Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Hillsborough County

on 04/17/2013

CINS/FINS Rating Profile

Standard 1: Management Accountability	
1.01 Background Screening	Satisfactory
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Limited
1.05 Interagency Agreements and Outreach	Satisfactory
1.06 Disaster Planning	Satisfactory
1.07 Analyzing and Reporting Information	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 Psychosocial Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management and Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petitiion Process	Satisfactory
2.07 Youth Records	Satisfactory

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

Standard 3: Shelter Care	
3.01 Youth Room Assignment	Satisfactory
3.02 Program Orientation	Satisfactory
3.03 Shelter Environment	Satisfactory
3.04 Log Books	Satisfactory
3.05 Daily Programming	Satisfactory
3.06 Behavior Management Strategies	Satisfactory
3.07 Behavior Interventions	Satisfactory
3.08 Staffing and Youth Supervision	Satisfactory
3.09 Staff Secure Shelter	Satisfactory

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

Standard 4: Mental Health/Health Services	
4.01 Healthcare Admission Screening	Satisfactory
4.02 Suicide Prevention	Satisfactory
4.03 Medications	Satisfactory
4.04 Medical/Mental Health Alert Process	Satisfactory
4.05 Episodic/Emergency Care	Satisfactory

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

Overall Rating Summary

Percent of indicators rated Satisfactory:96.43%
Percent of indicators rated Limited:3.57%
Percent of indicators rated Failed:0.00%

Rating Definitions

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

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

Review Team

Members

Keith Carr, Lead Reviewer, Florida Network of Youth and Family Services/Forefront LLC

Tom Popadak, Training Director, Florida Network of Youth and Family Services/ Diversified Consulting

Linda Sessions, Program Manager, Tampa Housing Authority

Stacey Welton: Vice President of Residential, Family Resources

Persons Interviewed

- [x] Program Director
- [ ] DJJ Monitor
- [ ] DHA or designee
- [ ] DMHA or designee

8 Case Managers
6 Clinical Staff
5 Food Service Personnel
1 Health Care Staff

1 Maintenance Personnel
7 Program Supervisors
13 Other

Documents Reviewed

- [ ] Accreditation Reports
- [ ] Affidavit of Good Moral Character
- [ ] CCC Reports
- [ ] Confinement Reports
- [ ] Continuity of Operation Plan
- [ ] Contract Monitoring Reports
- [ ] Contract Scope of Services
- [ ] Egress Plans
- [ ] Escape Notification/Logs
- [ ] Exposure Control Plan
- [ ] Fire Drill Log
- [ ] Fire Inspection Report
- [ ] Fire Prevention Plan
- [ ] Grievance Process/Records
- [ ] Key Control Log
- [ ] Logbooks
- [ ] Medical and Mental Health Alerts
- [ ] PAR Reports
- [ ] Precautionary Observation Logs
- [ ] Program Schedules
- [ ] Sick Call Logs
- [ ] Supplemental Contracts
- [ ] Table of Organization
- [ ] Telephone Logs
- [ ] Vehicle Inspection Reports
- [ ] Visitation Logs
- [ ] Youth Handbook

8 Health Records
10 MH/SA Records
18 Personnel Records
Training Records/CORE
Youth Records (Closed)
Youth Records (Open)
Other

Surveys

2 Youth | 7 Direct Care Staff | 0 Other

Observations During Review

- [x] Admissions
- [ ] Confinement
- [ ] Facility and Grounds
- [ ] First Aid Kit(s)
- [ ] Group
- [ ] Meals
- [ ] Medical Clinic
- [ ] Medication Administration
- [ ] Posting of Abuse Hotline
- [ ] Program Activities
- [ ] Recreation
- [ ] Searches
- [ ] Security Video Tapes
- [ ] Sick Call
- [ ] Social Skill Modeling by Staff
- [ ] Staff Interactions with Youth
- [ ] Staff Supervision of Youth
- [ ] Tool Inventory and Storage
- [ ] Toxic Item Inventory and Storage
- [ ] Transition/Exit Conferences
- [ ] Treatment Team Meetings
- [ ] Use of Mechanical Restraints
- [ ] Youth Movement and Counts

Comments

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

The agency has an outstanding physical plant that incorporates modern residential cottages, administrative offices, dining hall and recreational green space.

The staff members were extremely cooperative and professional throughout the entire program review.

The agency General Manager demonstrated a high level of technical knowledge regarding all operation and programmatic aspects of the Hillsborough County CINS/FINS program.

Strengths and Innovative Approaches

Rating Narrative

Hillsborough County Government has appointed Erica Moore, Esquire as the new Children's Services Director of the Hillsborough County Division of Family and Aging Services in January 2013.

The agency reports that Dr. Nancy Pape, Ph.D., Clinical Director oversees all clinical and counseling services provided by the Division of Family and Aging Services.

The Hillsborough County General Manager II was elected as the Secretary of the Juvenile Justice Circuit 13 Board. The agency maintains on-going membership on many boards and councils in the Tampa Bay area, including the JAC interagency meeting, JDAI Collaborative and JDAI Steering Committee, The Youth at Risk Committee, Community Alliance, Children's Committee.

The agency hosted a Dedication and Renaming of the CINS/FINS Girls Shelter ceremony to promote the new name the Mary Jane Martinez Cottage. The agency held a large ceremony and press exposure.

The agency completed significant outreach involvement with the RNC 2012, which included community collaboration, physical outreach to local hotels and motels, and media exposure to raise awareness.

The agency celebrated National Runaway Prevention Month with two (2) large displays in the main County Center building in downtown Tampa.

The agency has received major public networking and donations, including from the Ryan Nece Foundation, Grace Family Church, Society for Marketing Professionals, Idelwild Baptist Church, Kids Charity Tampa Bay and other local organizations.

The agency has added new campus enhancements to include a security guard that makes rounds 12 hours a night on campus, 7 days a week, increased perimeter lightening, and the process has been started for perimeter fencing to reduce foot traffic from the public on campus.

The agency has worked on a major focus on community partnerships, collaborations, and including the training of law enforcement officers. As a part of this effort, agency developed a partnership with the Watoto program. This program assists children that have become orphans due to ongoing war and conflict in their home countries in Africa. Through this program children primarily from Uganda are provided a new homeland and other services. The youth from the CINS/FINS program visited the Watoto program and attend a local concert with Watoto program participants. In addition, the agency secured a partnership with Phoenix House to provide onsite substance abuse screenings at two (2) locations in the county. The agency has also entered into a partnership with the Prodigy Cultural Arts program that provides experiences for the youth to participate in music, arts, drawing, ceramics. These experiences are also provided following the resident's discharge from the youth shelter. The agency has also partnered with the Derrick Brooks Foundation.

The agency has instituted a two (2) Trauma Informed Care (TIC) training program. The agency has also revised its Non-residential program to expand the services to 4-5 counselors. These counselors also attend truancy and Juvenile Assessment Center meetings on a weekly basis.

The agency has automated to major areas of its daily operation. The agency continues to use digital files in its Non-Residential Program for all of its clients and families. In addition, the agency maintains digital personnel and training records for all of its employees and staff members.

The Hillsborough County Lake Magdalene campus is located on 55 acres just Northeast of Tampa. The campus has undergone extensive renovation over the last three years making it one of the top facilities with some of the most on-site resources in the State.

The program has implemented Trauma Informed Care practices into its service delivery process.

Standard 1: Management Accountability

Overview

Narrative

The Hillsborough County Government provides both Residential and Non-Residential CINS/FINS services for youth and their families in Hillsborough County, Florida. The program located at3110 Clay Mangum Lane Tampa, Florida is under the leadership of the Hillsborough County Government. Division's Director oversees the residential and non-residential components of the program, including the volunteer and outreach initiatives. The program managers are responsible for supervising and conducting staff meetings with their respective staff members and conducting direct residential and non-residential services and program specific outreach. The shelter is licensed by the Department of Children and Families.

The program's Emergency Disaster Plan has been approved by the Florida Network. The Florida Network received the program's emergency response plan and hurricane plan that did have major revision in 2012. A Universal Agreement for Emergency Disaster Shelter is also in force and was signed by the agency representative in 2012. The agency administrative offices and youth shelters are recently built structures and the shelter other building on campus can be utilized up to a level three and four hurricane category.

The agency maintains key partnerships in the community with major local service providers, as well as community base program and agencies. The agency has key partnerships with the local school system, law enforcement, social services and cultural and arts programs.

The program maintains an individual training file for each employee, with training provided through a broad array of local service provider options and sources. The agency does utilize the Florida Network, computer-based trainings and training delivered in house by Hillsborough County staff. Upon attending outside trainings, staff members are responsible for submitting the documentation for recording in their training file. Annual training is tracked according to the employee's date of hire. All personnel and training records are maintained in a digital record format.

1.01 Background Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

7 background screenings were reviewed consisting of 5 staff that were screened for the 5 year rescreen, 1 new staff, and 1 staff promoted. The staff member that was promoted was screened originally on 2/17/09. She was promoted to counselor on 11/5/12 with no break of service. The original screen sufficed for background screening. The one new staff was hired on 1/28/13. Her background clearance was received on 1/31/13. She was in training at an off site location and did not have any contact with youth within the 1/28 -1/31 timeframe.

Hillsborough County has many long term employees. The 5 year re-screens were contained in the employee personnel files and were within the required timeframe.

The Annual Affadavit of Compliance with Level 2 Screening Standards was sent by Danielle Hubbard to BGSU on 1/14/13. This met the required time frame.

1.02 Provision of an Abuse Free Environment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

A total of fifteen (15) grievances submitted by participants were reviewed on site to determine their adherence to agency policy. These documented grievances encompassed reports citing client issues regarding their dissatisfaction with the agency's behavior management system, regarding food, program rules, facility (auto off and on lights; teen center; and social/free time). The process for resolving grievances involves the agency policy that requires a response to a submitted grievance by a resident within seventy-two (72) hours of receiving the written resident grievance.

A total of seven (7) randomly selected Direct Care staff members across all work shifts were selected to complete the Florida Network online Quality Improvement survey. Of these completed surveys, 7 out of 7 surveys reported that they never witnessed youth ever been sent to their room or an isolation room for punishment. Staff report that they never observed a co-worker telling a youth that they could not call the Abuse Hotline or have ever seen a youth being sent to their room or an isolation room for punishment. In addition, staff reported that they never observed a co-worker using profanity when speaking to youth or observed a co-worker using threats, intimidation, or humiliation when interacting with the youth.

A this time of this onsite QI Review, a total of two (2) CINS/FINS youth were available to complete an online QI youth survey. Of these

completed surveys, 2 out of 2 surveys reported that they felt safe in the youth survey and knew about the Abuse Hotline. Youth did report that they if you have a complaint about something in the shelter they would inform a staff or contact the Program Manager. Youth also reported that staff are respectful when talking to youth and have not heard staff use profanity.

A total of six (6) DJJ CCC incidents were documented in the DJJ CCC database over the last six (6) months. Of these incidents none contained evidence of events related to program participants being subjected threat, intimidation, humiliation or abuse. Incidents are specifically related to medication errors and items four during searches and a program disruption issue.

The agency provided evidence of all administrative reported documented for the last six (6) months for violations of code of conduct and below acceptable work performance. These reports include seven (7) administrative Memorandums and two (2) Coaching Cards.

One (1) grievance reported by a client does not appear to have been addressed by the program within the 72 hour response requirement. One youth survey reported that they did not know where the Abuse Hotline was located to report abuse. One (1) youth survey reported that they heard an adult threaten them or other youth during their shelter stay.

1.03 Incident Reporting

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a current policy for incident reporting. The policy is in adherence to the required guidelines.

the Incident Report Book was reviewed for all incidents occurring for the past 6 months. Documentation was thorough and legible. All incidents meeting requirements for CCC reporting were reported within the timeframe or contained documentation of leaving a message with the CCC for a return call. There were 6 incident reports that were reported to CCC. All were reviewed and had complete documentation of the incident, time frames, dates, and follow up.

1.04 Training Requirements

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

Staff reported that training is accessible, offered at multiple times. Staff report that the agency supoorts training both in house and off site.

The agency is about to embark on a training "palooza", that is scheduled to begin April 23rd. They are in the process of hiring a training coordinator.

5 of 9 staff met the required amount of training hours for on-going training.

1 staff fell into the first year training. This staff was 5.5 months into the first year and had only 16.5 hours

There was inconsistent reporting on hours for suicide training. 4 hours are required. 1 staff had 0 hours, 5 staff reported 2 hours, and 4 staff met or exceeded the 4 hours. Interview with the program director stated that the staff were underreporting the on-line training credit given for a session.

9 out of 10 staff were current in CPR/First Aid, leaving one staff expired.

Training data entry seems to be a systemic issue. The data is not being entered, resulting in records received day 1 differing from those received on the second day. The data appeared to be at least 7 months in the arrears.

1.05 Interagency Agreements and Outreach

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

This is an area of strength for the agency. The agency has 181 Safe Place sites. The presentations that are provided in the community are to a variety of audiences. These include judges, schools, domestic violence, homeless coalitions, and law enforcement. The agency has safeplace materials and handouts.

Staff are on the executive committe of the JJ board as of 10/12. There are obvious connections in the faith community through events attended, outreach and involvement in services provided.

Staff attend focus groups and/or meetings for target populations such as DJJ, truancy, runaway, LBGTQ youth, homeless youth.

The agency has both formal and informal agreements with community providers. These include providers of the arts, career counseling, FJJA, Camelot Street Outreach, Eckerd, Youth Advocate Program, LBGTQ, Homeless Coalition, and the Crisis Center.

The agency has access to the continuum of services offered through Hillsborough County. There is a recent implementation of on-line substace abuse screenings. The agency has also started a partnership with a group Watoto, which deals with Trauma Informed Care.

1.06 Disaster Planning

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The disaster notebook is well organized and up to date with current staff and positions. The disaster plan includes hurricane information in both english and spanish. The plan includes disasters such as tornado, wildfire, chemical, power outage, and flood.

Hillsborough County is part of the Florida Network Universal Agreement for evacuation.

Staff were able to discuss the training and the process of disaster preparation and evacuation. There is an annual all campus training that occurs at the location where staff are to go to for evacuation (gym). The staff are also aware that if off site evacuation is needed for a higher level, they would go to a county approved site.

Emergency supplies are adequate and housed in the cafeteria. A generator is available for emergency/disaster.

The Disaster Plan does not have documentation dating an annual update. It is evident that it is updated via the phone tree being current.

1.07 Analyzing and Reporting Information

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has developed a policy to address the provisions of the requirements of this Quality Improvement indicator. The agency is a public sector entity that is highly structured. Hillsborough County government developed a Division of Children's Services survey to rate the services provided on the Lake Magdalene campus. This survey included the Child Welfare Residential Group Care program (for youth in foster care); CINS/FINS Child and Family Counseling programs.

In addition, the agency conducted monthly assessments of data entry practice to detect and correct errors. The agency runs two (2) different reports to review their productivity and accuracy in this area. These reports address date entry errors that includes all results related to blanks and incorrect entries. The agency provides the NETMIS Error Reports to all staff that entered data for the specific period. All staff members are then required to review and correct the identified error associated with their data entry. The agency then produces the report again to see if the errors were corrected. Over the last six (6) months the agency has tracked all six (6) months for errors.

The agency reviews risk management, operations and program issues to ensure that major trends and patterns are identified and solutions are developed and implemented to address the problem. The agency had a recent series of contraband items found in the youth shelter three (3) days in a row in December 2012. See documented incident reports for more details (cigarette lighters and part of a pill). The agency reassessed its current search methods and put new search practices in place. The agency stopped permitting purses, bags and book bags with pockets, shorts, tops jackets and pants with concealed pockets. Staff members also assessed potential hiding places and identified various locations in the youth shelter that could be places where clients could hide or conceal items throughout the facility. The agency also purchased large metal detectors to screen for disallowable items.

The agency identified an additional service delivery trend associated with Non-Residential service delivery. The agency identified that the staff service level was below the minimum requirement of referrals in high crime zip numbers at 40% percent. The agency reassessed where counselors were assigned to provide services in the Tampa-Hillsborough County area. As a result of this exercise, the agency decided to reposition Non-Residential counselors to different zip codes. The agency assessed other competing referral services that were working against their ability to secure potential referrals. Agency management also conducted direct zip code promotions. The agency has focused on outreach and promotion of its service offerings to the local Juvenile Justice Board, local School, Children's Committee, internet marketing and other means to let all potential referral sources know that they are open to receiving referrals. The agency completed a reprioritization of CINS/FINS referrals that allowed agency to take more clients that were in the designated high crime zip codes. The agency also discovered that high crime zip codes were removed from the list.

The agency experienced medication errors in the last six (6) month. A major medication incident occurred in October 2012. The agency analyzed the incident and addressed the issue by conducting a training of all staff by the agency's ARNP to all CINS/FINS staff. This training

included a comprehensive training on all major medication distribution practices. The youth in question was on liquid Risperdol. The agency moved away from assisting in the delivery of liquid medications to providing the pills equivalent. The agency no longer accepts admissions with liquid medications. The agency now requires the nurse to administer medication when onsite and staff retrained. The staff that committed this error is no longer providing medications to youth admitted to the youth shelter.

Shift lead and direct care staff were written up on Administrative Memorandum related to not providing medication properly. The youth was provided comprehensive follow up as it relates to the incident. The youth was seen by local hospital, observed the nurse onsite for several days following this incident.

Agency has several teams that review trends and patterns related to risk management, operations and programming. The current structure includes work groups, committees, a Quality Improvement Coordinator, Management and Division Director. The major areas of review are made up of four (4) groups that include Incident Reporting, Utilization Management, Program Evaluation and Safety and Risk Management. The teams track information on a monthly basis and that information is provided to the QI Committee that produces a Quarterly report. The agency provided copies of quarterly reports for the agency fiscal year starting in October of 2012 through March 2013. The agency provide graphs and tables reflecting topics that includes Client Satisfaction Survey Results; Case Record review; 180 Day Follow up; Incident Reporting; and Stake Holder survey.

The agency was approved as an official COA Accredited agency in December 2012.

The agency did not make reference to the percentage or its effort to reduce certain risks related to addressing a certain outcome. For example, the agency could develop a plan to address the problem and set a target goal to address the identified problem. At the time of this onsite review, the internal oversight process used by the agency demonstrates general awareness of issues. The agency should utilize focus on increasing its efforts to document the various intervention and strategies it uses to address a problem in more detail.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

The Hillsborough County Non-Residential Counseling Program provides non-residential services for youth and their families throughout Hillsborough County. The program's main office is located at the Clay Magnum Campus. The program also has partnerships with agencies to have office space at various community sites in the Tamp area. Primary services delivered include a full range of individual and family Counseling. The Non-residential services component includes a Clinical Director and additional staff members that include several Non-Residential Treatment Counselors. The Clinical Director is a Psychologist. In addition, the agency has access to an additional Psychologist and several Licensed Clinical Social Workers, Mental Health Counselors and Registered Interns that assist all facets of the Non-Residential and Residential program for the success daily operation of the program.

Screenings are conducted by youth care staff and counselors twenty-four hours a day, seven days a week. The program's intake and screening unit screens calls for service from the public and its partners. The screening counselor will either refer the youth and family to one of the program's counselors, or will make a referral for the family to another appropriate community agency, according to the youth's zip code. Case management and substance abuse prevention education are also offered. Referral and aftercare services begin when the youth are admitted for services.

A case plan is developed for each client. In addition, home visits are conducted on a case by case basis to offer support the client and their family and to ensure the completion of the case plan. If deemed applicable and after further evaluation, Family and Individual Counseling is offered by Hillsborough County with shelter care as a possible option for youth that need additional support services.

The non-residential program also offers an intervention called a Case Staffing Committee meeting to address non-productive outcomes for either or both the youth and their family. The youth along with their family, representative from the local school board, Department of Juvenile Justice attorney and other social services agencies are gathered together to address the services that are being provided by the program or entities that are not doing their part or taking part in the services. The result of the meeting is that another Plan of Service is developed to meet the needs of the youth and family members. The Case Staffing Committee can also recommend a CINS Petition to be filed in court to order participation with additional treatment services to assist resolve issues faced by the youth and their family.

Hillsborough County Children's Services is contracted to provide both shelter and non-residential services for youth and their families in Hillsborough County. The program provides centralized intake and screening twenty-four hours per day, seven days per week, and each day of the year. Trained staff are available at the program site to determine the needs of the family and youth. Upon referral, a screening for eligibility is conducted and the screening is the initiation of the assessment process. Information regarding the youths' presenting problems, living situation, etc. is collected. Upon intake into either program (residential shelter or non-residential services), a more thorough assessment is completed. After all assessments are completed, the assigned counselor develops a case services plan with the family during the initial family session. If the assessment indicates the need for a referral to a more intensive or specialized service such as substance abuse or mental health treatment, the counselor makes the necessary referral for service. After the development of the case service plan, the counselor works with the family to implement the plan. Counselors document progress towards completion of the service plan goals.

The agency maintains a "paperless" non-residential client file system, while the residential program maintains paper files. The system utilizes electronic documents in which each counselor maintains all files on a dedicated drive. Because non-residential counselors work remotely throughout the county, each counselor utilizes a laptop to manage scanned files that are organized in folders. The agency utilizes folders to contain each component of the client file, such as; "Bio"- Biopsychosocial assessment, "TP"- Treatment plan and "TPR" a document labeled "Florida Network of Youth and Family Services -Introduction to Services" , this is used to provide: Confidentiality; Rights and Responsibilities of Youth/Parents/Guardians; Services Options; Actions; and the Grievance policy. The NetMis/CINS/FINS intake form is used during the initial process.

2.01 Screening and Intake

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

A screening and intake review included an onsite review of randomly selected number of open and closed files from the last 6 months. The reviewer requested that the agency to assist with clarifying search instructions and proper identification of files. A random selection of four (4) Non-Res files were reviewed which consisted of two (2) open and two (2) closed files.

A total of four (4) nonresidential files reviewed had the required information for the DJJ standard 2.01. Of the 4 files, only

1 file did not include evidence of a completed service plan but the bio-psychosocial assessment was signed by all parties.

All files reviewed documented eligibility screening was completed within seven calendar days of the referral.

Residential Progam - Parents are given a consumer handbook, available in both English and Spanish, which explains rights and responsibilities, how to receive services, release of confidential information, grievance procedures, and other relevant program information.

Screening and intake areas meet each standard required. Case notes on each file were detailed and specific regarding family information. Parent receive brochures on the agency's other programs and a brochure on parent options for ungovernable children and possible actions occurring through involvement with CINS/FINS services. The brochure also includes information about the Case Staffing Committee, CINS Petition, and CINS Adjudication. Youth also receive a Safe Place 2B Resident Handbook that explains program procedures, services, expectations, as well as similar information that was provided to the parents

The reviewer of this indicator encountered multiple obstacles during the course of the file review due to inconsistent document/form identification and submission.

The reviewer requested information from non-residential treatment counselors regarding how services options are presented, there was no standard procedure. Counselors also stated that they do not have printed brochures or a standard grievance form for their clients. This reviewer reccommended that standardized procedures be created.

In addition, this reviewer reccommended that procedures are created and written for each counselor regarding document submission. This reviewer found that files listed as open in Netmis were actually closed.

One of the files identified for review was not in the electronic system and had to be physically brought to the facility via thumb drive, this case was opened in February 2013. In addition, several intake documents were not available

2.02 Psychosocial Assessment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

This reviewer found an updated and approved policy for indicator 2.02 Psychosocial Assessment. A total of eight (8) client files were reviewed for this indicator – 4 residential and 4 non-residential client files. Three (3) of residential client files reviewed onsite document that psychosocial assessments were initiated within 72 hours. Three (3) non-residential files document that the psychosocial assessment was completed within 2-3 face-to-face contacts. All psychosocial assessments are completed by bachelor's or master's level staff, seven (7) include supervisor review and signature. Required signatures were captured for seven (7) files.

Non- residential -

- Two (2) of the four (4) files did not complete the psychosocial assessment within 2-3 face-to-face contacts.
- No explanation was found in the progress notes for the incomplete file.

Residential -

- One (1) of the four files did not have a biopsychosocial in the file (Date of admission 4/10/13), however, the trearment counselor (TC) presented the incomplete document, before the exit. The TC stated that the file was incomplete due to unforseen events with the parent and child.

2.03 Case/Service Plan

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency provided an updated and approved policy for this indicator. A review of this policy indicates that it addresses the requirements contained in this indicator. Eight (8) client files were reviewed for this indicator, four (4) residential and 4 non-residential client files.

A review of six (6) of eight (8) client files documents that case plans reviewed onsite were developed within 7 working days. All (8) case plans have a date initiated and signatures of youth, parent/guardian, counselor, and supervisor.

Non-residential -

- Treatment plans do not include frequency, only location and type of service.
- There were no actual completion dates found on the form, counselors and supervisior indicate that this information is found in the notes.
- Two (2) of the four (4) electronic files did not include a treatment plan in the electronic file. The dates of admission and session times indicate that there was ample time to complete the treatment plans.

Residential -

- None of the four (4) case/service plans include individualized and prioritized need(s) and goal(s).
- None of the four (4) files include, frequency, location; or actual completion dates.

Recommendations -

All tretment plans are standardized, agency wide. The treatment/case plans should include frequency, location, type of service, target and actual completion dates.

It was strongly reccommended to the residential program to include individualized goals, as there were specific, immediate concerns with most client files reviewed, such as; grief, substance abuse, etc.

Residential treatment counselors identify individualized goals that the client can realize even during their brief stay.

2.04 Case Management and Service Delivery

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency provided an updated and approved policy for this indicator. A review of this policy indicates that it addresses the requirements contained in this indicator. A total of eight (8) client files were reviewed for this indicator. Of these files, four (4) were residential and four (4) non-residential client files.

All 8 client files reviewed contained the required elements for this indicator. The agency has a comprehensive policy and procedure for client assignment and caseload that indicates cases are assigned to a counseling staff person at Intake.

Interviews with staff and program director state that support agency case management and service delivery procedures are consistent. Six (6) of eight (8) files reviewed showed evidence of service coordination with community resources, such as interpreters, school personnel, DCF and non-residential service providers.

Non-Residential -

- One (1) of four (4) files did not contain progress notes.
- Presenting problems indicated parenting and substance abuse issues; however, no referral was found in the file.

2.05 Counseling Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency provided an updated and approved policy for this indicator. A review of this policy indicates that it addresses the requirements contained in this indicator. A total of four (4) residential and four (4) non-residential client files were reviewed onsite. All files reviewed contained the required counseling elements, when applicable.

All files reviewed showed appropriate case service delivery and flow of addressing problems identified at screening and intake, throughout the

development of the Psychosocial Assessment and Plan of Service. Each file contains progress notes and Service Plan updates that specifically addressed issues as identified on Plans of Service. All residential client files indicated coordination of services with parents was noted on the chronological notes following telephone conversations about the Plan of Service. Group Counseling is provided to shelter youth five (5) days a week, which meets the requirement. Overall, the Psychosocial Assessment is thorough and contains a completed summary at the end.

2.06 Adjudication/Petitiion Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency provided an updated and approved policy for this indicator. A review of this policy indicates that it addresses the requirements contained in this indicator. A total of four (4) residential and four (4) non-residential client files were reviewed onsite.

There were no case staffing files reviewed by this reviewer. A review of the policy indicates that it addresses the requirements contained for the Adjudication/Petition process indicator. There is Policy and Procedure in place that specifically outlines the reasons for convening a Case Staffing Committee (CSC) meeting and the parties to be involved. This policy further states that a CSC will be held within seven (7) days of a parent's written request and that parents will be given a copy of the completed CSC Recommendation Form at the end of the meeting, or mailed to them within 7 days of the meeting if they did not attend.

2.07 Youth Records

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a client case file format the requires that all client files be organized in a uniform manner. Each file must contain the same set of core documents that include, screening, assessment, parent client consent, service/treatment plan, risk factor form, intake form and NETMIS.

A total of 8 files were reviewed to assess the agency's adherence to this performance indicator. All files reviewed were stamped confidential or protected electronically. The files were organized in a standard format. All closed client files, were said to be stored onsite behind a locked door in a secure area in metal cabinets with locking mechnisms. Electronics files are protected by passwords and dedicated computer drives.

Non-residential -

- The files were organized in a standard format. However, it was discovered that the some counselors are not utilizing revised forms.

This reviewer found files listed as open in Netmis (printed client list), that were actually found in the closed electronic folder.

Standard 3: Shelter Care

Overview

Rating Narrative

The Hillsborough County CINS/FINS program is located on a 33 acre campus and consists of three primary buildings: a boys shelter, a girls shelter and a recreation building. Major facility constructuction projects and campus grounds renovations have occurred over the last three years creating a spacious, safe and secure setting for youth on site.

The shelter facilities are located at 3169 and 3173 Clay Magnum Lane, Tampa, FL 33618. Also on the campus is a new, modern and professionally designed cafeteria, a gymnasium, a recreation pavillion, several large recreation fields and a relaxing pond area (fenced) with a gazebo and pier.

3.01 Youth Room Assignment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy and procedure in place to address all of the key elements of this CQI indicator. A review of program documentation and interviews with both staff and youth revealed that service delivery practices were consistent with written agency policies and CQI requirements.

The youth room assigment process begins during the new client screening process. The staff conducting the NETMIS screening begins to identify critical client care issues that led to the referral for services and also resulted in the youth's placement at the facility. Related eligibility criteria and risk management issues are captured on the screening form and are incorporated into the intake process when the youth arrives at the facility.

During the intake process staff complete the CINS Intake Form that includes brief assessments on the youth's mental health, substance abuse, suicide risk amd health/medical issues. In addition, at the bottom of page 2 of this form is the room assignment section that evaluates all of the criteria necessary for the room/bed assigment process.

A review of 6 open residential case files indicated that in all six cases the room/bed assignment section was completed for each youth at intake. The appropriate indicators, notes, comments and other documentation were completed in all six cases.

An interview with three staff members (youth care, counselor, residential supervisor) all confirmed that this process is clearly understood by all staff and that the policy and procedure is consistently followed.

An interview with four male youth also confirmed that the room/bed assignment process was consistently conducted at intake.

None were noted during this CQI review.

3.02 Program Orientation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy and procedure in place to address all of the key elements of this CQI indicator. A review of program documentation and interviews with both staff and youth revealed that service delivery practices were consistent with written agency policies and CQI requirements.

During the initial intake process youth are provided an extensive and thorough orientation to the program, including introduction to staff, tour of facilities and a summary of services available through the CINS/FINS program and the Hillsborough County Department of Children's Services.

The orientation process is documented on the program's Orientation Checklist for new residents. There are 17 specific areas that are discussed with youth and documented on the checklist. The youth, parent and staff conducting the orientation sign and date the checklist to confirm this process.

A review of 6 client case files revealed that in all cases the orientation checklist was completed the same date as the intake or admission to the shelter facility. All were signed and dated as required by agency policy and all of the CQI requirements listed on the checklist provided for this indicator were addressed on the checklist and/or in the client handbook given to youth during the intake process.

An interview with three staff and four youth at the facility also confirmed that the orientation process was comprehensive, consistent and effective in all of the cases reviewed during this CQI site visit.

There were no exceptions related to this CQI indicator.

3.03 Shelter Environment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy and procedure in place to address all of the key elements of this CQI indicator. A review of program documentation and interviews with both staff and youth revealed that service delivery practices were consistent with written agency policies and CQI requirements.

The CINS/FINS facilities on the 33 acre campus at Lake Magdelene are newly constructed, modernly equipped buildings that were completed in July, 2010. The design and layout of the buildings is an ideal environment for youth shelter placement, supervison and behavior management.

There are a plethora of recreational areas, activities and opportunities on campus and a new, state-of-the-art kitchen and dining facility that is adjacent to the shelters. The shelter buildings are nicely decorated and furnished and the youth living areas and bedrooms in both shelters are decorated with various comfortable themes in accordance with Trauma Informed Care principles and practices.

The grounds of the facility are beautifully lanscaped and very well maintained. There are four maintenance staff on-site to assist with facility management and maintenance issues. There was no evidence of any facility damage or grafitti during this site visit.

The program has four vehicles: three vans and one car that are used to transport youth. Weekly vehicle inspections are conducted by an assigned CINS/FINS program employee and the Hillsborough County fleet maintenance department also schedules and completes routine vehicle maintenance and repairs. All vehicles were in excellent condition at the time of this CQI review.

BEST PRACTICE.

No exceptions were identified during this site visit.

3.04 Log Books

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy and procedure in place to address all of the key elements of this CQI indicator. A review of program documentation and interviews with both staff and youth revealed that service delivery practices were consistent with written agency policies and CQI requirements.

The program maintains two log books: one for youth care staff and one for program supervisors/shift leads. The youth care log book primarily is used to document the number, movement and location of youth in the program at any given time. The supervisory log book is used to document significant program events such as intakes/discharges, major incidents, program activities and recereational events, client appointments, facility supervision, safety and security issues and other critical client care information.

A review of the current program log books revealed that all of the requirements listed in this CQI indicator are currently being complied with on a consistent basis. An interview with several youth care and supervisory staff also confirmed that an efficient and effective communication process is in place to transfer information from shift to shift and day to day.

No exceptions were noted during this CQI review.

Rating Narrative

The agency has a policy and procedure in place to address all of the key elements of this CQI indicator. A review of program documentation and interviews with both staff and youth revealed that service delivery practices were consistent with written agency policies and CQI requirements.

The agency has a program schedule that is developed and posted on a daily basis for each shelter (boys/girls). The schedule includes activities such as meals, chores, hygiene, school, recreation/leisure time and group counseling.

A variety of faith based activities are offered to youth on and off site through various religious organizations and groups.

All activities take place between 5:00 AM (wake up)and 9:30 PM (bed time).

Exception: The program needs to identify a daily scheduled time for homework, studying, tutoring, quiet time.

Recommendation: Add weekday and weekend schedule to client handbook.

3.06 Behavior Management Strategies

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy and procedure in place to address all of the key elements of this CQI indicator. A review of program documentation and interviews with both staff and youth revealed that service delivery practices were consistent with written agency policies and CQI requirements.

The agency has a behavior management system based on concrete and specific rewards and consequences that are in place to promote positive youth behaviors and discourage inappropriate behaviors.

There are four levels in the system. Upon admission to the shelter youth are placed on Orientation Level for the first 24 hours. Then youth are offered the opportunity to earn additional privileges and rewards by being placed on one of three levels: Level 1, Level 2 and Level 3. Level three is the lowest level with the fewest privileges and Level 1 is the highest level with the most significant number and type of rewards.

Youth earn points for their daily activities and behaviors. To earn levels youth must earn a certain number of points that are awarded by staff on each shift. Level 3 requires 0-79 points, Level 2 requires 80-89 points and level 3 requires 90-105 points.

There is a shelter store (Swap Shop) where youth can purchase items by using their accumlated points (token economy). Points are compiled over a two week period and redeemed for items such as extra snacks, hygiene items and clothing and electronics.

Interviews conducted with two youth care staff, one shift leader and the program manager supported the operational effectiveness of the behavior management system as defined above. An interview with two youth also indicated that the behavior management system is fair, consistent and effective and that they have a right to appeal their points and/or levels and the ability to file a grievance if they feel it is necessary.

The only complaint by youth about the system that was listed in the youth surveys completed during this review was: "There are too many rules!"

No exceptions were noted during this CQI review.

3.07 Behavior Interventions

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy and procedure in place to address all of the key elements of this CQI indicator. A review of program documentation and interviews with both staff and youth revealed that service delivery practices were consistent with written agency policies and CQI requirements.

Staff at this agency are trained in the behavioral intervention techniques known commonly as NAPPI: Non-Abusive Pyschological and Physical Interventions.

The agency has five managers (Mark, David, Delicia, Julie and Kristen) and five other staff that are trained as trainers in NAPPI and provide regular training for new staff and on-going annual refresher training for all staff.

All direct service employees receive 16 hours of initial training in NAPPI their first year and then 8 hours or refresher training each year after that.

An interview of two youth care staff members indicated that one was a certified trainer in NAPPI and the other had been trained. Both staff verbally reported during interview that they were not aware of any violations of the agency policies. Youth and staff interviews also confirmed that there were no incidents involving inappropriate behavior by staff towards youth.

No exceptions were found during this CQI site visit.

3.08 Staffing and Youth Supervision

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy and procedure in place to address all of the key elements of this CQI indicator. A review of program documentation and interviews with both staff and youth revealed that service delivery practices were consistent with written agency policies and CQI requirements.

The agency has three shifts that youth care staff typically work: 6 AM to 2 PM, 2 PM to 10 PM and 10 PM to 6 AM. There are two male and two female staff that work each shift to supervise a maximum total of 22 youth and ensure compliance with the 1:6 ratio during awake hours and the 1:12 ratio during sleeping hours. On most shifts the ratio is exceeded to ensure that youth supervision and safety is never compromised.

In addition, there is a shift leader that also works each of the three shifts and a manager that also on duty on campus. Furthermore, a security guard that works from 6 PM to 6 AM to ensure that the property and perimeter of the grounds are secure and that youth are safe.

An review of 3 months of staff schedules and interviews with two youth care staff and one shift leader confirmed the staffing patterns mentioned above. Direct observations of shelter operations also supported the staff schedules reviewed during this site visit.

No exceptions were noted during this site visit.

3.09 Staff Secure Shelter

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

NOT APPLICABLE: The agency is not contracted to provide Staff Secure shelter services.

N/A

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The Hillsborough County program provides screening, counseling and mental health assessment services. The agency has a Program General Manager oversees the daily service duties and responsibilities of the program. The Hillsborough County Government has Child Care Specialist staff members are that are trained to screen, assess and notify all staff members of conditions and risks of all youth admitted to both residential and non-residential CINS/FINS programs. The agency provides risk screening and identification methods to detect youth referred to their programs with mental health and health related risks. Specifically, the agency utilizes screening and a CINS Intake form to determine eligibility and various screening methods to determine the presence of risks in the youth past mental health status, as well as their current status. The agency also screens for the presence for acute health issues and the agency's ability to address these existing health issues. Further, the agency has Registered Nurses on staff to provide health screenings within seventy-two (72) hours of a youth being admitted to the program. The agency also uses a general alert board to inform all staff members on each shift of the health and mental health status of all youth in residential youth shelter.

The Hillsborough County program assists in the delivery of medications to all youth admitted to the youth shelter. The agency operates a detailed medication distribution system that includes direct assistance from two (2) Registered Nurses. The agency provides medication distribution training to all direct care staff members, first aid response, CPR, first aid, fire safety, emergency drills and exercises and training on suicide prevention, observation and intervention techniques. Agency staff members are also required to notify parents/guardians in the event that a resident has a health injury. At the time of this onsite Quality Improvement review, the agency has two (2) Psychologists, 2 LCSW, 1 LMHC and 3 Registered Interns on staff members that are licensed/Registered by the State of Florida. These staff members are involved in the review of all residential clients that screen positive for suicide risk.

The agency has a full complement of staff of both male and female staff members across all three (3) work shifts. Agency training files indicate that direct care staff members received annual crisis intervention, first aid, CPR, suicide prevention and medication distribution training. During this onsite QI review, the agency provided an up to date list of more than a dozen agency staff members that have received medication distribution training and are authorized to provide distributed medication to residential clients.

4.01 Healthcare Admission Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has developed a policy to address the provisions of the requirements of this Quality Improvement indicator. The agency screens for initial medical and health issues upon their admission to the program. This information is captured on the Admissions Checklist and Physical Health Screening (Current and Health Conditions Section). This form is primarily used during screening. The agency also documents family medical history in the client's psycho-social assessment. The agency has access to a full-time Registered Nurse that conducts a health screening on all residents admitted to the youth shelter in 72 hours or less.

The agency utilizes the CINS Intake form upon admission to the program to capture all health and medical issues. A randomly selected group of client files were reviewed to assess the agency's adherence to the requirements of this standard. A total of four (4) open and two (2) closed cases were selected. All client files reviewed included evidence the date of the Healthcare Screening that included preliminary healthcare verification checks for Current Medications; Existing Conditions; Allergies; Recent Injuries or Illnesses; Current Observation for Evidence of Illness, Injury, Pain or Physical Distress, difficulty Moving, etc.; Observation of Scars, Tattoos, or Skin Markings; Diabetes; Pregnancy; Seizure Disorder; Cardiac Disorder; Asthma; Tuberculosis; Hemophilia; Head Injuries; Parental Involvement and Coordination and Scheduling of Follow-Up Appointments; and Documentation of Medical Referrals. The agency nurse also captures all health screening and treatment sessions with clients on routine Sick Calls. Overall the program has procedures in place that include a thorough referral process and a mechanism for necessary follow-up medical care for youth admitted with existing or chronic medical conditions.

Three (3) of the client files reviewed on site has evidence of parental involvement that required coordination, documentation and medical follow up. A review of cases included evidence that the agency followed the general requirements related to this indicator. During routine health screen prior to referring for possible referral to Foster Care, a USF pediatrics office diagnosed Asthma. The program then placed a blue dot and form in the youth's file to indicate a medical health issue had been issued by a doctor on 02/25/13. The program uses a Medical care Information form to formally note when a child goes to the doctor. Parental notification is confirmed by the CPI representation and parent took youth.

On 04/14/13 a youth was taken to the doctor and was diagnosed. The youth received initial treatment at the doctor's office and was required to wait on results. The doctor's office was to notify the program only if there is a change in her testing results and or medical condition. The program then placed blue dot and form in youth file to indicate a medical health issued had been issued by a doctor on 04/14/13. The program uses a Medical care Information form to document notes when a child goes to the doctor. Parental notification is confirmed by the parent and released in the log on 04/14/13.

On 04/11/13 a client was seen by the Registered Nurse for an eye irritation due to accidentally being poked in the eye. The agency then placed a blue dot and form in youth file to indicate a medical health alert. The program uses a Medical care Information form to formally note when a

child goes to the doctor. Parental notification was initially completed by the Manager 04/11/13. On 04/14/13 client had an additional injury to right cheek for running into a pole. This resident was documented as being seen by the nurse. The nurse offered medical assistance as needed. In this case the parent was notified by 04/16/13.

4.02 Suicide Prevention

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The shelter had a written plan that outlined the suicide prevention and response procedures. The title of this policy is Suicide Prevention and Intervention policy. This policy was last updated on March 1, 2012. The agency also has a Comprehensive Master Plan. This policy was last updated on March 1, 2012. Further, the agency also has a Medical Information, Behavioral Concerns, and Mental Health Communication Alert Process. This policy was last updated on April 12, 2013. The agency has two (2) Psychologist, 2 Licensed Clinical Social Workers, one (1) Licensed Mental Health Counselor, 1 Advanced Registered Nurse Practitioner, 1 Registered Nurse and 3 Registered Interns.

The shelter utilizes two (2) levels of supervision: constant Sight and Sound and Elevated supervision. The plan addresses all elements of the indicator and complies with the procedures outlined in the Florida Network's Policy and Procedure Manual for CINS/FINS. This policy was initially approved and has not been revised since the initial approval date.

The plan indicated each youth admitted to the shelter will be screened for suicidal risk by using the six (6) suicide risk questions on the CINS/FINS Intake form. The agency's Suicide Risk Assessment Policy was approved by the FNYFS on July 18, 2012. If the youth answers "yes" to any of the 6 questions, the Shift Leader or Child Care Specialist places the youth on Constant Sight and Sound. This level of supervision requires uninterrupted observation of the youth. The agency uses a specific Constant Sight and Sound form that uses a total of more than twenty (20) codes and behaviors that correspond with a number that is documented on what type of behavior or warning sign that the youth is displaying at that time. This is documented every 30 minutes during the shift. The agency posts a color code magnet that displays either red dot with a C for Constant supervision. A red dot is placed on the client's folder. Additional a red alert is added in Section C that indicates the youth's supervision status. The current sheet should offer a line that this "Other" for other possible outcomes such as (Running, feelings, etc.) The Shift lead sends email notification that attaches an internal incident report to explain that the client was place on sight and sound status for the following reasons. This internal incident email report goes to Shift Leaders, Counselors, Managers and the General Manager. The agency also notifies the parent/guardian on the client's status and any changes. The shelter/cottage staff completes section 1 of the Suicide Risk Assessment Summary to confirm the youth's supervision status prior to assessment being conducted by the Residential Counselor. The Residential counselor conducts an in depth assessment by conducting an interview with the youth. The Counselor uses the agency's Assessment of Suicide Risk tool. The tool collects all current indicators and that allows the counselor to determine that the youth should remain on Constant or be stepped to Elevated status. The Residential Counselor then consults with the Licensed staff person. If the youth remains on Constant Supervision the Counselor must complete a new Suicide Risk on the client. If the client is stepped down or remove from the current status the Counselor completes Section 2 (Summary) and the licensed staff person signs that they have reviewed the assessment. The non-licensed and confirms that the youth can be removed from Constant Supervision status. The youth care staff are now required to document Elevated Status observations every 10 minutes for a minimum of eight (8) hours unless otherwise specified by the counselor. The licensed staff can give a verbal authorization to remove the youth and then follows up to confirm receiving the licensed staff signature. The agency documents all clients that are either removed from status or remain on status in 2 places in the progress note and section 2 of the suicide risk assessment summary.

A total of three (3) licensed staff are accessible to the CINS/FINS at the time of this onsite review. The outcome of the client's suicide assessment summary notes are documented in the client's progress notes. Youth that Baker Acted are taken by law enforcement to Mental Healthcare Children's Crisis Unit or ST. Joseph's Children's Crisis Unit. Upon return and clearance the resident is screen for current risks and then placed on constant sight and sound until consulted by a licensed staff person. Youth on either status are placed in a single room or room by themselves if available.

Documentation of the initial placement of the youth on supervision status was initially unclear (see logbook). The Monitor identified times for initiating close watch observation on the Observation form. The times for screening and intakes are not listed on the Screening or CINS Intake form. The agency should consider adding a time indicating that upon the completion of the Client Intake Check List or the CINS/FINS intake form.

In addition, there are missing times on Elevated supervision by the manager or designee from the 6am to the 1400 shift for Client.

In a separate case, there was no indication of a change of status from Constant to Elevated status per the agency policy. This caused the observation status of Constant Supervision to be exercised throughout the observation period. In this case, the youth should have been moved to Elevated status around 11:00-12:00 on client. Following this there was a delayed removal from Elevated status12:00am on the April 12, 2013. Client stayed on constant observation form until 3:51am on April 13, 2013 until removed. The agency

Agency policy states that an 8 hour elevated watch period is required. The removal from the elevated period on client indicated a reduced period on elevated status for four (4) hours instead of required eight (8) hours. However, the review indicated that a Senior Child worker consulted with the licensed professional at the time that the Elevated Supervision stopped to confirm removal.

4.03 Medications

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has detailed policies related to the delivery of medication to youth admitted to the youth shelter. The agency policies are highly structured and meet the general requirements of the current indicator. The agency had written procedures that addressed the safe and secure storage, access, inventory, disposal and administration of medication in accordance with the DJJ Health Services Manual. The agency has a Advance Registered Nurse Practitioner overseeing the medication documentation and inventory of the agency's medication process.

The program had a list delineated in writing of staff that are designated to have access to secured medications, and limited access to controlled substances. All medications in the shelter are stored in a separate, secure area, which is inaccessible to youth. There were no injectable medications on site, or identified as needed for any youth during the time of the review. The shelter has a system in place for refrigeration of medication if needed, however there was no medication that required refrigeration during the time of review.

Controlled medications are locked in large metal cabinets behind two (2) locks. One cabinet is designated for controlled/narcotic medications and prescribed medication. This cabinet features metal housing with a locking metal door and individual locks on each slotted shelf that houses a medication. The other cabinet houses over the counter medications. Shift-to-shift counts and a perpetual inventory is maintained, and documented for controlled and prescribed medications. Oral medications are stored separately from topical medications. When both medication are required, each is placed in a baggie or tray to ensure separation. Shift to shift counts are conducted and documented for controlled substances three (3) times per day once on each shift. Non-controlled is counted on a perpetual basis and when given. Over the counter (OTC) are accessed regularly and are inventoried weekly by maintaining a perpetual inventory.

The agency utilizes a Medication Distribution Record to capture major information related to each youth admitted to the youth shelter on a daily basis. The MDR includes name, date of birth, picture, allergies, side effects, staff initials, youth's full name and initials, staff member initials and name. The format of the MDR is function and user-friendly. The majority of the document has typed information to reduce legibility.

Sharps are secured as required. The agency maintains an inventory of three (3) sharps that include nail clippers, shaving razor, wire cutter, tweezers, scissors and a pill cutter. The agency also maintains six (6) first aid kits that are sealed with break-away tabs. The agency also inventories all creams/ointments; bandages; and miscellaneous that are counted weekly. A 1 page inventory sheet with each of the aforementioned items is listed and counted by the Registered Nurse on a weekly basis. The agency utilizes bio hazard waste disposal bags in each first aid kits and waste bin.

The agency's medication verification process is not in practice on a consistent basis. The agency is required to have practice in place that verifies and confirms all medications that enters the youth shelter with the licensed pharmacy that filled the prescription. See the FNYFS policy and procedure manual for guidance related to the medication verification policy.

One (1) youth's MDR reviewed onsite is missing initials and another MDR contains an incorrect date of birth is incorrect on 1 of four (4) medication distribution records.

The agency list of staff authorized to assist in the delivery of medications should be updated in the MDR binder. The agency has two (2) medication error related incidents that involve the agency's direct care staff and the agency's Registered Nurse.

4.04 Medical/Mental Health Alert Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy and procedure in place to address all of the key elements of this CQI indicator. A review of program documentation and interviews with both staff and youth revealed that service delivery practices were consistent with written agency policies and CQI requirements.

The agency has a comprehensive medical/mental health alert system in place that is utilized to communicate critical client care information across shifts and from staff to staff. The system uses a series of colored dots and colored paper in client case files to designate the staus of youth at the shelter.

Red: Suicide Alert

Yellow: Behavioral Issues

Blue: Medical Isssues

All client case files also marked with a color coded dot. In Section C of the client case file are the color coded papers identifying the specific alerts, conditions and issues related to the individual youth. In addition this information is posted in color on the client board located in the shift leaders office and the female dorm.

Furthermore, the information is communicated via email to all residential staff to ensure a closed loop of communication among all staff.

An interview was conducted with a manager about the alert system. He confirmed that the agency policy is clear and consistently followed by all staff. The information is collected during the intake process and documented in the client case file, the shift leader book and the client board.

The Alert Book (binder) was not current or up-to-date. May be redundant and/or uneccessary.

Log book entries and use of highlighters (yellow) was inconsistent in Shif Leaders log book.

4.05 Episodic/Emergency Care

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

4 incidents were listed on the episodic log. All supportive documentation was included. All 4 incidents had parental notification and were documented in the daily log.