"/> Egress Plans                      | <input checked="" type="checkbox"/> Program Schedules                | 4 # Youth Records (Closed)                          |
| <input checked="" type="checkbox"/> Fire Inspection Report            | <input type="checkbox"/> Telephone Logs                              | 7 # Youth Records (Open)                            |
| <input type="checkbox"/> Exposure Control Plan                        | <input checked="" type="checkbox"/> Supplemental Contracts           | 0 # Other   |

**Surveys**

3 Youth                      3 Direct Care Staff

**Observations During Review**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Intake                               | <input checked="" type="checkbox"/> Posting of Abuse Hotline         | <input 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 checked="" type="checkbox"/> Security Video Tapes      | <input type="checkbox"/> Treatment Team Meetings                     | <input checked="" type="checkbox"/> Meals                |
| <input 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

Boys Town of Central Florida began serving children and families in 1986 and recently celebrated its 30th anniversary. In 2016, the program served 2,086 individuals in the Orlando area. The program is located in Oviedo, Florida and is an affiliate of Father Flanagan's Boys Home, a national non-profit agency, which has its headquarters in the Village of Boys Town in Omaha, Nebraska. This year, Boys Town as a nationwide organization will celebrate its 100th anniversary.

Boys Town of Central Florida provides a spectrum of services that are funded by the Department of Juvenile Justice, Department of Children and Families, Community Based Care of Central Florida, Seminole County School Board, and Ounce of Prevention. Services include intervention and assessment services; treatment family homes; in-home family services; a national hotline; free online resources; parenting; project Safe Place; and comprehensive behavioral health assessments.

The agency shared a few of its program highlights that occurred during the past year and since its last Quality Improvement review in May 2016.

- In December 2016, the program was re-certified for the next 3 years as a result of an internal site certification review.
- A total of 848 youth were served in the first quarter of 2016 and achieved 90% combined occupancy through April 2016.
- The agency was a Disney Grant recipient for 2016.
- A decision was made to over-hire and add an extra position to make up for the low served numbers in the non-residential program. Consequently, the non-residential program increased outreach to families and now has a waiting list.
- A video segment was produced featuring the success of one of the CINS/FINS families.
- The agency announced two promotions during the visit. Erica Vagle, a former supervisor, has accepted the In-Home Family Services Director position previously held by Bethany Lacey who is being promoted to Senior Director of Operations at the north Florida program site.
- Ms. Lacey was voted in as the Vice Chair of the Juvenile Justice Advisory Board. In light of Ms. Lacey's promotion, Kristi Casteneda will be attending the Juvenile Justice Board meetings in her stead.

## Standard 1: Management Accountability

### Overview

#### Narrative

Boys Town of Central Florida, Inc. is under the leadership of a management team that consists of an Executive Director, Sr. Directors of Program Operations, Director of Program Support, a Psychiatrist, Clinical Support Coordinator, Clinical Support Specialist, Shelter Program Director, Compliance Specialist, Shelter Teacher, Administrative Assistant, Health Coordinator Nurse, In-Home Family Services (IHFS) Director, IHFS Supervisor, and two Youth Care Supervisors.

The Program Director is responsible for the daily financial accounting at the site as well as the annual program budgets and expenditures. The Director of Program Support, Shelter Program Director, and IHFS Supervisor conduct supervisory meetings as needed with staff members to review programs, staff issues and development, and quality improvement/quality assurance.

According to the organization chart reviewed during the visit, the Intervention and Assessment Center, also known as the youth shelter, is staffed by 21 Youth Care Workers (YCW), four of which are on-call staff. The IHFS non-residential program staff consists of three IHFS Diversion Consultants, one IHFS Consultant (Ounce of Prevention), and an Administrative Assistant.

At the time of the onsite visit there were no vacant positions. The shelter program is operated around three shifts. Boys Town provides both residential and non-residential services to dependency, status offenders and other youth and families in need of services in Seminole County.

Training for the staff is provided through the agency's online training system as well as the Florida Network of Youth and Family Services online Katniss training. Per the Director of Program Support, the internal training system maintains individual training logs of training completed by staff but does not issue training certificates, agendas or other supporting documentation. 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 provider's policy and procedure for Background Screening, IAP 19, was last reviewed on January 28, 2016.

Policy IAP 19 requires all Boys Town staff and volunteers to complete a background screening that includes: employment and personal references; motor vehicle records; credit check, if applicable; education verification, if applicable; social security number verification; criminal history check; and other reports required by contractual regulation. The policy also states that re-screenings can be initiated up to 6 months prior to the five year anniversary of the employee's hiring date. In addition, an Annual Affidavit of Compliance with Good Moral Character will be completed at the end of each calendar year prior to January 31st.

A total of ten background screening files were reviewed for six new staff, two 5-year re-screened staff, and two volunteers. All of the new employees were background screened prior to hire date and e-verified. Similarly, the two program intern volunteers were background screened with eligible results prior to their start dates. Two of the program staff met the criteria for 5-year re-screening. Both staff were re-screened by DJJ prior to their 5-year anniversaries.

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 3, 2017, prior to the January 31st deadline.

No exceptions to this indicator were noted as of the QI visit.

### 1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

#### Rating Narrative

The program has policies and procedures in place to ensure the provision of an abuse free environment. Specifically, FFBH #13275 provides guidelines for Code of Ethics and Professional Conduct, FFBH #2675 – Youth Safety Line, IAP 24 – Child Abuse/Neglect, and grievance policy outlined in Youth Care Policy #9225 and IAP 22. The policies and procedures were last reviewed August 2015, June 2015, May 2015, and January 2016, respectively.

Upon hire, employees receive the Agency's Code of Ethics and Professional Conduct which outlines the agency's guidelines for professional and ethical behavior. Employees also sign agreement with the agency's confidentiality and child abuse reporting requirement. Six personnel files were reviewed.

Employees are required to report all known or suspected cases of abuse and/or neglect and youth have unimpeded access to self-report. Abuse reports are maintained in the agency's database and a copy is placed in the youth's file.

During intake, youth are informed of their rights and responsibilities, abuse hotline procedures and telephone number, and the grievance procedures. This information, including the abuse hotline number is included on the orientation checklist and in the Resident Handbook.

Upon initial review, four of the six files included signed Code of Ethics and Professional Boundaries forms and only one of the six included acknowledgement of abuse reporting requirement. The program staff subsequently provided copies of the missing documents that were uploaded into the agency's database during the employees' pre-service orientation but were not yet included in their files.

One non-administrative abuse call was made by the program during the reporting period. There were no reported incidents of youth being deprived of basic needs or physical abuse by program staff was reported during youth surveys conducted during the review or observed during the visit.

The Florida Abuse Registry Hotline number, rights and responsibility, and other relevant numbers are visible posted in both male and female dorm wings. The program has grievance forms accessible to youth in their respective dormitories. However, no grievance box was observed and youth interviewed indicated they submit their grievances directly to staff.

The three youth survey indicated knowledge of the abuse hotline and location of the posting of the number in the facility. None of the youth surveyed reported being stopped from reporting abuse. None of the youth surveyed indicated feeling unsafe in the program and have never heard staff threaten them or other youth.

The three staff surveyed said they have never witnessed another staff prohibit youth from calling the abuse hotline and have never heard the use of profanity in the presence of youth or have observed staff use threat or intimidation when interacting with youth. All staff agreed the working conditions have been fair and/or good at the program. All of the staff's training files reviewed documented staff training in Child Abuse Reporting.

A review of two (2) grievances during the review period showed that the grievances are being addressed by the program within 72 hours. None of the grievances pertained to staff's mistreatment of youth.

#### Exceptions:

As required by the indicator, the program's grievance policy and procedure IAP 22, reviewed January 28, 2016, does not indicate that direct care staff are prohibited from handling youth grievances, with the

exception of when assistance is required by youth.

The shelter does not have a grievance box for the youth to deposit grievances; consequently, grievances are given to direct care staff. Youth interviewed during the review indicated they submit their grievances directly to staff. However, the indicator prohibits direct care workers from handling complaint/grievances unless assistance is requested by youth.

### 1.03 Incident Reporting

Satisfactory

Limited

Failed

#### Rating Narrative

The program has a written policy for reporting incidents (I&A Protocol 21) effective January 14, 2007, last revised January 28, 2016 and signed by the Executive Director.

The process is after a reportable incident occurs, the program notifies the Central Communications Center (CCC) within two hours of the incident or within two hours of learning of the incident.

During the review period, there were ten CCC reportable incidents. All incident reports were called in to the CCC within the required timeframe. At least half of the reports occurred within an hour of the 2-hour requirement. The program maintains a binder that contains a CCC reporting form. This form contains the youth's initials, date and time of incident, incident details, time call was made to CCC, and the outcome of the call (accepted or not accepted by CCC).

For this review period, there were no follow-up communication tasks or special instructions as required by the CCC for the incidents.

No exceptions to this indicator were noted as of the QI visit.

### 1.04 Training Requirements

Satisfactory

Limited

Failed

#### Rating Narrative

The program has a written policy and procedure, IAP 37, initially dated November 16, 2007 that was last revised on August 26, 2016. A review of IAP 37 revealed a few agency training topics that are listed as recommended and not mandatory as required by the indicator.

The agency's requirement for first year employees is the completion of 80 hours of training related to their job. First year training includes orientation, additional training required by the QI indicator during the first 120 days of hire, and in-service training. After the first year, the requirement is 40 hours of annual training of which 24 hours is job related.

Two versions of IAP 37 were reviewed. The former version revised on January 28, 2016 was reviewed on day one of the QI review and during the second day of the review, the Director of Program Support provided an updated program protocol, dated 08/26/16. The latter included some of the additional training required within the 120 day time frame but was still missing some of the mandatory training.

Three first year employee files were reviewed. All three files had more than the required 80 training hours for the first year: 85.5 hours, 88.5 hours, and 85.25 hours. Training completed included Suicide Prevention, Signs/Symptoms of Mental Health and Substance Abuse, Behavior Management, Fire Safety Equipment, CPR, Medication Distribution, Confidentiality and Child Abuse Reporting. The files had evidence of in-service training for staff.

Two files did not have evidence of completing EEO training, but the program was able to provide training descriptions for an alternate training that satisfied the required component.

Two in-service employee files were reviewed. One file had exceeded the 40-hour training requirement

(51.75) though the anniversary isn't until 04/28/17. The second file had completed 19.25 hours but has until 04/12/17 to complete the training requirement. Both files had current training documentation for Suicide Prevention, CPR, First Aid, Managing Aggressive Behavior, Fire Safety Equipment, and Prison Rape Elimination Act (PREA).

There were no new non-licensed mental health clinical shelter staff since the last review.

**Exceptions:**

The agency's policy IAP 37, does not include all the updates made to the CINS/FINS Indicator 1.04 that was effective July 1, 2016. IAP 37 lists Signs and Symptoms of Mental Health and Substance Abuse, Information Security Awareness, and Trauma Informed Care as recommended training or topics that may be included during in-service training; however, these training topics are mandatory within the first 120 days. In addition, IAP 37 does not include training for first year non-licensed mental health clinical shelter staff in Assessment of Suicide Risk.

None of the 3 new staff had completed all of the mandatory training required in the first 120 days of hire and were beyond the time frame.

- Two files had no documentation of completing CINS/FINS CORE and Title IV-E Procedures.
- One file did not have evidence of completion of Prison Rape Elimination Act (PREA).
- All three files had no documentation of completing Serving LGBTQ Youth training.

All the files reviewed did not have certificates, sign-in sheets, or agendas. The provider indicated the majority of these trainings are completed online where a training record is maintained but no certificates are provided.

**1.05 Analyzing and Reporting Information**

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy (CINS/FINS protocol 6, IAP 41) initially dated December 7, 2007 and was last reviewed, signed and dated by the Executive Director on January 28, 2016. The purpose is to maintain a system of monitoring incidents for risk management purposes and develop strategies of how to minimize these incidents. One of the procedures used to identify and address significant incidents is the Plan Do Check Act Model (PDCA) to ensure a Continuous Improvement Cycle.

Quality Management Council (QMC) is a committee comprised of staff from all programs that meets monthly to review data from Monthly Risk Management Reports. In addition, the meeting reviews the monthly scorecard (program, financial, audit and development data). "Red Flags" – changes in the number or severity of incidents) identified through other committees, reports, or critical success factors are also reviewed and a plan is created to reduce future incidents/risks.

Program record reviews are conducted and reviewed by the QMC. Client surveys are completed monthly for the shelter by the Central Florida Site. The agency's home campus completes client satisfaction surveys annually for both programs.

Several other committees are part of the risk management process including: Safety & Health, Staff & Program Requirements, Youth and Family Records Review, and Service Review. Together these committees identify potential areas of concern or risk and implement solutions designed to reduce/eliminate incidents that can affect all areas of programs.

The Director of Program Support is responsible for compiling all the data into a "risk management assessment" for the programs and distributed to the Program Directors for their review.

For the review period, August was the only month with minutes in the team meeting binder for the

Intervention and Assessment Shelter Program. The July, October and December sections were blank. The September and November sections had a page with “no staff meeting” printed on it. A program team meeting binder was provided by the Program Director showing team meetings were held regularly.

**Exception:**

Though management regularly identified and reviewed findings or improvements through QMC, there is no evidence it is regularly communicated with direct care staff. An interview with the Program Director confirmed that management could be disseminating the information at team meetings but was unsure it was consistently reviewed and documented in shelter staff meeting minutes.

**1.06 Client Transportation**

Satisfactory

Limited

Failed

Rating Narrative

A written policy, initially dated January 4, 2007 and last revised January 27, 2016 was reviewed, signed and dated by the Executive Director on January 28, 2016.

The agency maintains a list of approved drivers and staff are required to sign the Boys Town Driver Agreement. Per the policy, staff are covered under the agency’s insurance. The policy/protocol does address single client transport, “at all times we strive to have a third party (staff, youth, volunteer, and intern) in the vehicle as best practice”.

The client transportation logs contain columns for date, time, driver’s name, youth passengers, staff passengers, starting & ending mileage, number of passengers, purpose of travel, location and supervisor approval is solo (1 staff/1 youth).

A review of transportation logs for the review period was conducted. It was observed that the transportation logs were not consistently completed. A couple of entries do not list number of passengers. Several entries have a discrepancy between ending mileage of one trip and beginning mileage of the next listed trip. Most entries list youth names, but when there are several youth passengers, the size of the box is not large enough for the entries and it is difficult to read. It makes it difficult to determine number of youth passengers. Errors are not initialed and some errors were attempted to be corrected by writing over the item. Additionally, most entries do not indicate a.m. or p.m. and do not list the year, just month and day.

A number of inconsistencies were noted in counting the number of people in the van. Some entries include the staff in the number of passengers and other entries do not include the staff in that number. Another example of an inconsistency counted the driver in the total number of passengers (12/12/16 -youth passengers - one; staff passengers - 0 and number of passengers – two).

The log has a column designated for supervisor approval, which are all filled out (initialed) but there is no documentation that indicates approval was given before the single client transport. A review of the log book found no prior approval documented. An interview with the supervisor confirmed staff do not complete a single client transport without prior approval of supervisor. When asked about the initials in all of the supervisor approval columns, despite all entries not being single client transports, the supervisor explained that as a result of findings from a previous review, the initials served as a quality check by the supervisor to ensure the entry is completed correctly. The supervisor confirmed there was no documentation that clearly indicated approval was given before the single client transport.

While the agency’s policy/protocol states, “if a third party cannot be obtained for transport, the client’s history, evaluation, and recent behavior is considered”, there is no evidence of how this was done for the single client transports listed on the client transportation log.

**Exception:**

The transportation logs were not consistently completed. There is no documentation that indicates approval by a supervisor was given prior to single client transport.

### 1.07 Outreach Services

Satisfactory

Limited

Failed

#### Rating Narrative

The provider has a policy (IAP 49) in regards to outreach services and Interagency Agreements. The policy was last revised on January 27, 2016.

Per the P&P, the community engagement coordinator, In-Home Director, In-Home Supervisor, Parenting Coordinator and other designated staff participate in community events to inform youth and families about available program services. Staff also conducts presentations to community agencies, low performing schools, other prevention programs, and high crime neighborhoods. All presentations and events are documented in an Outreach log.

A list of outreach activities documented in Netmis for the review period was reviewed. The list captures a variety of outreach events, fairs, presentations, and meetings that are regularly conducted to both youth and adult audiences.

A total of 31 interagency agreements are maintained by the provider. The agreements include partners such as prevention/intervention programs, medical facilities, educational centers, clinical providers, and recreation facilities.

The program's Program Director is an active participant and Vice Chair of the Juvenile Justice Board. This role will be delegated to the Director of Program Support as of January 13, 2017 since the Program Director is promoted to a new position in the agency. Three Juvenile Justice Board meetings were held during the review period. The program Director provided documentation for one of the meetings but indicated she attended all three meetings.

No exceptions to this indicator were noted as of the QI visit.

## Standard 2: Intervention and Case Management

### Overview

#### Rating Narrative

Boys Town of Central Florida is contracted with the Florida Network of Youth and Families to provide both shelter and non-residential CINS/FINS services for youth and their families in Seminole County and the surrounding counties. The CINS/FINS program consists of the Intervention and Assessment center (I&A Shelter) and the In Home Family Services (IHFS) non-residential program.

The I&A program provides centralized intake and screening twenty-four hours per day, seven days per week, and every day of the year. The shelter program provides critical temporary shelter care services to youth meeting the criteria for CINS/FINS, Domestic Violence and Probation Respite, Staff Secure as well as Domestic Minor Sex Trafficking (DMST). Trained staff are available to determine the immediate needs of the family and youth. Each youth at the program receives an initial eligibility screening, CINS/FINS Intake Assessment, additional assessments to identify the needs of the youth and family, and a service plan. The I&A Supervisors (Bachelor's level) are responsible for completing assessments, developing case plans, providing case management services, and linking youth and families to community services. The youth's progress is documented by the YCW on Daily Skills logs that are maintained in the youth's file.

Similarly, IHFS Consultants hold Bachelor's degrees and are responsible for intake and assessments of community based referrals and deliver services through the agency's non-residential component. Non-residential services are provided at the agency's office, in the client's homes with families, local schools, and other community based organizations. All direct care staff are supervised by and have access to Licensed Clinicians. The agency has two licensed mental health counselors (LMHC) and a Psychiatrist on staff.

As needed, Boys Town coordinates the Case Staffing Committee, a statutorily-mandated committee that develops a treatment plan for habitual truancy, lockout, ungovernable, and runaway youth when all other services have been exhausted or upon request from the parents/guardians. The Case Staffing Committee meets 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 recommendations by the committee are included in a revised service plan that is provided to 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

Boys Town has indicated that this practice is not currently governed by a policy. The Screening Eligibility and Intake Assessment practice was effective and last reviewed on June 29, 2015.

The program has centralized Intake services that are provided twenty-four hours a day, seven days a week. These services include a screening for eligibility, crisis counseling and information, and referral. Boys Town practice requires that a CINS/FINS consultant or designated employee initiate an initial eligibility screening with each youth and their family within seven days of receiving the initial referral to determine eligibility. All exceptions must be noted. The screening date taken by assessment and short-term residential staff and CINS/FINS consultant staff is the same date as the referral date.

The Initial Screening shall include the following:

- At Risk Screening

- Description of presenting issues and problems
- Youth needs and family needs
- Immediate needs
- Whether or not the youth is eligible for CINS/FINS services; and
- Informed of wait list if eligibility is determined and the family is not in crisis.

A total of ten files were reviewed (7 Residential and 3 Non-Residential files). All files indicated family contact within seven days from the date of the referral. All files contained acknowledgement that the youth and parents received the following information: CINS/FINS Services Brochure, youth rights and responsibilities, Grievance procedures. All seven residential files documented that the youth and parents received the Youth Information Handbook and Intervention and Assessment Center Guide explaining services and available options. All three non-residential files documented that the youth and parents received Intervention and Assessment Center Guide and In-home Family Services brochure explaining services and available options.

There are no exceptions noted for this indicator.

## 2.02 Needs Assessment

Satisfactory

Limited

Failed

### Rating Narrative

Boys Town has indicated that this practice is not currently governed by a policy. The Screening Eligibility and Intake Assessment practice was effective and last reviewed on June 29, 2015.

The practice requires that each youth have a Needs Assessment completed. For Intervention and Assessment Services (Residential), the Needs Assessment is initiated within 72 hours of admission to Boys Town. For all other services, including Non-Residential, the Needs Assessment must be initiated during the first face-to-face visit/session with the youth and must be completed within two to three visits/sessions. If the youth is being readmitted after a minimum of six months away from the program, he or she will receive an updated assessment.

Boys Town requires that the Needs Assessments are completed by an employee with a Bachelor's Degree or Master's Degree and signed by a supervisor. If the suicide risk component of the Assessment is required (as a result of the At-Risk Screening), it must be reviewed (signed and dated) by a licensed clinical supervisor or written by a licensed clinical supervisor.

A total of ten files were reviewed (7 Residential and 3 Non-Residential). The program's assessments were completed within the required time frame in all of the residential and non-residential cases reviewed. Non-Residential files were initiated by an employee with a Bachelor's Degree or Master's Degree and signed by a licensed clinical supervisor. Five of the seven Residential files reviewed showed that the Needs Assessment were initiated by a Bachelors or Masters Level staff Member.

### Exceptions:

The documents utilized as the Needs Assessment by the provider are missing certain elements required by FN P&P 3.03, namely: date of assessment, date initiated, person(s) present during assessment, what the youth and family want to see changed, family home constellation, developmental history, and youth and family strengths and weaknesses.

The Child Ecological Assessment is missing the signature and date of staff member completing the assessment. When a youth was identified as a risk of suicide, the Child Ecological Assessment was not reviewed and signed by a licensed clinician, as required by the FN 3.03.

Part one of the Ecological Assessment in all of the Residential files reviewed was not signed by a supervisor.

None of the files reviewed included a summary of the staff's impression, comments, and recommendations based on completion of the assessments.

Two of seven residential files showed that the needs assessments were not initiated by a Bachelor or Master's level staff Member.

### 2.03 Case/Service Plan

Satisfactory

Limited

Failed

#### Rating Narrative

Boys Town has a written Policy and Procedure in place to address Case/Service Plans. This policy is labeled Service Plans, Implementation, Review, and Revision. The Effective date was January 4, 2007, revised dates of July 19, 2010 and March 27, 2014, and reviewed dates of July 30, 2015 and January 28, 2016.

Boys Town policy indicates that the Service Plan will be developed within seven business days following the psycho-social (Ecological) assessment to identify the services that will be needed to assist youth/family in reaching their identified goals. If possible, the youth and family help develop the service plan. The service plan shall address the needs of the youth and family as identified by the assessment and contain the following:

- realistic timeframes for completion
- measurable objectives that address the identified problems or needs
- responsibilities of the youth and family to complete goals
- specific needs of the youth and family
- responsibilities of the program to assist the youth and family in goal completion,

services, and treatment to be provided, to include: identified needs and goals, type of service or treatment, frequency of service or treatment, location and accountable service providers or staff, person responsible, target dates for completion, actual completion dates, signature of youth, parent/guardian, counselor, and supervisor, date the plan was initiated.

The Boys Town policies indicate they provide an array of services to youth and families and the Service Plan should incorporate these services. The services to be provided may include, but are not limited to: Intensive crisis counseling, parental training, Individual, group, or family counseling, community mental health services, prevention and diversion services, services provided by volunteers or community agencies, runaway center services, special education, tutorial, or remedial services, vocational, job training, or employment services, recreational services, and homemaker or parent aide services.

Boys Town policy indicated that a review of the Service Plan will occur every thirty days for the first three months, and every six months thereafter for progress in achieving goals and making any necessary revisions, if indicated.

A total of ten files were reviewed (7 Residential and 3 Non-Residential files). In seven of the files, the Case/Service Plans were developed within seven working days of the completion of the needs assessments. The plans included some of the elements required by the indicator.

Five applicable residential cases and two of the three non-residential cases were reviewed for progress every 30 days for the first three months of the youth being in care and every six months after.

Boys Town's policy does not address when the youth, parent, or guardian are not available to sign the Service Plan.

Exceptions:

Service Plans were not developed within seven working days of the completion of the needs assessment in three of the ten files reviewed.

The Case/Service Plans did not include service type, frequency and person responsible in all ten files reviewed.

One file did not include the youth's signature, three did not include the signature of a supervisor, and one was missing the parent's signature.

One of three Non-Residential files did not include the Service Plan being reviewed every thirty days for the first three months.

#### 2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

##### Rating Narrative

Boys Town does not have a specific policy that addresses every requirement for this indicator. Multiple policies were provided. Boys Town has a written Policy and Procedure in place to address Case/Service Plans. This policy is labeled Service Plans, Implementation, Review, and Revision. The Effective date was January 4, 2007 and last review date January 28, 2016. Referrals to Community-Based Services, Policy #13525, was signed by Boys Town President and National Executive Director with an effective date of June 8, 2015. Case Closure/Discharge Planning Policy#13600 was signed by Boys Town President and National Executive Director with an effective date of November 9, 2015. Family Involvement CINS/FINS I-12 IAP43 was last reviewed January 28, 2016. Substance Abuse Education and Referral for Treatment CINS/FINS Protocol 1 IAP6 was last reviewed January 28, 2016.

While initiating and completing the eligibility screening and Child Ecological Assessment, Boys Town staff may recognize the need for referral services. These referrals are documented on said forms.

The Residential program utilizes the "Intervention and Service Plan and Progress Report" form to track progress towards service plan goals and objectives and status of referrals. During these reviews, any barriers or recommendations regarding services, treatment, or referrals are documented and then followed up by the Primary Counselor/Consultant. These follow-ups are documented on the Intervention and Assessment Services Daily Skill Review and the next Service Plan Review.

Boys Town's procedures indicate that the Initial Screening shall include the following: At Risk Screening; Description of presenting issues and problems; Youth Needs and Family Needs; Immediate Needs, Whether or not the youth is eligible for CINS/FINS Services; and Informed of Wait List if eligibility is determined and the family is not in crisis. Upon review, it was noted that 8 of 10 files documented that the youth and family were in crisis and placed on a waiting list. Two of the youth were given a scheduled intake date 19 and 36 days out. This waiting list included: 7 days, 18 days, 19 days, 36 days, 81 days, 158 days, 159 days, and 251 days. A thorough review of the files indicated that there was not any contact to the families to discuss the status of placement and three families who were in crisis while on the waiting list were not provided any referrals for services.

A total of ten files were reviewed (7 Residential and 3 Non-Residential files). During the screening for eligibility, the youth should be assigned to a CINS staff member. Two of the seven Residential files indicated N/A on the Youth Screening assignment to a CINS staff member. Upon admission to the Residential Program, there is no notation of a specific staff who is assigned; however, each youth is assigned a staff to complete the assessments, develop case plan, and provide case monitoring.

Five of the seven residential files and all three non-residential files that were reviewed established youth's needs, based on ongoing assessment of the youth and family's needs. Service plan implementation was evident in all ten files reviewed as well as the monitoring of progress and demonstration of support for families. None of the files reviewed were eligible to be referred to case staffing committee but one of the files needed court involvement and the program staff accompanied the youth and parent/guardian to court.

In one of the three Non-Residential files, the IHFS Consultant identified the need for individual therapy for the youth father to address depression, social skills, and family conflict. Also included on this referral was marriage/family counseling to address relationship issues between the parents and the child.

Upon discharge, youth and their families are provided with a form labeled "Boys Town Central Florida Quick Referral List Orange and Seminole County" with applicable referral sources marked. Included on this form is the family member and consultant's signature to verify a copy has been provided to the youth and family.

**Exception:**

Two of the seven Residential files indicated that one of the youth was in need of therapeutic services and one youth reporting hallucinations. However, there was no indication of a referral being made for the two youth to receive these services.

**2.05 Counseling Services**

Satisfactory

Limited

Failed

Rating Narrative

Boys Town has two written Policy and Procedure in place to address Counseling Services. The first policy is labeled Mental Health Services and Referrals. The Effective date was January 4, 2007, revised dates of June 22, 2012 and March 27, 2014, and reviewed dates of July 30, 2015 and January 28, 2016. The second policy is labeled Crisis Intervention Counseling and Access to Mental Health. The Effective date was June 1, 2002, revised dates of June 20, 2010 and March 27, 2014, and reviewed dates of July 30, 2015 and January 28, 2016.

The agency requires that mental health services for youth and families in the program be provided by the Boys Town Clinical Support Specialist (Licensed Clinician) or a community-based licensed therapist/provider. The agency notes that all mental health services must be documented in the youth's case record and integrated within the service plan. Boys Town CINS/FINS staff will make recommendations for services that they do not provide for the youth and families to receive needed services provided by the community. Boys Town staff are trained in identification of signs and symptoms of emotional distress, mental illness, and substance use in children and adolescents appropriate to their position in pre-service training, weekly staff meetings, treatment team meetings, supervisors meetings, planned training events and Continuing education requirements for licensed staff.

A total of ten files were reviewed (7 Residential and 3 Non-Residential files). Zero out of ten Residential and Non-Residential files included documentation of individual, family, and group therapy services being provided to the youth and their family. There appeared to be no documentation of counseling services or referrals for those services.

An interview was conducted with the Clinical Support Coordinator to discuss group services. She acknowledged that Boys Town Family Meetings are considered as group counseling in the Residential Program. Random review of Intervention & Assessment Program Family Meeting Sign-In sheets indicated that these meetings last from 5 to 35 minutes, more frequently 5-15 minutes. Topics included the following: snack, MLK Day, Greeting Others, Accepting No for An Answer, Motivation, Gossip, and Make-Up.

**Exceptions:**

Zero out of ten Residential and Non-Residential files included documentation of individual, family, and group therapy services being provided to the youth and their family. The Clinical Support Coordinator indicated that daily progress notes are documented on the "Intervention and Assessment Services Daily Skill Review" form in D.A.P. format. However, review of progress notes did not produce any documentation of counseling services or referrals for those services.

For the Residential program, the requirement is to provide individual and family counseling, as well as, group counseling sessions held a minimum of five days per week. Per the provider, family meetings are held daily. However, these meetings are brief and the topics as well as the activities are not consistent with formal, structured group counseling sessions based on established group process procedures.

## 2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

### Rating Narrative

The agency indicates that this practice is not governed by a policy. The Case Staffing Committee practice was effective on June 8, 2015. The agency has an established Case Staffing Committee to review cases when a CINS/FINS Staff member is unable to resolve matters with youth and/or family that may negatively affect the outcome of their program participation. There is regular communication among members throughout the year via email and scheduled committee meetings.

The agency Case Staffing Committee reviews these cases to help establish a workable solution to meet program objectives. A parent/guardian or any CINS/FINS staff member may requests that a Case Staffing Committee be assembled to provide further guidance and support to a service recipient in formulating a solutions to a service plan.

The agency explained situation(s) when a Case Staffing Committee may be requested includes: Cases in which the youth has not demonstrated substantial progress in achieving goals identified in the service plan, the selected services and/or treatment have not addressed the problems and needs of the youth, and/or the youth will not participate in identified services. The Case Staffing must be scheduled at a time and place that is convenient for the youth. Furthermore, after the receipt of written request by a parent and/or legal guardian for a Case Staffing Committee it will convene within seven days. The youth and committee must be contacted within five working days of the scheduled meeting to confirm the meeting scheduled.

The last Case Staffing was held on July 7, 2016. During this case staffing, there were representatives from Boys Town, Department of Juvenile Justice, Seminole County School Board, Seminole County Sheriff's Office, youth, and parent/guardian. Boys Town canceled all remaining Case Staffing for the 2016 year due to reporting that they had no youth needing the service.

Two closed files were reviewed that contained Case Staffing's. Both staffing's 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. All required staff were present. The service plans were updated to include the goals and recommendations from the case staffing committee. Documentation indicated that the youth and guardian received copies of the recommendations at the time of case staffing.

No exceptions to this indicator were noted as of the QI visit.

## 2.07 Youth Records

Satisfactory

Limited

Failed

### Rating Narrative

Boys Town has a written policy and procedure that addresses all of the key elements of this indicator. This policy is labeled Youth Records Contents. The Effective date was August 2008, revised dates of March 14, 2013 and March 27, 2014, and reviewed on January 28, 2016. The signature of the staff member approving the policy is not legible and there is not a printed name or position.

Boys Town maintains a system of records for each youth admitted to the Residential and Non-Residential Program. To ensure youth rights to privacy, all youth records are marked and kept confidential. Boys

**Town limits access to third parties to only lawful access and disclosure. This includes accreditation bodies and appropriate legal authority.**

**A total of ten files were reviewed. The Residential files and Non-Residential files are kept in different locations. The files are kept in a secure room that remains locked and is only accessible by program staff. All of the files were marked confidential on both sides of the folders. The records are neat and in order. Staff have indicated that they do not transport files. However, in the event that it could occur they have a locked, opaque container that is marked confidential and accessible by all program staff.**

**No exceptions to this indicator were noted as of the QI visit.**

## Standard 3: Shelter Care

### Overview

#### Rating Narrative

The Boys Town shelter is licensed by DCF for eighteen beds and is located on a large, attractive campus in Oviedo, FL which is located Northeast of Orlando in Seminole County, Central Florida. The program has adequate space for all indoor and outdoor activities and is equipped with 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. The dormitories, kitchen, restrooms, classroom, and common areas were observed to be clean during the visit. Each bedroom is furnished with two or three beds with separate pillows and bed covering, dressers, and closets for youth belongings. Youth have access to a large yard for outdoor activities.

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 Youth Information Handbook during the orientation process. Youth rights, emergency procedures, rules and expectation, behavior management system, 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 shelter is designated by the Florida Network to provide Staff Secure, Domestic Violence Respite (DVR), Probation Respite, and Domestic Minor Sex Trafficking (DMST) services.

### 3.01 Shelter Environment

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of the CQI Indicator. The policy was last reviewed on January 28, 2016.

The provider's practices request that the shelter environment be safe, clean, neat, and well maintained. The program's goals also provide youth the ability to participate in structured activities focusing on health, social, emotional, intellectual, and physical development. The program also ensures the following:

1. Health and fire safety inspections are current.
2. Furnishings are in good repair.
3. The program is free of insect infestation.
4. Grounds are landscaped and well maintained.
5. Bathrooms and shower areas are clean and functional.
6. There is no graffiti on walls, doors, or windows.
7. Each youth has own individual bed with clean covered mattress, pillow, sufficient linens and blanket.
8. Lighting is adequate for tasks performed there.
9. Youth have a safe, lockable place to keep personal belongings, if requested.
10. Youth are engaged in meaningful, structured activities (e.g., education, recreation, counseling services, life and social skill training) seven days a week during awake hours. Idle time is minimal.
11. At least one hour of physical activity is provided daily.

12. Youth are provided the opportunity to participate in a variety of faith based activities. Non-punitive structured activities are offered to youth who do not choose to participate in faith-based activities.

13. Daily programming includes opportunities for youth to complete homework and access a variety of age appropriate, program approved books for reading. Youth are allowed quiet time to read.

14. Daily programming schedule is publicly posted and accessible to both staff and youth.

Upon reviewing, the facility's health (10/19/2016) and fire (10/25/2016) inspections were current and up-to-date. The grounds were well kept and the facility was free of insect infestation. All youth rooms contained appropriate bedding, no contraband was found, and lighting was appropriate for daily tasks. Youth are provided a locked/secure area to house personal belongings within a safe located in the Supervisors office.

According to the daily schedule, youth are provided the opportunity to participate in structured activities pertaining, but not limited to education, recreation, counseling, life/social skills. The schedule also demonstrates time set aside on a daily basis for physical activity. Youth are also given the opportunity to participate in faith-based activities on a weekly basis. The daily schedule is posted for both staff and youth to see.

**Exceptions:**

Bathroom 1 (Girls Hall) needs a light bulb replaced, the vents need cleaning, and the shower needs to be cleaned and free of mildew and mold.

Bathroom 2 (Boys Hall) needs shower to be cleaned and free of mildew and mold.

Room 2 (Girls Hall) contained writing on bulletin board.

The office chair in girl's common area has a youth's name engraved on arm.

The bulletin board in boy's hall contains a picture of male genitalia.

### 3.02 Program Orientation

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of the CQI Indicator. The policy was last reviewed on January 28, 2016.

The provider's practice is to provide youth with the opportunity to learn about the program and expectations through the orientation process. This is to be done upon intake, or within 24 hours of admission. The youth orientation process should include the following:

A review of expectations, program rules and the behavior management strategies are explained as follows:

- each youth is given a list of contraband items
- each youth shall be informed of disciplinary actions
- explain program's dress code
- access to medical and mental health services
- procedures for visitation, mail and telephone
- grievance procedure

- disaster preparedness instructions
- physical layout of the facility
- sleeping room assignment and introductions
- suicide prevention- alerting staff of feelings or awareness of others having suicidal thoughts.

A total of four (4) shelter files were reviewed for program orientation process. All files demonstrated youth had received comprehensive handbooks within twenty-four hours of admission. Additionally, there were documents indicating youth were educated on the discipline and grievance policies. Youth are also provided a contraband list, and the physical layout of the facility is reviewed. All intake forms were signed by designated parties. The census board was up-to-date.

No exceptions to this indicator were noted as of the QI visit.

### 3.03 Youth Room Assignment

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of the CQI Indicator. The policy was last reviewed on January 28, 2016.

The provider's practice is to protect youth through the classification system ensuring the most suitable room assignment. The room assignment process should contain the following:

1. There is an initial classification of the youth for purposes of room or living area assignment with consideration given to potential safety and security concerns. This includes but is not limited to:

- Review of available information about the youth's history, status and exposure to trauma
- Initial collateral contacts,
- Initial interactions with and observations of the youth,
- Separation of younger youth from older youth,
- Separation of violent youth from non-violent youth,
- Identification of youth susceptible to victimization,
- Presence of medical, mental or physical disabilities,
- Suicide risk,
- Sexual aggression and predatory behavior.

2. An alert is immediately entered into the program's alert system when a youth is admitted with special needs and risks such as risk of suicide, mental health, substance abuse, physical health or security risk factors.

A total of four (4) shelter files were reviewed for youth room assignments. All files provided youth information pertaining to their age, gender, history, and trauma. Two (2) out of the four (4) files contained evidence of youth having a history of violence, and two (2) out of four (4) files indicated youth being a suicide risk. Four (4) out of four (4) files contained proper alerts and additional contacts. Zero (0) out of four (4) files demonstrated youth affiliated with gangs or sexually aggressive behavior. Three (3) out of four (4) files provided initial interactions and observations with youth and staff. All youth were provided

appropriate room assignments, and alerts were documented in charts.

**Exception:**

One (1) out four (4) files did not contain behavioral and speech observations on the CINS/FINS screening.

**3.04 Log Books**

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of the CQI Indicator. The policy was last reviewed on January 28, 2016.

The provider's practice is to document daily functions, activities, and episodes pertaining to the program. The log book should ensure the following:

1. Log book entries that could impact the security and safety of the youth and/or program are highlighted.
2. All entries are brief and legibly written in ink and include:
  - Date and time of the incident, event or activity
  - Names of youth and staff involved
  - A brief statement providing pertinent information
  - The name and signature of the person making the entry.
3. All recording errors are struck through with a single line. The staff person must initial and date the correction. The use of whiteout is prohibited.
4. The program director or designee reviews the facility logbook(s) every week and makes a note chronologically in the logbook indicating the dates reviewed and if any correction, recommendations and follow-up are required and sign/date the entry.
5. The oncoming supervisor reviews the logbook of the previous two shifts (at a minimum) to become aware of any unusual occurrences, problems, etc. and makes an entry signed and dated into the logbook indicating the dates reviewed to document the review.
6. Direct care staff in the unit reviews the logbook for the previous two shifts (at a minimum) in order to be aware of any unusual occurrences, problems, etc. They make an entry in the logbook and sign/date that they have reviewed it and the dates reviewed.

Log book entries were reviewed for the past six months. Entries pertaining to security and safety were documented and highlighted in the appropriate color. Log book entries were detailed, pertaining but not limited to: Constant Sight and Sound, Mediation Counts, Intakes, and Alerts.

It was noted throughout the log book staff were re-writing over entries to prevent an error or mistake. In doing so, entries at times were difficult to read. Additionally, there were times (depending on the type of ink being used) when it was difficult to read the entries.

The log book contained regular reviews from Residential Supervisor, along with notes pertaining to review. The log book also indicated oncoming staff reading previous shifts and signing/initialing name on a regular basis.

**Exception:**

Upon review, it was noted that not all errors were addressed properly. Errors contained multiple lines, missing dates, times, and initials. (07/30/16, 08/01/16, 10/25/16, 10/29/16, 11/04/16, 12/25/16, 12/31/16)

### 3.05 Behavior Management Strategies

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of the CQI Indicator. The policy manual was last updated on March 4, 2016.

The provider's practice is to ensure the program has a behavior management system in place not only following program rules, but also encouraging youth to make positive choices, and increase personal and social responsibility.

1. The program has a detailed written description of the behavioral management strategies that includes:

- A wide variety of positive incentives used by the program.
- Appropriate interventions are used by the program in order to teach youth new behaviors and help youth understand the natural consequences for their actions.
- Behavioral interventions are applied immediately, with certainty, and reflect the severity of the behavior.

2. Consequences for violation of program rules are applied logically and consistently.

3. The program uses a variety of rewards/incentives to encourage participation and completion of the program.

4. All staff is trained in the theory and practice of facilitating successful interventions. There is a protocol for providing feedback and evaluation of staff regarding their use of positive and negative consequences.

5. Supervisors are trained to monitor the use of behavioral interventions by their staff to include the use of point-based and level-based interventions.

The program has a detailed Behavior Management System focusing on encouraging positive behavior from youth. The BMS supports and assists youth on becoming successful. It also provides opportunity for youth to receive assistance in meeting needs and learning new coping skills in order to deal with challenges they face. Youth receive points for demonstrating positive behaviors, which in turn are used to redeem for special activities and incentives. The system also contains consequences for negative behavior, which youth can locate in handbook.

No exceptions to this indicator were noted as of the QI visit.

### 3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of the CQI Indicator. The policy was last reviewed on January 28, 2016.

The provider's practice is to ensure sufficient staffing is provided according to the following:

1. The program maintains minimum staffing ratios as required by Florida Administrative Code and contract-

- 1 staff to 6 youth during awake hours and community activities
- 1 staff to 12 youth during the sleep period.

2. There is always at least one staff on duty of the same gender as the youth. If a program accepts both males and females, there should always be both a male and a female staff present, including the overnight or sleep period. Overnight shifts must always provide a minimum of two staff present.

3. The staff schedule is provided to staff or posted in a place visible to staff.

4. There is a holdover or overtime rotation roster which includes the home telephone numbers of staff who may be accessed when additional coverage is needed.

5. Staff observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or room restriction. (This does not supersede requirements for constant supervision of youth at risk of suicide or short room-check times when authorized by treatment staff or management. Times are documented in real time.)

The program contains written policy ensuring appropriate staffing are obtained for safety and security purposes of youth. There are three different shifts the program works: 7am-3pm, 3pm-10pm, and 9:30pm-7:30am. There is always one staff of each gender on shift. In the event there is a call off, the Residential Supervisor will cover the shift. There were a minimum of three staff working during waking hours and a minimum of two during overnight shift. Proper documentation indicated bed checks were being conducted on a routine basis of fifteen minutes or less. The holdover rotation roster and schedule are both located in the staff office in multiple places.

No exceptions to this indicator were noted as of the QI visit.

### 3.07 Special Populations

Satisfactory

Limited

Failed

#### Rating Narrative

A written policy, initially dated November 19, 2007 and last revised January 28, 2016 was reviewed, signed and dated by the Executive Director on January 28, 2016.

Three closed Domestic Violence Respite files were reviewed. The youth did have a pending DV charge, had been screened by the JAC/Detention and didn't meet criteria for secure detention. The length of stays did not exceed 21 days and case plans reflected goals that were appropriate: aggression management, coping skills, etc. Two of the files contained documentation of the transition from DV Respite to CINS/FINS and this was not applicable for the third file. The files' service plans listed group therapy for "4 units/ 60 minutes 1 time per week for the next 45 days". The CINS/FINS policies & procedures require "group counseling sessions, based upon established group process principles, are conducted a minimum of five (5) days per week." There is no evidence in the files that this requirement was met.

Two closed Probation Respite files were reviewed. Both files contained referrals from DJJ Probation and were classified as "probation with adjudication withheld status". Both files reviewed did not exceed the requirement for length of stay and length of stay was determined at time of admission. The files contained initial service plans with goals specific to anger and respecting authority but do not address the requirement of CINS/FINS standard re: group counseling sessions. Per Policies & Procedures, 4.01, Shelter Program Services, "group counseling sessions, based upon established group process principles, are conducted a minimum of five (5) days per week." There is no evidence in the files that this requirement was met.

There were no Staff Secure clients or DMST clients served during this period but the agency does have appropriate policies and procedures in place regarding these special populations.

#### Exceptions:

The policy/protocol does not include updates made to the CINS/FINS standards dated 07/01/16 which includes the change for Domestic Violence Respite, "Youth length of stay in DV Respite placement does not exceed 21 days." The current policy/protocol still lists 14 days. Upon speaking to the Director of

Program Support, she stated there were no updates to the policy/protocol.

Part of the CINS/FINS services to be provided to Domestic Violence and Probation Respite youth, such as group counseling, were not observed in the files reviewed.

### 3.08 Video Surveillance System

#### Rating Narrative

#### **THIS INDICATOR WILL NOT BE RATED PER THE FLORIDA NETWORK**

Policy for the Video Surveillance indicator states a system is in place and operational 24 hours a day, 7 days a week. The purpose of the surveillance system is to ensure the safety of youth, staff, and visitors.

The minimum the program must demonstrate:

1. System can capture and retain video photographic images which must be stored for a minimum of 30 days.
2. System can record date, time, and location; maintain resolution that enables facial recognition.
3. Back-up capabilities consist of cameras' ability to operate during a power outage.
4. The locations of the cameras placed in interior (e.g. intake office, counseling office, cafeteria, day room) and exterior (e.g. entrance/exit, recreation area, parking lot) general locations of the shelter where youth and staff congregate and where visitors enter and exit. Cameras are never placed in bathrooms or sleeping quarters.
5. Video surveillance system is only accessible to designated personnel (a list is maintained which also includes off-site capability per personnel).
6. Supervisory review of video is conducted a minimum of once every 14 days and noted in the logbook. The reviews assess the activities of the facility and include a review of a random sample of overnight shifts. All cameras are visible to persons in the area (no covert cameras) and a written notice is conspicuously posted on the premises for the purpose of security.
7. The process of third party review of video recordings after a request from program quality improvement visits and when an investigation is pursued after an allegation of an incident.

The program received a policy for indicator 3.08 on 01/12/17. Once provided and reviewed, certain components of the policy were not reflected in FL Network Standards. The following were missing components: System can record date, time, and location; maintain resolution that enables facial recognition, back-up capabilities and ability to operate during a power outage, the time frame in which Supervisory review is conducted at a minimum of once every 14 days, then noted in the logbook.

Currently there is no Video Surveillance System set up, however, documentation reveals there are plans in order for a system to be installed. Monthly Minutes ranging from August of 2016-December 2016 show discussion on installation of Video Surveillance System. The initial date for installation was set for January first, however there were setbacks, and a new time frame was set for some time in February 2017.

#### Exceptions:

The following exceptions are found to be lacking based on the requirements of the indicator:

Provider's policy does not state the system can record date, time, and location; maintain resolution that enables facial recognition.

The policy does not indicate back-up capabilities and ability to operate during a power outage.

Additionally, the policy does not include a time frame in which Supervisory review is conducted, which should be at a minimum of once every 14 days, then noted in the logbook.



**Quality Improvement Review**

Boys Town - 01/11/2017

Lead Reviewer: Marcia Tavares

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## Standard 4: Mental Health/Health Services

### Overview

#### Rating Narrative

The Boys Town of Central Florida has 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 Workers, residential and non-residential staff members utilize agency screening forms that include the general screening forms, CINS Intake form, child ecological and bio-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 the SPS Suicide Risk Assessment instrument that is conducted on youth that indicate a positive on the CINS Intake form. Staff conducting the initial interview and assessment considers the youth's physical characteristics, maturity level, history (including gang or criminal involvement), potential for aggression, and apparent medical, emotional or mental health issues. Alerts are documented on the alert board that is mounted in the shelter administrative office and in the youth's file. Based on the intake assessment, the youth is assigned a room which can change after further assessment. Room assignment is documented on page 2 of the CINS/FINS Intake Assessment form. Youth admitted to the shelter with prescribed or over-the-counter medication will surrender those medication to staff during admission.

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 initially screen for potential risks prior to placing all youth on sight and sound supervision status. The agency's direct care staff members also have access to two (2) licensed clinicians and a contracted psychiatrist on an as needed basis.

At the time of the QI review there was not a licensed registered nurse (RN) or licensed practical nurse (LPN) on staff or on-site. Per the Program Director, the most recent nurse contracted was 4 months prior to the review and the program's effort to recruit a nurse was not successful until recently. The new nurse will begin by the end of January 2017. The program is currently utilizing the Pyxis Med-Station system via administration by non-licensed trained staff.

During the tour of the facility, medications were observed to be stored in a locked room in the Pyxis Med-Station system. Topical and/or injectable medications are stored separately from oral medication. The program has a list of staff who are authorized to distribute medication including super users. Medication records for each youth are maintained in the youth's file.

#### 4.01 Healthcare Admission Screening

Satisfactory

Limited

Failed

#### Rating Narrative

The provider has a written policy in place, (IAP Protocol 28) last updated January 28, 2016, which outlines the administration of a Preliminary Physical Health Screening upon a youth's admission to the shelter.

The provider's procedure lists the several areas of inquiry the Preliminary Screening should address consistent with the indicator and exceeding the indicator in relation to specific inquiry into symptoms of active tuberculosis and indications of substance abuse and/or intoxication. During the intake process, information regarding a youth's health is accessed via self-report during an interview with the youth when the CINS/FINS Intake Assessment Form is completed. The Preliminary Physical Health Screening completed at intake includes, but is not limited to, information regarding the youth's medical history (chronic conditions, allergies, and past injuries). The Screening also addresses the youth's current health status (acute medical conditions, current medications, observations of current injury/distress such as any indications of pain, discomfort or difficulty with walking or other body movement and exceeding the requirements of the indicator, the screening seeks information regarding any symptoms of active

tuberculosis and indications of substance abuse and/or intoxication).

The provider does not have one Preliminary Health Screening Form where all required information is documented. Rather, all questions regarding chronic health conditions and the majority of the other questions applicable to the health screening are listed within the intake document which is primarily completed by a youth care worker. There is an additional form (The Initial Health Screen Form) completed by the designated staff which is divided into three sections (some of which is also included on the aforementioned intake form) to include information regarding current medications/allergies/ height and weight, and other information.

Subsequent to the Preliminary Physical Health Screening, additional information can also be obtained from the youth's parent/legal guardian and/or the referral source. Information about the youth's health status is also obtained through observation of the youth and the completion of a body chart indicating any marks on the body including bruising, scars, birthmarks, tattoos, etc.

Three open and two closed residential youth files were reviewed for documentation of the Preliminary Physical Health Screening. Each youth file documented completion of a CINS/FINS Intake form with inclusion of preliminary health screening on the date of admission which included all of the required information of the indicator. Information from the provider staff indicates there has not been a nurse working on-site since September 2016. The provider hired a registered nurse in November 2016, who is set to start training in mid-January 2017.

Accordingly, the review of open files affirms review of the Preliminary Physical Health Screening by a nurse has not been a program practice due to the absence of a nurse.

Upon review of three open youth files, it was unclear if identification of acute and chronic conditions were accurately documented during healthcare admission screening. Three of three health screenings reviewed in active youth files did not clearly document review of the chronic medical conditions listed in the Physical Health Screening section of the form and there were significant variations in the documentation. One of the Physical Health Screenings was left completely blank, another had a line seemingly arbitrarily drawn through some of the listed conditions, and another form just listed N/A on the line below the list of medical conditions. The health screening indicating "N/A" was for a youth who had no allergies listed on the form, but alerts were posted regarding allergies to penicillin and antibiotic skin cream. No box was checked regarding a history of Attention Deficit Disorder with Hyperactivity, though other documentation indicated the youth was prescribed medication for that specific disorder. Additionally, the youth was noted to have stated he was experiencing auditory and visual hallucinations, but there was no indication of a need for medical or psychiatric follow-up by the youth care worker and shift supervisor who completed the screenings. The youth was prescribed several psychotropic medications and likely required further medical referral or follow-up care. Despite documentation of the physical concerns, medical condition, medications, and allergies, the reviewer was unable to find any indication of program practice of the required policy that all medical referrals and follow-up are documented and highlighted in the daily (transition) log. It remains unclear, in the long-standing absence of a nurse, who is responsible for medical referral and/or follow-up to the program director or his designee so that there is a mechanism for necessary follow-up medical care for youth with chronic medical conditions and appropriate services are coordinated.

Two closed files were reviewed to assess completion and review of preliminary health screenings during the time the provider had a contracted nurse. A thyroid condition was identified for one of the youth and asthma for the other youth. Youth care staff completed the physical health screenings for the two youth; however, as required, there is no documentation to support the review of the intake and health screenings within 5 days by the nurse.

Exceptions:

Indicator 4.01 states a registered nurse shall complete the Preliminary Health Screening (which includes the information on the generalized Intake Assessment Form) when on-site. There is no mention in the provider's policy IAP 28 approved 1/28/16, as stated in the indicator, that in the event the nurse does not conduct the Preliminary Health Screening, the nurse shall review all screenings within five business days

of the intake. Two applicable files reviewed, during the period that the program had a nurse, did not demonstrate practice of the nurse reviewing the intake and health screenings within 5 days of the youths' intakes.

Per the indicator, the provider is to have written policy and procedures to ensure medical care be accessed for youth with chronic conditions and a referral process/mechanism for any necessary follow-up care as needed. One reviewed written program policy indicated follow-up would be documented on chronic conditions and in the youth's file and documented and highlighted on the transition log. However, despite the review of youth files where they identified chronic conditions, there was no evidence that the staff were completing the tasks as stated in the policy. Furthermore, specific procedures outlining the mechanism for medical referral (who assesses and determines needs, makes appointments, arranges transport, informs parent/guardian) and actual provision of follow-up of care were not documented.

The indicator requires the Preliminary Physical Health Screening to document chronic conditions including but not limited to diabetes, asthma, seizure disorder, cardiac/digestive disorders, hemophilia, hepatitis, tuberculosis, vision or hearing disorders and headaches or other pain. Three of three health screenings reviewed in active youth files did not clearly document review of the chronic medical conditions listed in the Physical Health Screening section of the form and there were significant variations in the documentation. One of the Physical Health Screenings was left completely blank, another had a line seemingly arbitrarily drawn through some of the listed conditions, and another form just listed N/A on the line below the list of medical conditions.

#### 4.02 Suicide Prevention

Satisfactory

Limited

Failed

##### Rating Narrative

The program has written policies and procedures regarding suicide prevention and response. These policies include an Emergency Response Plan (IAP Protocol 7) and the At Risk Screening and Assessment (IAP Protocol 5), both last updated January 28, 2016. Other policies, documented as effective June 29, 2015, also address elements of this indicator including one relating to the Qualified Risk Screener and another entitled Risk and Self-Harm Screening.

The reviewer found that the current program policies address only youth who are deemed at risk for self-harm/suicide at intake. They do not address the procedures to be implemented when a youth manifests self-harm or expressed suicidal ideation after admission procedures have taken place.

The program's procedure is to screen all youth for risk for self-harm/suicide upon admission. This initial screening is comprised of six questions on the CINS/FINS Intake Form. Any affirmative response by a youth triggers further assessment by a licensed professional, clinical support staff, the program director, or a trained supervisor using either the Suicide Probability Scale (SPS) or Child Suicide Risk Assessment, (dependent on the youth's chronological age and/or maturity level). An elevated score on either of these assessments results in either the youth being referred for Baker Act admission to an appropriate psychiatric facility or, if not deemed to be an emergent risk for suicide, the youth is maintained in the program and placed on a higher level of supervision (either one-to-one or constant sight and sound) until an evaluation can take place by licensed mental health professional or a non-licensed mental health professional under the supervision of a licensed mental health/social work professional.

A component of this assessment is a youth's contract for safety. During consultation with the licensed clinician, the youth is then either maintained on the level of supervision or the level of supervision is changed to the least restrictive level.

While a youth is on an elevated level of supervision the staff document supervision of the youth in the transitional log (the program's daily log) at least every thirty minutes and any changes in the level of supervision are highlighted. The higher level of supervision is also noted on the program's alert board to ensure all staff are aware of a given youth's status at any time.

An e-mail confirming the program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services was reviewed.

Four open files of youth who had been placed on suicide precautions at admission were reviewed to determine program practice in regards to suicide prevention. Each of the four reviewed files included documentation of a suicide-risk screening upon admission to the program and each screening was reviewed and signed by the shift supervisor. One reviewed file reflected a youth who was evaluated by a licensed mental health professional and determined to be at no risk for suicide and not in need of an elevated level of supervision.

Each of the remaining three files documented the youth was placed on constant sight and sound supervision until assessed by licensed mental health professional or a non-licensed mental health professional under the supervision of a licensed mental health/social work professional. A review of the program logbook indicates each of these three youth were assigned to a higher level of supervision and the youth's behavior was documented at least every thirty minutes. The policy requires after the completion of the Suicide Probability Scale or Child Suicide Risk Assessment by a trained supervisor, the program director or a clinical support staff, if the youth responds affirmatively to any of the questions, these results are communicated to the licensed mental health professional and a note of the conversation is documented on the assessment form. The licensed clinician then later documents the call with a signature.

A review of four of these follow-up suicide risk assessments indicated the licensed staff was notified rather than consulted with findings when the decision was made by the Program Director. Two of the three applicable files reviewed on the first day of the QI review did not initially include documentation of communication with the licensed clinician by the Program Director; the licensed clinician's name and date of notification were added following the Reviewer's interview with the Program Director.

#### Exceptions:

The program's policy IAP 5 incorrectly references indicator 4.03 in describing the time restraints for the licensed professional to review and sign the suicide assessment form. The correct indicator reference should be 4.02 and the referenced sentence is incorrect in substance stating there are no time constraints for the licensed mental health professional to review and sign the suicide assessment form.

Documentation of supervision of youth on constant site and sound supervision in the logbook for the three applicable files reviewed lacks the signature of the supervisory staff after each shift as required by the indicator.

Documentation of the consultation between the non-licensed staff and the licensed clinician in the decision-making process as to whether or not there is to be a change in the youth's level of supervision status was initially missing and lacked clarity in two of three applicable reviewed instances.

In addition, the name of one licensed clinician is typed onto the At Risk Assessment form when it appears this clinician is not consistently involved in the assessment of the youth.

#### 4.03 Medications

Satisfactory

Limited

Failed

#### Rating Narrative

There is a site-specific policy (IAP Protocol 13) last updated on January 28, 2016, which addresses medication storage, access, inventories, the medication administration log and provision of medications. There is also a set of written policies and procedures regarding medication administration, storage of medications, accountability of controlled substances, over the counter medications, prescription medications, investigational medications, medication recall, medical neglect referrals, and disposal of medications from the corporate office. Each of these policies date back to 2015, with the exception of storage of medications, which dates back to December 2014.

All youth medication (prescribed and over the counter), with the exception of medications in need of refrigeration, are stored in various sections of the locked Pyxis Med-Station 4000. Medications requiring refrigeration are stored in a locked refrigerator used solely for this purpose. Both the Pyxis Med-Station and the padlocked medication-only refrigerator are located in the Youth Care Worker office of the shelter facility. This office is inaccessible to youth.

Since the nursing position has been vacant for the past four months, it has been a program practice for non-healthcare staff to administer all medications to the youth. The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy maintained on a shelf next to the Pyxis Med-Station 4000. The program provided a list of fourteen staff that, having completed specialized training and supervision of medication administration, are authorized access to the medication and provide medication to youth. Additionally, two staff, the program director and each shift supervisor are designated "Super-Users" of the Med-Station. The Super-Users have access to secured medications and limited access to controlled substances.

In the absence of the nurse, staff authorized to dispense medication also maintain perpetual counts of all medications. All controlled medications are counted perpetually and at the end of each shift by two staff, one who serves as a witness to the count. Counts of all other medications occur perpetually and inventoried a minimum of once every twenty-four hours. Syringes and sharp counts are conducted at least weekly. A medication log binder is maintained to document the provision of medication to the youth, to maintain records of perpetual and daily counts of the medications and to maintain a list of staff authorized to access the secured medications. The Pyxis Med-Station provides reports regarding medication management. Reviews of medication management practice based on these reports are conducted at least monthly.

Reviewer observed all medications, including over-the counter and prescription medications including narcotics and controlled medications, are stored separately within a Pyxis Med-Station 4000, with the exception of medications that require refrigeration. These medications are stored in a nearby mini-refrigerator, maintained at a specific temperature and marked medications only, which has a large padlock barring entry without access to a key. At the time of the review, the refrigerator was empty.

Reviewer observed all medications are inaccessible to youth, even when the youth's medications are being dispensed due to the use of a half-door system between the office wall and a hallway. Within the medication station, reviewer observed oral medications are stored separately from topical and injectable medications. (Notably, the program had no injectable medications on-site at the time of the review.) Reviewer observed three youth being administered medication. One of the youth was provided with a dosage of Concerta, a controlled substance. Before the medication was administered, the youth stated the medication being requested, the dosage, the color of the tablet/capsule and the reason the medication was being ingested and possible side effects of the medications. One youth was asked if this information was routinely requested before medication administration, he affirmed it is. Each time a youth is provided medication it is documented in the Medication Distribution Log with the staff and both youth and staff initial the documentation as observed on count sheets maintained in the Medication Log Binder.

Also, writer reviewed reviews of medication practice derived from the Pyxis Med-Station 4000 completed at least monthly but often weekly. The shelter has had two reports to the Central Communications Center (CCC) related to medication errors in the past six months, specifically one in September and the second one in December 2016.

No exceptions to this indicator were noted as of the QI visit.

#### 4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

#### Rating Narrative

The program has a policy and written procedures addressing the Medic Alert Process (IAP 3) to ensure staff are aware of information concerning a youth's medical or mental health condition, allergies, common

side effects of prescribed medication and other treatment. This policy was last updated on January 28, 2016.

Upon completion of the Preliminary Physical Health Screening and CINS/FINS admission process, any chronic medical condition, health problem, special diet, allergies, common side effects of prescribed medications or treatments, or any other medical or mental health concern is documented on the front page of a youth's file, in the shelter log book and on the youth alert board. Alerts are also documented on the agency's national data base and, at intake, in the Juvenile Justice Information System, if applicable.

This reviewer reviewed the youth files of three applicable youth for medical alerts. Each of the youth were prescribed psychotropic medications. Each of the youth were appropriately placed on the program's alert board located in the Youth Care Worker office of the shelter facility. This office is inaccessible to youth. Additionally, all three youth had alert information documented on the front page of their file. Two of the three youth alerts reviewed were documented in the transition (daily) logbook. Three of three interviewed staff were able to state where they could seek information regarding a youth's medical/mental health alerts. Each staff also verified they have been trained in CPR and how to recognize and respond to any kind of medical or mental health emergency. Each staff also verified they are authorized to call 911 anytime they observe the need to do so.

**Exception:**

One of three reviewed youth alerts in logbook failed to document a psychiatric diagnosis and prescribed psychotropic medications.

**4.05 Episodic/Emergency Care**

Satisfactory

Limited

Failed

Rating Narrative

The program has a written policy and procedure (IAP 16) addressing First Aid and Episodic Emergency Care with the purpose of providing training to staff regarding first aid and safety to ensure proper use of equipment and proper procedures for first aid and emergency care. This policy was last updated on January 28, 2016. Additionally, there is a policy (IAP 15) which addresses the required first aid equipment to be on hand in the shelter at all times.

The program ensures all direct care staff will receive training and certification in first aid and cardiopulmonary resuscitation. Staff also attend re-trainings as needed to maintain certification.

The program also provides first aid/emergency drills for staff at least once per quarter on each shift. These drills may include incidents of suicide attempt, arterial bleeding, dental trauma, insect bites and other emergencies.

The program maintains stocked first aid kits in each dorm area (two-one for boys' dorm and one for girls), one in each of the two vans used to transport youth and two additional kits in the Youth Care Worker office of the shelter facility. All kits are inaccessible to youth. All first aid kits are checked monthly during safety checks to ensure they contain, at minimum, a variety of bandages, adhesive tape, nickel plated scissors, a one-way barrier CPR mask, a small biohazard bag and disposable gloves.

Each van is to have a seat belt cutter and a window punch to use in case of emergency.

The program maintains knife for life tool and wire cutters in a secure area in each dorm and in the Youth Care Worker office of the shelter facility.

A listing of emergency telephone numbers of service providers in the community is posted and available to all staff.

Staff are informed in the event of a medical or dental emergency, a nurse should be notified, and in the absence of a nurse, the program director and shift supervisor should be notified immediately regardless of the hour. The program director will notify the site director immediately and if needed, 911 will be contacted.

If the youth is hospitalized, the program director or designee will secure all medical insurance information and accompany the youth to the hospital or meet the emergency transport at the hospital if such transport is necessary. All medical information will be communicated to the parent/guardian.

Additionally, the youth's parent or guardian is to be informed immediately of any emergency by the shelter supervisor, program director or a designee of any incident involving serious illness or injury to the youth, as well as, any severe psychiatric event requiring hospitalization of the youth.

If a CINS/FINS youth experiences a non-emergent illness, injury or psychiatric event, the parent/guardian will be contacted and notified the youth requires medical attention and they must transport the child for treatment. If the parent/guardian refuses to access needed medical treatment for the youth, the shelter staff can make the decision to contact the Florida Abuse Hotline to report medical neglect.

All instances of a youth receiving first aid or emergency care will be reported to the Central Communications Center (CCC) within two hours of the incident and documented in the CCC Incident Binder.

Intake and Assessment maintains a separate log to document all youth with chronic medical conditions. The log will also document all medical appointments or needed referrals for youth with chronic illnesses.

According to the CCC reports during the review period, there have been three instances when a CINS/FINS shelter youth has accessed off-site care in a local emergency room. One youth went once due to complaints of pain in her big toe of her left foot and suspected of having a dislocated toe at the facility while jumping on the bed. The other two emergency room visits were related to the same youth. One emergency room visit related to Dysuria and the other visit was due to complaints of a severe headache lasting three days. There were no instances of dental emergencies documented during the past six months. Incident reports were completed in two of the three instances. Upon youth return from off-site care, in two of the three instances there was documentation regarding discharge instructions and medical clearance to return to the shelter in the youth's file. In all three instances there is documentation the youth's parent was notified of the medical issue and need for an emergency room visit.

The Episodic Log Book is developed to maintain documentation of any instance of episodic care. A review of the logbook indicated youth have received first aid care in the program on various occasions. Reviewer checked to verify the entries in the logbook were congruent with the entries in the program transition (daily) logbook and the alert sheet, applicable for four randomly selected incidents. Reviewer observed three of four instances were documented in both logbooks and the entries in the daily logbook verified parental notification regarding the injury.

The program also maintains the Episodic Care Logbook, per program policy, for all youth who are admitted to the program with a chronic condition. A review of the logbook indicated there is no current list of such youth currently or the past six months. Rather, there are blank forms to be completed identifying the chronic condition, the staff responsible for managing the youth's condition (i.e. medication administration/basic first aid) and a listing of appointments needed and reason for the appointment, and a list of any appointment referrals. When program staff was asked why there were no youth listed in the log for the past six months, the staff indicated there have been no youth with chronic conditions. When asked about a specific youth who presented at admission with a history of asthma, the staff responded they were unaware asthma was a chronic condition.

#### Exceptions:

Of the two reviewed instances when a youth went out to the hospital from the program, discharge information was not documented in the file. The youth was prescribed Fiorinal at the hospital per the associated CCC. This medication change was not indicated on the logbook, nor was an alert for the new medication posted on the alert board.

One of the two instances when a youth went to the hospital, there was no documentation in the youth record of the referral for a follow-up appointment as indicated on the hospital discharge summary.

In one of the reviewed instances in the Episodic Log when a youth suffered a back injury after a fall, there

**was no documentation of the incident in the program logbook or of parent notification.**

**The program failed to address on discharge summaries any indication of follow-up recommendations for a youth with a chronic medical condition, a youth who had been prescribed psychotropic medications and a youth who was diagnosed with a medical illness at the hospital. Furthermore, there was no documentation the parent/guardian ever received a copy of the youth's medical discharge information from the hospital.**

**The program failed to maintain a list of youth with chronic medical conditions and documentation of follow-up while in the program as stated in their policy.**