



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Hillsborough County

on 03/09/2016

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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 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	Limited

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	Satisfactory
2.03 Case/Service Plan	Limited
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 4: Mental Health/Health Services

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

Percent of indicators rated Satisfactory:80.00%
Percent of indicators rated Limited:20.00%
Percent of indicators rated Failed:0.00%

Overall Rating Summary

Percent of indicators rated Satisfactory:88.00%
Percent of indicators rated Limited:12.00%
Percent of indicators rated Failed:0.00%

Rating Definitions

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

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

Review Team

Members

Ashley Davies, Lead Reviewer and Consultant, Forefront LLC

Mark Shearon, VP of Quality Assurance, Arnette House

Tim Langlo, CINS/FINS Non Residential Supervisor, Youth and Family Alternatives (Citrus County)



Quality Improvement Review

Hillsborough County - 03/09/2016

Lead Reviewer: Ashley Davies

Naomi Thompson, Residential Counselor, CDS Central

Felicia Goldstein, Program Monitor, Department of Juvenile Justice

Persons Interviewed

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

Documents Reviewed

- | | | |
|---|--|--|
| <input type="checkbox"/> Accreditation Reports | <input checked="" type="checkbox"/> Fire Prevention Plan | <input checked="" type="checkbox"/> Vehicle Inspection Reports |
| <input checked="" type="checkbox"/> Affidavit of Good Moral Character | <input checked="" type="checkbox"/> Grievance Process/Records | <input type="checkbox"/> Visitation Logs |
| <input checked="" type="checkbox"/> CCC Reports | <input type="checkbox"/> Key Control Log | <input checked="" type="checkbox"/> Youth Handbook |
| <input type="checkbox"/> Confinement Reports | <input checked="" type="checkbox"/> Logbooks | 5 Health Records |
| <input type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 5 MH/SA Records |
| <input type="checkbox"/> Contract Monitoring Reports | <input type="checkbox"/> PAR Reports | 31 Personnel Records |
| <input type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 8 Training Records/CORE |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 3 Youth Records (Closed) |
| <input type="checkbox"/> Escape Notification/Logs | <input type="checkbox"/> Sick Call Logs | 5 Youth Records (Open) |
| <input type="checkbox"/> Exposure Control Plan | <input type="checkbox"/> Supplemental Contracts | 0 Other |
| <input checked="" type="checkbox"/> Fire Drill Log | <input checked="" type="checkbox"/> Table of Organization | |
| <input checked="" type="checkbox"/> Fire Inspection Report | <input type="checkbox"/> Telephone Logs | |

Surveys

- | | | |
|---------|---------------------|---------|
| 6 Youth | 8 Direct Care Staff | 0 Other |
|---------|---------------------|---------|

Observations During Review

- | | | |
|--|--|--|
| <input type="checkbox"/> Intake | <input checked="" type="checkbox"/> Posting of Abuse Hotline | <input checked="" type="checkbox"/> Staff Supervision of Youth |
| <input checked="" type="checkbox"/> Program Activities | <input 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 type="checkbox"/> Meals |
| <input checked="" type="checkbox"/> Medical Clinic | <input checked="" type="checkbox"/> Social Skill Modeling by Staff | <input type="checkbox"/> Youth Movement and Counts |
| <input 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

Campus Safety

The agency is working on increasing campus safety. A security fence has been installed around the perimeter of the campus. They have increased the lighting around the exterior of the campus. They have installed and are using Encore Campus-wide Multimedia Communications. A keycard system is being installed at the gates at the driveway and on all exterior doors. Cameras across the campus are fully functioning and monitored by a new company. Sensors on bedroom windows have been installed.

Programmatic Changes

The agency has implemented a new hybrid model for child care. Management fused two existing models together—the Direct Child Care and Primary Care Model.

The agency moved from a three-shift schedule to a two-shift schedule. Staff work twelve hour shifts for three days and the fourth day is a four-hour training day. This change was done to improve the continuity of care to the youth. Instead of the youth answering to six to nine individuals per day in the three-day model, youth interactions are reduced to four people per day in the two shift model. The same staff are available to the youth when they wake up and when they come home from school. These same staff transition them to dinner and homework and then the evening staff transition them into their bedtime routines.

Another reason for the change to the two-shift schedule was to increase stability and safety. The change assisted in decreasing the incident rates by 87.9% which moved the agency from a triple digit incident rate to now being under the state average. This also assisted in decreasing the number of runaways per month from being in the double digits down to zero or one per month.

Training and Professional development are now included in the work schedule. The four hours include training, planning, and committee meetings. As a result, staff do not have to come in on their day off for trainings. It allows the agency to conduct ongoing training on a weekly basis, focused on knowledge, skills, and abilities. Each program is responsible for training components. For example, clinical services therapists are responsible for all mental health and behavioral topics. Whereas, maintenance is responsible for all campus-wide security, radio techniques, and emergency preparedness. The nursing program conducts First Aid/CPR, nursing procedures, and universal precautions trainings.

Programmatic Challenges

Challenges center on old behaviors versus new philosophical approaches (i.e. old staff vs. new staff). The Six Pillars of Character Model is the agency's identified values and are monumental to the agency being successful. The Six Pillars of Character are: Trustworthiness, Respect, Responsibility, Fairness, Citizenship, and Caring. They are using this model to set the structure of expected behaviors of the adults so that the youth can learn and model these behaviors so that they can become productive and responsible citizens in their community.

Clinical Services Program Improvements

EVOLVE is the agency's new behavioral management system. The Behavioral Analyst developed the new behavioral management system in an effort to replace the previous system that was based on a "point system" where youth earned or lost a certain number of points as a result of certain behaviors. This former system proved to be cumbersome, making it difficult for staff to track points. It was inconsistent and often discouraging for youth because it seemed to place an emphasis on negative behaviors. The new system, EVOLVE, is designed to encourage prosocial, adaptive behaviors, increase levels of independence, and educate and model more desirable behaviors.

In a continued effort to reduce recidivism and enhance parents' skills, the agency will offer a parenting program aimed at providing valuable skills and tools for parents to use to help strengthen child-parental relationships and promote healthier family dynamics. The system has been designed and will be rolled out in April 2016.

The Clinical Team redesigned and implemented a new system for the Interdisciplinary Team. This was done in order to facilitate better information sharing, stronger collaboration between team members and ultimately to produce better outcomes for youth and families. Key processes have been refined and redesigned in the area of scheduling, documentation, and communication protocol. Information will move across communication lines in a more seamless manner and services will be better interconnected.

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 at 3110 Clay Mangum Lane Tampa, Florida is under the leadership of the Hillsborough County Government. The Division Director oversees the residential and non-residential components of the program, including the volunteer and outreach initiatives.

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 agency administrative offices and youth shelters are housed in buildings co-located on campus and 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 based programs and agencies. The agency has key partnerships with the local school system, law enforcement, social services, and cultural and arts programs.

At the time of this Quality Improvement Review the agency has employed fourteen Child Care Specialist, twenty-four Senior Child Care Specialist, ten relief Child Care Specialist, a Clinical Director, four Residential Services Coordinators, a Director of Children's Services, two Managers of Residential Services, one Manager of Youth Program Operations, two Registered Nurses, two Senior Case Managers, a Senior Program Manager, a Training Specialist, five Residential Treatment Counselors, and five Non-Residential Treatment Counselors.

1.01 Background Screening

Satisfactory

Limited

Failed

Rating Narrative

A total of twenty-five staff members have been hired since the last compliance review. Only one of the twenty-five staff did not have a completed background screening prior to their date of hire. This member was hired on April 6, 2015 and the background screening was received by the background screening unit (BSU) on April 16, 2015 and finalized by the BSU on April 17, 2016. The Annual Affidavit of Compliance with Level 2 Screening standards was completed and sent to the BSU on January 20, 2016.

A total of six staff were eligible for a five year background rescreening and three were completed on or before their date of hire anniversary date. Of the three screenings not completed on time: one screening was completed three months late (DOH 5/1/95 and background done 8/20/15), one screening was due June 4, 2015 and has not yet been completed and the last screening was due in February of 2016 but the staff has been out on extended medical leave since December 2015.

Exceptions:

There was one staff, out of twenty-five newly hired staff, who did not have a completed background screening prior to being hired. There was one five year re-screening that was completed late and two more five year re-screenings that were due but had not yet been completed.

1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

Rating Narrative

Upon being hired all staff are provided a review of agency policies and procedures which includes the policy for Neglect or Abuse of Clients. This policy notifies all staff that they are required to adhere to the codes of conduct that prohibits the use of physical abuse, profanity, threats, or intimidation. In addition, upon hire, all staff receive orientation training that covers a variety of human resource policies and procedures which includes but is not

limited to staff expectations and behavior. The program's Six Pillars of Character values are posted throughout the facility and is included with most programming and milieu.

Three examples of staff discipline were provided but only one of the three were disciplined for performance and unprofessional behavior. The agency has not had to take immediate action (in this review cycle) to address incidents of physical and/or psychological abuse, verbal intimidation, use of profanity, and/or excessive use of force.

The agency has an accessible and responsive grievance process for youth to provide feedback and address complaints. Youth can complete a grievance form and submit to the supervisor requesting resolution to their complaint. Grievance forms are available to youth on each living unit and readily accessible.

All six youth surveyed indicated that they know the abuse hotline number and have never needed to call. One of six youth surveyed state that they have heard adults being disrespectful when talking to youth and two of six have heard staff use curse words when speaking to youth.

There were no exceptions to this indicator.

1.03 Incident Reporting

Satisfactory

Limited

Failed

Rating Narrative

A total of eighteen Central Communications Reports (CCC), over the last six months, were reviewed for this indicator. All eighteen were called into the CCC within two hours of the incident or becoming aware of the incident. Only one of the eighteen required follow-up tasks assigned by the CCC and it was for a program review which was completed and filed in the CCC Log binder. All incidents were reviewed by a supervisor/manager within twenty-four hours. All eighteen incidents were documented in the master control logbook.

There were no exceptions to this indicator.

1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

A total of nine staff training files were reviewed—four new staff hired in 2015 (two hired after July 1, 2015 and two hired before July 1, 2015) and five staff hired prior to 2015.

Of the four newly hired staff all four were missing documented training in the required following topics: Title IV-E Procedures and In-Service component. Of the four new hired staff, three did not have documentation of professionalism and ethics, and one was missing documented training in behavior management. None of the four staff had training in the recommended topic of cultural competency and two staff were missing training in three topics: ethics and boundaries, human trafficking and positive youth development. All four staff are still within their first year of training so still have time remaining to receive the missing trainings and range in hours of eighty to 116. Each staff has a training file that contains a completed training tracking sheet, agendas, certificates, and sign-in sheets.

Of the five previously hired staff, all five are still within their annual training year and all have completed more than the required twenty-four hours of training; hours completed range from forty-two to 138. One of the five staff did not have documented training in fire safety equipment. All five staff have training/certifications in suicide prevention, crisis intervention skills, universal precautions, and cardio pulmonary resuscitation (CPR) and first aid certification. Only one of five staff has not yet received training in signs and symptoms of mental health and substance abuse and they just returned this week from medical leave that started in December 2015. All five are missing training in the recommended training topic of cultural competency; however, all staff received training in cultural competency

for lesbian, gay, bisexual, questioning and transgender (LGBTQ) youth. Each staff has a training file that contains a completed training tracking sheet, agendas, certificates, and sign-in sheets. These five staff have until June 30, 2016 to receive additional trainings.

There were no exceptions to this indicator.

1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

The agency collects and reviews several sources of information to identify patterns and trends. The program has a Quality Improvement (QI) Plan that operates on an annual outcome basis and uses monthly, quarterly, semi-annual, and annual data collected to make on-going improvements to the agency. The program has a quality improvement committee that will compile, review, and analyze the collected data to determine compliance and status of goal completion. The results are put into the Division of Children and Youth Services QI Outcome Measure Summary Annual Report. Results are disseminated at least quarterly to the department director and management team and this information is published annually for all staff to review. Management team meeting minutes were provided to show discussion from the QI committee on their progress with and the distribution of the annual report. As of February 1, 2016 the program has a process in place to provide quarterly reviews of medication management practices from CareFusion data base in reference to the new Pyxis Med-Station. Case records are reviewed monthly via peer review and results are reported quarterly in addition to the review of incidents, accidents grievances.

Outcome and customer satisfaction data is collected and reported on annually. All reports were analyzed and compiled in the last annual QI Outcome Measure Summary ending in September of 2015. The report includes outcome to be measured, reporting frequency, target outcome and each quarter's reported percentage toward target outcome.

There were no exceptions to this indicator.

1.06 Client Transportation

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy that addresses client transportation. This policy specifically outlines how clients are to be transported and protocol when there is only one staff and youth.

Transportation logs were reviewed for eleven dates between 9/21/15 - 2/26/16. There were a total of 102 transport log sheets for the time period. Documentation was inconsistent on these logs. Missing information was documented in the program log book.

Two vehicle mileage logs were also reviewed which documented arrival and departure dates and times, destination, and condition of vehicles. These logs were consistently documented.

Exception:

Transportation logs sheets were not consistently completed in their entirety.

1.07 Outreach Services

Satisfactory

Limited

Failed

Rating Narrative

The Agency has written policy that addresses the standard. The program has a folder with all interagency agreements with other providers. Providers include St. Leo's University Master of Social Work Program, Tampa Metropolitan Area YMCA, United Way HandsOn Suncoast, Hillsborough Community College Educational Internship program, and The University of South Florida College of Behavioral and Community Services Affiliation Agreement.

The agency provided evidence of twenty-nine outreach events between 09/02/15 and 11/07/15 which included area schools and community organizations.

The agency provided sample agendas for the Juvenile Justice Circuit Advisory Board meetings on 11/2015 and 01/2016. As well, for the Juvenile Justice Advisory Committee on 07/2015.

There were no exceptions to this indicator.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

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.

2.01 Screening and Intake

Satisfactory

Limited

Failed

Rating Narrative

Program has a Screening and Intake policy requiring eligibility screening to be completed within seven days of referral. There were five non-residential and five residential files reviewed. All ten files included documentation of eligibility screening completed on the day of referral. Additionally, all ten files included documentation of receipt by parent and youth of Program Services, Right and Responsibilities, and Grievance Procedures. Pamphlets describing the CINS/FINS process were handed out and documented in the files.

There were no exceptions to this indicator.

2.02 Needs Assessment

Satisfactory

Limited

Failed

Rating Narrative

The agency's policy requires the residential Psychosocial Assessments to be completed or attempted within 72 hours of admission. Non-residential Psychosocial Assessments must be completed within first two to three contacts. The policy requires the Psychosocial Assessments to be reviewed and signed-off by the Clinical Supervisor.

There were five residential and five non-residential files reviewed. All five non-residential assessments were completed within two to three face-to-face contacts. None of the files noted any suicidal tendencies on the part of the youth and this was cross referenced with the screenings and CINS/FINS Intake Assessment Form. All signatures were evident.

In the five residential files reviewed, four of the five assessments were completed. One file reviewed did not document a completed assessment. None of these youth had an elevated risk of suicide. All signatures were evident.

Exception:

One residential file reviewed did not have a Psychosocial Assessment completed.

2.03 Case/Service Plan

Satisfactory

Limited

Failed

Rating Narrative

The agency's policy requires Case Plans to be developed within seven days following completion of Psychosocial Assessment and to be reviewed every thirty days. The policy also requires Case Plan issues be driven by the needs identified in the Psychosocial Assessment. The Case Plans must include: services, responsible parties, target dates, completion dates, initiation date, and signatures by parent, youth, counselor, and supervisor.

There were five non-residential files reviewed. All five files had Case Plans developed within seven days of Psychosocial Assessment. In three of the five files reviewed, the thirty and sixty day reviews of the plan were completed late. Each of the thirty day reviews were late by five days and the sixty day reviews were late by three days each. One of the files noted substance abuse by the youth. A referral was made immediately and followed up by the counselor thirty days later.

There were five residential files reviewed. It was noted that there were two types of Case Plans—an Initial Case Plan that deals with the youth adapting to the shelter environment (that was identical for each youth) and an individualized Case Plan that was based on the Psychosocial Assessment. All files had the Initial Case Plan. Three of five the files contained an individualized Case Plan; however, two of the three did document the youth's signature and one did not document the parent/guardian signature. One of the three files required a thirty day review; however, there was no documentation on the Case Plan or in the Case Progress Notes that the review was completed. Two of the five files did not contain a completed Case Plan as required.

In both the residential and non-residential files, target dates for completion were noted on the Case Plans, but there was no designated area to document completion dates. There was an attempt to cross reference with Progress Notes and Case Progress Notes, but there was no specific documentation referencing completion of Case Plan goals.

Exceptions:

In three non-residential files reviewed, the thirty and sixty day Case Plan reviews were completed late.

Two of the five residential files reviewed did not have a completed Case Plan as required.

Two of the three residential Case Plans reviewed did not have the youth's signature and one did not document the parent/guardian signature.

One residential Case Plan requiring a thirty day review did not document it was completed.

Both residential and non-residential Case Plans did not document actual completion dates of goals.

2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place for Case Management and Service Delivery. There were five residential and five non-residential files reviewed. All ten files indicated all youth were assigned a Counselor/Case manager that coordinated the assessment of the youth's needs and referrals to appropriate services. All referrals were appropriately documented in the residential files. However, four of the five non-residential files documented the youth had substance abuse issues and referrals were only documented in two of those files. The Case Progress Notes in all applicable files noted coordination between the Case Plan and the progress made with services.

Exception:

Two non-residential files did not have a referral for substance abuse services.

2.05 Counseling Services

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place for Counseling Services. In the three of the five non-residential files reviewed, there was strong documentation showing the counseling services coordinated with the issues noted in the Needs Assessment and Treatment Plan goals. One file reviewed was a newer youth and was not yet due of any type of counseling services. In the last file reviewed it was clear counseling services were provided; however, the notes were not as detailed as in the first three files making it difficult to determine which specific issues were being addressed.

In the five residential files reviewed, it was evident group counseling was provided at least five days a week. There was documentation of the youth attending the sessions, but no notes were kept indicating how well the youth participated in group. In one of the files reviewed, progress notes were completed; however, could not be measured due to no Individualized Treatment Plan completed for the youth. In two of the five files reviewed, a signature was missing on the case progress note.

Exceptions:

One non-residential file reviewed did not have detailed progress notes making it difficult to determine specific issues being addressed.

Documentation of group notes did not indicate how well the youth participated in the group.

Two residential files were missing signatures on the case progress notes.

2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place for the Adjudication/Petition Process including the seven day notification letter to the parent for case staffing, the fifteen day notification letter, and the five day phone contact. The policy states the case staffing committee is a standing committee that meets monthly on the third Thursday with memo reminders prior to the meetings. The policy indicates the core members of case staffing team includes not only the required DJJ and School District Representative, but also the CINS/FINS provider, Hospice, Tampa Housing, PACE, and a Youth Advocate prevention organization. The policy also indicates the youth and family are provided immediately following the staffing, a copy of new/revised service plan recommendations. The policy includes provisions for the case staffing to recommend CINS petitions be filed in Circuit Court for judicial intervention when the youth refuses to follow staffing recommendations. The policy also requires the Case Staffing Coordinator to prepare and submit a case summary for CINS Court.

There were three files reviewed for the case staffing process. There is a set process in place for notifying families and case staffing committee members of upcoming case staffings. All files had a staffing within seven days. All had documentation of the five day notification. In all three files, there were documents showing copies of the staffing recommendations provided to the family after the staffing. The committee is consistently represented by Hillsborough County, the Hillsborough School District, DJJ, PACE, and a mental health professional.

There were no exceptions to this indicator.

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

Agency has several related policies to address the format, organization, storage, and security of records. These policies are called Confidentiality of Client Records, Organization of Client Records and Entry of Information Into Clinical Records, Storing/Disposition of Client Records, and Client Record Management and Security.

A review of the youth files reveals that they are in a folder divided into six sections. All files were stamped confidential in the front cover. All paper files are stored securely and are not accessible to youth. The files are stored in locked file cabinets in a room located in one of the cottages.

All non-residential files are maintained in a digital format. Staff scan in paper files and recall all necessary files by opening up PDF files saved under the youth's name.

There were no exceptions to this indicator.

Standard 3: Shelter Care

Overview

Rating Narrative

The Hillsborough Children's Services program provides shelter for CINS/FINS youth in Hillsborough County. The shelter environment consists of two CINS/FINS cottages along with a nurses building, cafeteria, administration building, and other cottages not related to this audit. The grounds are clean, neat and well maintained. There is ample room for the youth and their facilities are in good shape.

The youth are appropriately oriented to the program with the review of the Client Handbook. Room assignments are determined based on several factors, each of which is documented. The log books are maintained in the cottages and are reviewed by staff. The Behavior Management System is appropriately designed to address compliance and non-compliance of youth. Youth receive rewards for their behavior and the point sheets and documentation for behavior is appropriate. Youth are allowed to attend a "Swap Shop," to purchase items for those that demonstrate appropriate behavior. The agency is starting a conversion to a new Behavior Management System called EVOLVE, which is a level system that involves more counseling, goal setting, and reflections. The staff are currently being trained on this system and it will be rolled out after all the training is completed.

Since the last Quality Improvement Review the agency has switched having three eight hour shifts a day to two twelve hour shifts each day. Each staff is required to work four days each week, three twelve hour shifts and one four-hour shift. The four-hour shift is used for training and meeting purposes. Staff are not assigned direct care responsibilities while on the four-hour shift unless they finish their training assignments and meetings early and still have time remaining to reach four hours.

3.01 Shelter Environment

Satisfactory

Limited

Failed

Rating Narrative

The facility is located on a very large 33 acre lot that includes the Admin. Building, Cafeteria, School House, Hair Training Facility, and 8 cottages for youth. There are two CINS/FINS cottages that are used. The grounds are very well maintained and it really shows that the staff take pride in their campus. The two cottages that were viewed were well kept and free of graffiti. All inspections are conducted in a timely manner and within contractual time frames. Youth Activity logs are clearly posted with all required activities throughout the day. Youth are offered a locked room to store all their personal belongings. The facility is equipped with a camera system that stores video for thirty days and was reviewed to ensure bed checks were being completed properly. Director informed review team during the intake briefing that they were increasing the number of cameras and lighting around the property to increase the safety of staff and youth.

All Chemicals are locked up inside the cottages and a MSDS book is available for all chemicals stored. The chemicals are inventoried on a weekly basis and signed off by a Supervisor. The grievance log was reviewed and one youth wrote a Grievance on 12/27/15 but it was not reviewed until 1/10/16 (and the youth had already been discharged) which is outside the required time frame. Staff schedules are posted and meets all requirements for the Florida Network. Disaster plan is in place. Fire drills are completed on every shift, every month and evacuation times are all below the required two minutes. Mock Emergency Drills are held once a quarter but the standard states it is to be once a shift per quarter.

Exceptions:

One grievance was not reviewed in the required time frame.

Mock emergency drills were not completed on each shift.

3.02 Program Orientation

Satisfactory

Limited

Failed

Rating Narrative

There were eight files reviewed (five open and three closed). Of the eight files that were reviewed all of them contained all contractual requirements for Program Orientation. There was only one file that the youth signed the intake checklist but did not initial the form. All forms are clear and easy to read. They were found in section one of the file but not always in the same spot.

There were no exceptions to this indicator.

3.03 Youth Room Assignment

Satisfactory

Limited

Failed

Rating Narrative

The agency uses two forms to capture information for the youth's room assignment (the Hillsborough County Checklist and the CINS/FINS Admission Data Form). The forms are signed by the staff completing the form and a supervisor who reviews them. Alerts for the youth are marked with colored dots on the front of the files and colored dots on the youth alert board in the shelters. There were eight files reviewed (five open and three closed). All contractually required forms were reviewed and all youth were appropriately assigned to a room.

There were no exceptions to this indicator.

3.04 Log Books

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place for Log Books. The most recently closed log book and the current log book were reviewed. Entries were legible, written in ink, and signed by staff. Significant occurrences in reference to safety and security were documented and highlighted in yellow. Resident counts were occurring on a regular basis. Each staff coming on shift signs the logbook and receives a briefing from the previous staff. All mistakes were marked through with a single line and initialed. The Residential Services Coordinator (RSC) reviews the log book every time they come into shelter and the Residential Director reviews the logbooks at least once a month.

There were no exceptions to this indicator.

3.05 Behavior Management Strategies

Satisfactory

Limited

Failed

Rating Narrative

The agency is currently using a point-based Behavior Management System that is clearly identified in the Client Handbook and is monitored by the RSC daily (when they come on shift) and by the Residential Director monthly. The system is discussed regularly at monthly staff meetings and recommendations are made there. All staff are trained in the system during their initial CINS/FINS training and also receive NAPPI for Behavior Intervention Training in verbal intervention, de-escalation techniques, and physical interventions.

Five staff training files were reviewed and all files reflected that staff were trained in NAPPI and the Behavior Management System. No group discipline is enforced and room restrictions are not applied. Youth are offered a wide variety of rewards and incentives to participate in the Behavior Management System. The youth can use their points to shop at the Swap Store or get later bed times.

The agency is starting a conversion to a new Behavior Management System called EVOLVE, which is a level system that involves more counseling, goal setting, and reflections. The staff are currently being trained on this system and it will be rolled out after all the training is completed.

There were no exceptions to this indicator.

3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

Rating Narrative

Since the last Quality Improvement Review the agency has switched from having three eight-hour shifts a day to two twelve-hour shifts each day. Each staff is required to work four days each week, three twelve-hour shifts and one-four hour shift. The four-hour shift is used for training and meeting purposes. Staff are not assigned direct care responsibilities while on the four-hour shift unless they finish their training assignments and meetings early and still have time remaining to reach four-hours. A floater and on-call staff are clearly marked on the schedule. The schedule is posted for all staff to see. There is a RSC, a shift lead, a floater, and two staff listed for every shift. There is a male and female on every shift and each shelter is staffed accordingly.

Bed checks are conducted every ten minutes and are documented on the Bed Check Log Forms. This was also confirmation by reviewing random nights of video coverage.

There were no exceptions to this indicator.

3.07 Special Populations

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place that addresses Special Populations. There have been no Probation Respite, Staff Secure, or Domestic Minor Sex Trafficking youth since the last Quality Improvement Review.

There were three Domestic Violence (DV) files reviewed. Two of the three files contained necessary documentation to verify the youth was eligible for DV respite services. One file contained no documentation of a referral from the JAC/Detention Center or evidence in JJIS that the youth was eligible for DV services. In two of the three files there were missing signatures on documents in the file and two of the files also had incomplete Needs Assessments. Two of the three files reviewed contained DV Respite specific Treatment Plans and one file was missing a Treatment Plan. None of the youth were in the shelter more than twenty-one days.

Exceptions:

One of the three files reviewed did not contain any documentation the youth was eligible for DV services.

Two of the three files reviewed were missing signatures on documents in the file.

Two of the three files reviewed had incomplete Needs Assessments.

One of the files reviewed did not have a Treatment Plan.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The Hillsborough County program provides screening, counseling, and mental health assessment services to both residential and non-residential CINS/FINS youth. The Hillsborough County Government has Child Care Specialist staff members 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's past mental health status, as well as, their current status.

The agency also screens for the presence of acute health issues and the agency's ability to address these existing health issues. Further, the agency has two Registered Nurses permanently on staff to provide health screenings on youth admitted to the program. At the time of the Quality Improvement Review one nurse had resigned and last day of employment was the day after the last day of the review. The Hillsborough County program assists in the delivery of medications to all youth admitted to the youth shelter. The agency has been using the Pyxis Med-Station for the storage and delivery of medications for approximately the past month and a half prior to the on-site Quality Improvement Review. However, at the time of the review the agency was not storing controlled medications in the Pyxis Med-Station. The medications were instead stored in a double locked cabinet. Nurses oversee and distribute the majority of all medications during the week and direct care staff are responsible for the distribution of medication on the weekends. The agency provides medication distribution training delivered by Registered Nurses 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.

4.01 Healthcare Admission Screening

Satisfactory Limited Failed

Rating Narrative

The agency has a current policy in place with an effective date of March 1, 2012 and a review date of March 1, 2014. The agency uses the CINS/FINS Intake Assessment (at the time of intake) to screen youth for suicidal behavior, substance abuse, and the overall general health of the youth. If a youth is admitted with a chronic medical condition the Nurse is notified immediately through the completion of a Sick Call request form; which is given to the Nurse so the youth can be examined through documentation in the Medical Services Referral Log and through the Dot System (the agency's medical and mental health alert system).

There were six residential files reviewed (five open and one closed). All six files had the CINS/FINS Intake Assessment completed at admission. None of the files documented the youth had any type of chronic medical condition, however; procedures are in place in case a youth is admitted with one. There was one youth admitted who was taking medication and the medication, as well as, the reasons for taking it were documented.

There were no exceptions to this indicator.

4.02 Suicide Prevention

Satisfactory Limited Failed

Rating Narrative

The agency has a Suicide Prevention and Intervention policy that was last reviewed on March 1, 2014. Youth are screened for suicidal concerns during intake using the six questions on the CINS/FINS Intake Assessment Form. If the youth answer yes to any of the six screening questions the youth is placed on constant sight and sound

supervision until a Treatment Counselor completes a more in-depth assessment. A red dot is also placed next to the youth's name on the client board and on the outside of the youth's file. A red sheet of paper is placed in the client's file to identify the issue of concern. Any youth with risk factors for suicide are referred for a counselor's assessment within twenty-four hours. A Treatment Counselor will assess a youth using the Assessment of Suicide Risk form. Based on the outcome of this assessment the youth will either remain on constant sight and sound supervision, be Backer Acted, or be taken off constant supervision and be placed on an elevated status.

The shelter employs three licensed counselors, a licensed Clinical Director and a master's level counselor. There were three youth files available for review for youth who had been placed on suicide precautions. All three files documented the youth were placed on suicide precautions at intake due to issues identified during the screening process. All three youth remained on constant sight and sound supervision until assessed by a qualified professional. All youth were seen and assessed (using a suicide risk assessment) within twenty-four hours. All suicide risk assessments were completed by a licensed professional and also documented consultation with the Clinical Director prior to removal. All Youth were placed on an elevated supervision level upon completion of the suicide risk assessment. All three youth had thirty-minute observations documented the entire time they were on suicide precautions. Any youth on suicide precautions sleeps in the first room in the hallway in the appropriate boys' or girls' shelter. All changes in supervision levels were documented in the youth's file on the suicide assessment summary form, in all logbooks, and in an email to all staff.

There were no exceptions to this indicator.

4.03 Medications

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy on Medication Storage, Access, Inventory, and Disposal that last reviewed July 28, 2015. The policy has detailed procedures for the Utilization of the Pyxis Med-Station 4000 and for medication disposal.

The shelter provided a list of staff who are trained to supervise the self-administration of medications. There were nineteen staff on that list. The list was divided into three sections: Primary, Secondary, and Tertiary. There were two staff, the Nurses, listed as the Primary staff for distributing medications. The Residential Service Coordinators are the Secondary staff with five listed. And the remainder of the list, Tertiary, were Child Care Specialist IIs who were trained to distribute medications.

The shelter has a dedicated Nursing Services Building where all the youth's medical needs are attended to. At the time of the review there were two Registered Nurses (RN) who ran the medical clinic. However, one of the RN's informed the review team her last day working at the shelter would be the day following the last day of the on-site Quality Improvement Review. The agency has posted the Nursing position and it is scheduled to close on March 14, 2016. Currently there is an RN on-site Monday through Friday from 6:45am till 8:00pm. Direct care staff are responsible for distributing medications on the weekends and also to any youth requiring medications before 6:45am on weekdays, prior to the first RN arriving. Usually these are high school students who have to leave for school prior to a Nurse coming on-site.

At the time of the on-site review the shelter had been using the Pyxis Med-Station for approximately a month and a half. The RNs are the only ones who load new medications into the Pyxis Med-Station. If a youth is admitted when no RN is on-site the medication is stored in a locked cabinet, in the same room as the Pyxis Med-Station, until the next time an RN is on-site to load the medication. If the youth requires a dose of the medication before it is loaded in the Med-Station, the staff will give the dose out of the locked cabinet and document it on the youth's Medication Distribution Record (MDR). The RNs provide training to direct care staff on the use of the Pyxis Med-Station, general medical/healthcare, and CPR/first aid.

The RN reported there have been no major discrepancies with the Pyxis Med-Station. There have been minor discrepancies, mainly involving staff inventories of the over-the-counter medications and these discrepancies were easily fixed.

The RN completes a weekly inventory of all medications on-site. Staff conduct shift-to-shift inventories of all controlled medications. At the time of the review, the shelter did not have any youth on a controlled medication. However, it was reported for the past month and a half, that controlled medications were still being stored in a double locked cabinet. This process was not able to be verified due to not having any controlled medications on-site. The RN reported this process was still being used due to the need for a second witness to be present to open the Pyxis Med-Station for a controlled medication. With the location of the Pyxis Med-Station in another building, it was difficult for a second staff to be present for medication distribution when the RN was not present. The RN reported this is no longer their process and from this point forward all medications, including controlled medications, will be stored in the Pyxis Med-Station. All inventories of medications reviewed were completed as required.

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. There is also a separate locked cabinet where topical over-the-counter medications and sharps are stored. All sharps are also inventoried weekly and as used. The only sharps on-site are stored in the Nursing Services Building and staff must come to the building to sign-out the sharps and must bring them back after using.

There were no youth in the shelter currently on medications. There were three closed files reviewed of previous youth who had been on medication to verify the medication administration process. The youth's MDR is maintained in the youth's individual file after release. All MDRs reviewed documented the youth's name, a picture of the youth, date of birth, age, physician, allergies, side effects, medication the youth was taking with dosage, route, frequency, and reason. All MDRs have all staff names who are authorized to distribute medication typed on the bottom and staff must initial next to their name. The youth also signs the MDR. All MDRs reviewed on-site document that perpetual inventory counts with running balances are being maintained on each youth. All MDRs reviewed for the youth also documented that all medications were given at prescribed times.

The shelter has had no CCC reports relating to medication errors in the last six months.

Exception:

For the past month and a half (the time frame the agency has been using the Pyxis Med-Station) controlled medications have not been stored in the Med-Station.

4.04 Medical/Mental Health Alert Process

Satisfactory Limited Failed

Rating Narrative

The program has a policy in place that addresses the medical and mental health alert standard. The program has a color dot system that is used to communicate alerts, red- suicidal/mental health issues, blue- medical/substance abuse issues, and yellow- behavioral issues. Dots appear next to the youth's name on the client boards and corresponding color sheets are placed in the youth's file. Staff interviewed demonstrated knowledge of the alert system process outlined in the agency policy.

Youth with a suicide risk alert are placed on sight and sound supervision with appropriate documentation on the Suicide Precautions-Constant Sight and Sound Supervision Log form until a treatment counselor can further assess the youth. Staff interviewed were knowledgeable on the process. There were six files reviewed. Three of the six files were identified as having a need for heightened supervision. Documentation was present in the file to support that the appropriate level of supervision was provided.

There were no exceptions to this indicator.

4.05 Episodic/Emergency Care

Satisfactory Limited Failed

Rating Narrative

The agency had several different policies in place covering the requirements for Episodic/Emergency Care. The policies in place were Comprehensive Master Plan, First Aid Equipment, Infectious Outbreak, Residential Health Services, CCC Reporting, and Substance Abuse, Crisis Intervention and Emergency Procedures. All policies had a review date of March 1, 2014.

The shelter has had ten instances of off-site episodic emergency care since the last Quality Improvement Review. In all incidents, the youth's parent was notified and the incident was reported to the CCC. The RN maintains a very detailed Episodic Care Log. The log documents all incidents requiring any type of first aid care, as well as, all incidents that required transportation off-site for medical care. The log documents the date, the youth, the incident/information report, solution, and result. The RN also completes a Medical Information Report which documents consultation with parent/guardian, what care was given, and if any follow-up care is needed. If youth are transported off-site for care, copies of the doctor's orders are also placed in the Episodic Care Log.

All staff are trained in CPR, first aid, and AED. The shelter has completed one emergency medical drill in the last six months (in December 2015). The drill was an actual event of a youth fainting.

There are first aid kits located in the Nursing Services Building—in each cottage and one for each of the vehicles. The RN does an inventory of all first aid kits weekly. This was documented for the last six months. Each cottage also has a knife-for-life and wire cutters taped to a wall inside a closet.

There were no exceptions to this indicator.