



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

Review of Hillsborough County

on 10/26/2016

## CINS/FINS Rating Profile

### Standard 1: Management Accountability

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

Percent of indicators rated Satisfactory:87.50%  
Percent of indicators rated Limited:12.50%  
Percent of indicators rated Failed:0.00%

### Standard 2: Intervention and Case Management

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

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

### Standard 4: Mental Health/Health Services

4.01 Healthcare Admission Screening	Satisfactory
4.02 Suicide Prevention	Limited
4.03 Medications	Satisfactory
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:92.59%  
Percent of indicators rated Limited:7.41%  
Percent of indicators rated Failed:0.00%

### Rating Definitions

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

Satisfactory Compliance	Non-systemic exceptions that do not result in reduced or substandard service delivery; or exceptions with corrective action already applied and demonstrated.
Limited Compliance	Exceptions to the requirements of the indicator that result in the interruption of service delivery, and typically require oversight by management to address the issues systemically.
Failed Compliance	The absence of a component(s) essential to the requirements of the indicator that typically requires immediate follow-up and response to remediate the issue and ensure service delivery.
Not Applicable	Does not apply.

### Review Team

#### Members

**Ashley Davies, Lead Reviewer and Consultant, Forefront LLC**

**Canitha Taylor, Regional Monitor, Department of Juvenile Justice**

**Andy Coble, VP of Prevention Services, Youth and Family Alternatives**

**James Mabry, Residential Supervisor, Family Resources St. Petersburg**

**Sonia Santiago, Vice President, YMCA Sarasota**

**Persons Interviewed**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Chief Executive Officer         | <input checked="" type="checkbox"/> Executive Director     | <input type="checkbox"/> Chief Operating Officer            |
| <input type="checkbox"/> Chief Financial Officer         | <input checked="" type="checkbox"/> Program Director       | <input checked="" type="checkbox"/> Program Manager         |
| <input checked="" type="checkbox"/> Program Coordinator  | <input checked="" type="checkbox"/> Direct- Care Full time | <input checked="" type="checkbox"/> Direct-Care Part Time   |
| <input checked="" type="checkbox"/> Direct-Care On- Call | <input type="checkbox"/> Volunteer                         | <input type="checkbox"/> Intern                             |
| <input checked="" type="checkbox"/> Clinical Director    | <input checked="" type="checkbox"/> Counselor Licensed     | <input checked="" type="checkbox"/> Counselor Non- Licensed |
| <input checked="" type="checkbox"/> Case Manager         | <input type="checkbox"/> Advocate                          | <input checked="" type="checkbox"/> Human Resources         |
| <input checked="" type="checkbox"/> Nurse                |  |   |
| 2 Case Managers  | 1 Maintenance Personnel                                    | 2 Clinical Staff  |
| 2 Program Supervisors                                    | 0 Food Service Personnel                                   | 0 Other   |
| 2 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 checked="" type="checkbox"/> Logbooks                          | <input checked="" type="checkbox"/> Fire Drill Log                   | 5 # Health Records   |
| <input checked="" type="checkbox"/> Continuity of Operation Plan      | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 3 # MH/SA Records  |
| <input type="checkbox"/> Contract Monitoring Reports                  | <input checked="" type="checkbox"/> Table of Organization            | 10 # Personnel Records   |
| <input type="checkbox"/> Contract Scope of Services                   | <input checked="" type="checkbox"/> Precautionary Observation Logs   | 9 # Training Records   |
| <input checked="" type="checkbox"/> Egress Plans                      | <input checked="" type="checkbox"/> Program Schedules                | 5 # Youth Records (Closed)                                     |
| <input checked="" type="checkbox"/> Fire Inspection Report            | <input type="checkbox"/> Telephone Logs                              | 5 # Youth Records (Open)                                       |
| <input checked="" type="checkbox"/> Exposure Control Plan             | <input type="checkbox"/> Supplemental Contracts                      | 0 # Other  |

**Surveys**

5 Youth                      6 Direct Care Staff

**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 checked="" type="checkbox"/> Recreation                     | <input checked="" type="checkbox"/> Toxic Item Inventory and Storage | <input checked="" type="checkbox"/> First Aid Kit(s)           |
| <input type="checkbox"/> Searches                                  | <input type="checkbox"/> Discharge                                   | <input type="checkbox"/> Group                                 |
| <input checked="" type="checkbox"/> Security Video Tapes           | <input type="checkbox"/> Treatment Team Meetings                     | <input checked="" type="checkbox"/> Meals                      |
| <input checked="" type="checkbox"/> Social Skill Modeling by Staff | <input type="checkbox"/> Youth Movement and Counts                   |  |
| <input checked="" type="checkbox"/> Medication Administration      | <input checked="" type="checkbox"/> Staff Interactions with Youth    |  |

**Comments**

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

Rating Narrative

## Strengths and Innovative Approaches

### Rating Narrative

The agency recently finished installing a new camera system. A new communication system called Encore was also installed. It is an electronic announcement system. The agency can feed in information and do alert calls through televisions located throughout the campus. This system is not running yet but has been installed. It is in the training phase.

The youth in the program are participating in therapeutic yoga on Sundays.

The program is using the Six Pillars of Character and Character GPS and working with the youth weekly teaching them to become mentors.

The program is working with Motivational Edge and Prodigy teaching the youth how to write music and about art.

The program had about 200 volunteers come out to the campus and clean up.

The agency is using a scientific program developed by a research group called Korn Ferry, to help build a profile for each position within the agency. It then gives a list of interview questions geared for position and characteristics. There are screening questions for each position based on the profile information which helps create a better pool of potential employees.

Ninety-seven percent of the program youth go to school every day and this has helped stabilize the youth.

## **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 agency administrative offices and youth shelters are housed in buildings 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 twenty-two Child Care Specialist, twenty-one Senior 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 Coordinator, a Training Specialist, five Residential Treatment Counselors, and five Non-Residential Treatment Counselors.

#### 1.01 Background Screening

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has a written policy in place for background screening to address all the key elements of this indicator. The policy was last reviewed on March 1, 2016.

The agency's policy and procedure for background screening is conducted for all department employees, contracted provider and grant recipients employees, volunteers, mentors, and interns with access to youth. The background screen is completed prior to hiring or utilizing the services of a volunteer, mentors, or intern. All employees and volunteers are re-screened every five years. The annual Affidavit of Compliance with Good Moral Character Standards (form IG/BSU-006) is completed by the program and sent to the DJJ Background Screening Unit by January 31st of each year.

On this annual compliance review there was a total of eight new employees and two five-year re-screenings since the last review. All eight new employees had completed background screens prior to their hire date. The two five-year re-screen employees had completed a five-year re-screen on time. The annual Affidavit of Compliance with Good Moral Character Standards (form IG/BSU-006) was completed by the program and sent to the DJJ Background Screening Unit on January 20, 2016.

**There were no exceptions for this indicator.**

**1.02 Provision of an Abuse Free Environment**

Satisfactory

Limited

Failed

Rating Narrative

**The Agency has a policy in place for an abuse free environment to address all the key elements of this indicator. The policy was last reviewed on March 1, 2014.**

**The policy and procedure for an abuse free environment includes all program staff adheres to a code of conduct that prohibits the use of physical abuse, profanity, threats, or intimidation. The clients are not deprived of basic needs, such as clothing, food, shelter, medical care, and safety. Any person who knows, or has reasonable cause to suspect abuse, abandoned, or neglected by a parent, legal guardian, or person responsible as defined by the Florida Statue, is to report such knowledge to the Florida Abuse Hotline. The program is to have a grievance process for all youth to provide feedback and address complaints, and take immediate action to address incidents of abuse, abandonment, or neglect.**

**All staff, upon being hired, are provided the agency policies and procedures for neglect or abuse of clients. This policy addresses that all staff are required to adhere to the codes of conduct that prohibits the use of physical abuse, profanity, threats, or intimidation. All staff received orientation training that covers staff expectations and conduct. The agency has an accessible and responsive grievance procedure for clients to address complaints. The agency provided an example of staff acknowledging the code of conduct and employee handbook. The abuse hot line numbers are posted in the clients' living area. There were no examples of staff discipline for unprofessional behavior for this annual compliance review. Five youth surveyed stated they have access to call the abuse hot line and had never been denied access. Five staff surveyed stated they have never witnessed a staff refusing a youth to call the abuse hot line or use profanity.**

**There were no exceptions for indicator.**

**1.03 Incident Reporting**

Satisfactory

Limited

Failed

Rating Narrative

**The Agency has a written policy in place for incident reporting to address all the key elements of this indicator. The policy was last reviewed on March 1, 2014.**

**The agency's policy and produces for reporting incidents are that the agency will notify the Department of Juvenile Justice Central Communication Center (CCC) no later than two hours after any reportable incident. The agency completes follow-up communication**

as required by the CCC. All incidents are documented in agency logbooks and incident reporting forms. All incident reports are reviewed and signed by supervisors/directors.

On this annual compliance review there were a total of twenty-six Central Communication Center (CCC) reports for the last six months. All twenty-six incidents were called into the CCC; however, one incident was recorded late for a youth absconding. This report is closed with no follow-up. Only one of the twenty-six required follow-up. The agency complied with assigned tasks and this incident was eventually closed. All incident reports are kept in a binder and reviewed by the supervisor/directors within twenty-four hours. All logbooks reviewed contained written documentation of incidents.

**Exception:**

There was one CCC report called in outside the two-hour time frame.

**1.04 Training Requirements**

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place to address training requirements.

The agency has an annual training plan in place. Each staff has a training binder containing all applicable documents. Staff work three 12-hour shifts and one 4-hour shift each week. The 4-hour shift falls on a Wednesday and is used as a training day for those staff.

A total of nine staff training files were reviewed. There were four training files reviewed for first year training requirements (for newly hired staff) and five staff training files reviewed for annual training requirements.

All four of the newly hired staff documented more than the required 80 hours of first year training requirements with: 113, 138, 121, and 117 hours. All four staff still had approximately two months left to receive additional hours. All four staff had already completed a majority of all the required trainings, with the exception of two; however, the staff still have approximately two months left to receive those trainings.

All five of the staff training files reviewed for annual training requirements documented more than the required 40 hours of training for the last completed training cycle, 7/1/2015 – 6/30/2016. The staff documented 120, 129, 122, 146, and 128 hours of training. All required trainings, as well as, additional trainings were completed.

An individual training file was maintained for each staff that contained a print-out of a spreadsheet documenting all trainings completed, with hours and dates. Any related documentation such as agendas, sign-in sheets, copies of the training, and certificates were located in the file behind the tracking form.

There were no exceptions to this indicator.



### 1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place for analyzing and reporting information to address all of the key elements of this indicator. The policy was last reviewed on February 1, 2016.

The policy and procedure for collecting and reviewing several sources of information to identify patterns and trends to include monthly, quarterly, and annually reports. The results are to identify strengths and weaknesses. The findings are reviewed by management and communicated to staff and stakeholders.

The agency collects and reviews several sources of information to identify patterns and trends. The agency compiles all the information collected and enters it into the Division of Children and Youth Services QI Outcome Measure Summary Report. The results are reviewed and distributed through meetings held weekly, monthly, quarterly, and annually. The agency provided the Division of Children and Youth Services QI Outcome Measure Summary Annual Report and meeting minutes for review. The report included high quality services & programs, customer satisfaction, program utilization, financial responsibility, community connectivity, and employee success.

There were no exceptions to this indicator.

### 1.06 Client Transportation

Satisfactory

Limited

Failed

Rating Narrative

The agency does have a policy in place for this indicator: Department of Children's Services Staff should avoid situations that put youth or staff in danger of real or perceived harm, or allegations of inappropriate conduct by either staff or youth. Having a 3rd party presence in the vehicle is best practice for prevention of any of these events.

- 1) Vehicles will be operated in a safe manner at all times and obey all traffic laws.
- 2) Drivers must have a valid State of Florida driver's license and must have completed all training required by Hillsborough County for operation of the vehicle. Drivers must be covered under Division insurance policy.
- 3) The number of persons in a vehicle may not exceed the number of seats available.
- 4) Restraining/devices/seat belts will be used by the staff and children transported in the vehicle.
- 5) All vehicles transporting clients will be equipped with a fire extinguisher and a first aid kit.
- 6) The driver of the vehicle will be responsible for compliance of the above policies.
- 7) Travel outside of Hillsborough County will require a "Request and Authorization for

**Travel Outside of County in a County Vehicle" form be completed. All requests must be approved by the director, county fleet management and the assistance county administrator for community services.**

**8) Drivers must be approved by the division to drive client(s) in division approved vehicles.**

**9) Third party is an approved volunteer, intern, department staff, or other youth.**

**10) Documentation of use of vehicle notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.**

**11) Documentation in the staff/front desk logs states that a 3rd party will accompany a client transport.**

**Staff will document in the log books and on the Request for Authorization for Off Campus Activities Form that a third party will accompany staff on a client transport. In the event that a third party cannot be obtained for client transport, the client's history, evaluation, and recent behavior is considered. In addition, the department's approved driver's performance and history indicates no inappropriate behavior is likely to occur. If a driver is transporting a single client in a vehicle, there is evidence that the manager of residential services is aware (prior to the transportation) and consent is documented in email format and/or noted in the staff/front desk log books. A copy of the approval is also placed in the transportation binder accordingly.**

**Copies of daily transport forms were provided for the last six months. The forms contained all of the required notation per the standard; however, mileage is written into the side without a designated area. The form also designates between CINS and RGC youth due to their different funding sources and requirements. Staff are required to complete and turn in an Authorization Form prior to any transport and receiving keys. The form is turned into a designated supervisor, which could be a shift leader or above. Once the form is signed the staff may conduct the transport. The form also indicates that two staff are taken on all transports with very few exceptions. One exception was provided where a single party transport was provided for a CINS youth on 9/26/2016 and the director made a note in red pen in the log book denoting her approval prior to the staff picking the youth up.**

**Staff provided a copy of the current insurance card for all of the vehicles and documentation that staff are covered under the agency's insurance policy.**

**There were no exceptions to this indicator.**

#### 1.07 Outreach Services

Satisfactory

Limited

Failed

#### Rating Narrative

**The agency has a policy titled "Community Outreach and Partnerships" stating the intended purpose of their outreach activities and working in collaboration with the**

**community to draw awareness to the issues faced by the youth they serve.**

**The procedure notes the various ways the agency staff are responsible for implementing the policy as it relates to attendance and participation in community events, work groups, and meetings to include the local DJJ board and council meetings. The procedures note that the program will make material available to all stakeholders and interested parties. In addition, the procedures outline the purpose and process for the safe place program throughout the county. The procedures denote that the agency will develop written agreements and MOU's with local providers whom they interact with regularly. The procedures also introduce the entry of all outreach activities into NetMIS within 48 hours of the event occurring.**

**Documentation was provided (in the form of agendas) for the local DJJ meetings, along with sign-in sheets and minutes from March through September 2016.**

**The agency provided a list of inter-agency agreements, which totaled seven, and provided the MOU's for each.**

**The other documentation provided was agendas for the Hillsborough County Drug Alliance on 6/8/2016, the Prescription Task Force with agendas on 4/28/2016 and 6/22/2016, an anti-bullying community discussion agenda on 4/18/2016, and a training program agenda regarding the law and the community on 6/23/2016. In addition, a NetMIS print out was provided showing outreach activities throughout the review period. The program also held a family festival for the community that drew over 300 people and recently the agency did an outreach activity for the county's school social workers.**

**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

The program has a policy and procedure in place regarding the intake process for providing Shelter and Non Residential Counseling services to youth in Hillsborough County. The policy was reviewed on June 8, 2016.

Hillsborough County's policy is extensive and includes fourteen pages with clearly defined steps that are to be followed to initiate services with youth and their families. The policy outlines the screening process which determines eligibility of services. The screening also identifies their presenting issues, legal status, a threat to himself or others, medical issues, and other pertinent demographic information.

There were ten files reviewed: five residential and five non-residential. All ten files included the Screening and Intake form within the time frames. The files contained information regarding the presenting issue and eligibility for services. Information on the rights and responsibilities of all the parties including the parents, youth, and program was evident with signatures in place. Also evident was information on the Grievance process. The program presented to the reviewer the handouts given to

the parents regarding the CINS Petition process and other information to assist them.

There were no exceptions to this indicator.

## 2.02 Needs Assessment

Satisfactory

Limited

Failed

### Rating Narrative

**There is a Policy and Procedure in place regarding the Needs Assessment for the Shelter and for Non- Residential Services. The Policy and Procedure was updated on June 8, 2016. The criteria to be followed for the separate programs includes time frames and staff levels.**

**The Policy and Procedure clearly outlines the process for youth and families to participate in services. Time frames are clearly stated to initiate the services for both Shelter and Non-Residential clients. For youth placed in the Shelter, the Needs Assessment is initiated within 72 hours. The staff are diligent in striving to complete the Needs Assessment in both programs. Non-Residential staff can meet with the client and family more than one session to complete the needs assessment and may have a need for more sessions depending on the problems of the client and their family. The policy states the purpose of the Needs Assessment is to identify presenting issues/strengths and develop an appropriate Service Plan that meets the clients' needs including referrals that may assist the client/family.**

**This policy also includes the process for obtaining information from other agencies and the reporting of abuse/victimization.**

**The resulting Service Plan is developed with the participation of the youth and their parent/guardian, outlining the steps to be taken to reach the identified goal.**

**In all five residential files reviewed, the Needs Assessment was initiated within the 72 hour time frame and conducted by a Masters level staff. In four of the five files reviewed the Needs Assessment was signed by a supervisor. The program is proactive in conducting Assessments of Suicide Risks for all their clients and four of the five files had these forms signed and in place.**

**All five non-residential Needs Assessments reviewed were completed within the time frames. Through this process goals were developed that met the clients' needs and served as the frame work for change. The Needs Assessments were reviewed and signed by the supervisor.**

### **Exceptions:**

**One residential file identified as needing an Assessment of Suicide Risk documented one was initiated but not completed.**

**One residential Needs Assessment was not signed by a supervisor.**

**2.03 Case/Service Plan**

Satisfactory

Limited

Failed

Rating Narrative

**A Policy and Procedure is in place for the development of the Service Plan stating that it will be conducted by a qualified professional staff, developed within the appropriate time frame for shelter residents and non-residential clients and their families. The policy and procedure was updated on June 8, 2016. The policy and procedure states the Service Plan will be developed with goals and steps/actions to achieve the desired outcomes.**

**Service Plans are developed in compliance with agency policies. Through the Screening and Needs Assessment process, individualized Service Plans are created with participation of youth and parents. The procedure for developing the Service Plan is consistent in both the residential and non-residential files. Through the interview process, areas that are problematic are identified and specific steps to assist the clients and families are listed. Identifying their strengths, ethnicity, racial identity and sexual orientation are considerations in developing the plans.**

**Meeting individually with the client once they have entered into services allows the opportunity to pay particular attention to the areas that are causing some distress. There were five residential files reviewed and each Service Plan was individualized to meet the youth needs. There were five non-residential files also reviewed. The Service Plans developed reflected the issues and specific actions were identified. The individualized plans demonstrates that each case is assessed and goals are written to meet their needs.**

**All ten files included target dates, person responsible and signatures of youth, parent, and staff. Special situations arise and are individualized as needed.**

**There were no exceptions to this indicator.**

**2.04 Case Management and Service Delivery**

Satisfactory

Limited

Failed

Rating Narrative

**The Agency has a clearly defined Case Management and Service Delivery policy. The service delivery is what the staff does to provide services to youth and families. The services include assigning a Counselor, developing the Service Plan and providing the service needed to assist youth and their families.**

**There were five residential and five non-residential files reviewed. The residential files had an assigned counselor who met with them to begin the Needs Assessment and then developed the Service Plan. The counselor makes the initial contact, this is noted in each file, and completed within the appropriate time frames. Service delivery follows once the Service Plan is developed. Youth received appropriate referrals for substance use (this was identified on the Service Plans).**

**There were five residential files reviewed regarding Screening, Intake Forms, and Service**

**Plans. All were completed within the time frames established by the Agency. The plans outline services that would assist the youth and family. Group documentation was reviewed and groups are provided five times a week. They offer several different groups for youth to gain skills.**

**There were five non-residential Service Plans also checked for meeting required time frames and delivery of service. The service delivery involves meeting with the youth and families and was observed in the progress notes along with any case management needed.**

**Supervisors sign off on the Needs Assessment, Service Plans, and reviews the status of each case with their staff.**

**There were no exceptions to this indicator.**

#### 2.05 Counseling Services

Satisfactory

Limited

Failed

##### Rating Narrative

**The agency has a clearly defined policy in place for Counseling Services.**

**The policy and procedure states that the staff will be responsible for meeting with clients and families for progress toward improving their goals. Staff have specific time frames and a specific number of times they are to meet to engage them in services and before closing the case.**

**All five residential files included documentation of individual meetings with the youth and families, as well as, the specific issues they were addressing with them. Group sessions were noted as well. Supervisors sign off on the forms noting that the service is being provided.**

**The five non-residential files were viewed electronically and progress notes indicated meetings with the youth and parents, and case management components. Supervisors provided clinical reviews of the files.**

**All five residential files reviewed documented groups were being provided at least five days each week.**

**There were no exceptions to this indicator.**

#### 2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

##### Rating Narrative

**The agency's policy and procedure states they will be responsible for providing CINS/FINS services for Truancy, Ungovernable, and Runaway behaviors. Information is provided in the community regarding this process. Parents may make a written request for filing a CINS petition and be contacted when the Case Staffing meeting is arranged**



within seven days of receipt of the letter.

Monthly Case Staffing Meetings are scheduled. The program has an identified Case Manager who conducts these monthly Case Staffing meetings once truancy/runaway/ungovernable behaviors have been identified through referrals from the schools or a parent (written request). The Case Manager is responsible for all aspects of the CINS process. A Counselor is assigned to provide the counseling piece. The Case Manager arranges case staffing and informs community partners for their participation. The Case Manager maintains separate files with all the documentation regarding the case including the Case Staffing Recommendations, the formal CINS petition, PDR, and court reports indicating progress made.

Three separate files were reviewed and contained Case Staffing invite letters, recommendations made, and petition forms. Two files had parental requests and arrangements were made within the seven day period to comply with the standard. One file had not reached the petition status; however, that youth is presently in the shelter to assist the youth in changing truancy patterns. The Case Manager maintains these files and provides transportation if needed. The Service Plans were revised once the Case Staffing had made recommendations. The Supervisor was involved in the process with oversight.

There were no exceptions to this indicator.

#### 2.07 Youth Records

Satisfactory

Limited

Failed

#### Rating Narrative

The policy and procedure regarding Youth Records is extensive and provides a framework that the program adheres to. The policy encompasses both residential and non-residential services emphasizing confidentiality and privacy of the youth and family.

There were ten files reviewed. All five residential files were stamped with "confidentiality" easily visible. They are maintained in a locked file cabinet and the room is locked. The non-residential files are electronically maintained with access available only to the counselor and supervisor.

Files are not transported off campus and program staff are aware that in the event that it becomes necessary to transport files, they will be transported in a locked, opaque container.

All records are neatly arranged in an orderly, consistent manner.

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 medical 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. All staff are also trained in NAPPI. The agency has a detailed video surveillance system in place that has recently been updated.

#### 3.01 Shelter Environment

Satisfactory
  Limited
 Failed

Rating Narrative

The agency has several policies in place that addresses the key elements of this indicator.

The facility grounds were observed clean and in good repair.

The Fire and Sanitation Inspections were current, last completed on 3/11/2016 with no deficiencies. The Fire Sprinkler System inspection was completed 3/11/2016 also. The Range Hood System Inspection was completed 10/20/16 and noted no deficiencies. Fire Extinguishers were last inspected 3/3/16. Building Fire Inspections were current ranging from 6/8/16 to 8/4/16 and the Fire Alarm Systems Inspection was 8/25/16.

Staff complete a Cottage Safety and Sanitation Inspection once a week on each shift in all cottages.

The Daily Routine and Activity Schedule is posted on the Staff Office Doors and in the Command Center for the Residential Coordinators to monitor.

There were no exceptions to this indicator.

#### 3.02 Program Orientation

Satisfactory
  Limited
 Failed

Rating Narrative

The agency has a written policy in place that addresses all of the key elements of the indicator. The policy was last updated on 3/1/2014.

The agency has several procedures to implement that addresses the key elements of the indicator. When a youth is accepted for residential services, he/she will receive a comprehensive orientation to the program and services available to him/her. The comprehensive orientation for the youth and parent/guardian will include, at a minimum the following:

- 1) Program purpose and goals
- 2) Facility tour and introduction
- 3) Youth room assignment
- 4) Identification of key staff and their role
- 5) What conditions represent a crisis or emergency
- 6) Review of the Emergency Evacuation Procedures.
- 7) Review of the youth's rights and grievance procedure
- 8) Review of the visitation rights
- 9) Review of the telephone procedures

Orientation procedures are implemented during the admission process. There is a Youth Orientation check off list the intake staff reviews with the youth and guardian upon admission.

There were seven youth files reviewed. Each file documented a completed Youth Orientation check off list and met all elements of the indicator. This document was signed by the youth and guardian in each file.

There were no exceptions to this indicator.

### 3.03 Youth Room Assignment

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has a written policy in place that addresses all of the key elements of the indicator.

The agency has procedures in place to implement the key elements of the indicator.

Program staff will make every effort to separate and/or segregate dangerous youth from those who are not. Program action, based on youth classification, will be documented. When placing a youth in a multi-occupancy room, the following must be taken into consideration:

- 1) Physical characteristics including age, sex, height, weight, and general physical stature, and gang affiliation; history and status;
- 2) Initial interactions with and observations of the youth and collateral contacts;
- 3) Separation of younger youth from older and violent youth from non-violent youth;
- 4) Identification of youth susceptible to victimization (very small youth, youth with developmental disabilities, or very immature youth), presence of medical, mental, or physical disabilities;
- 5) Suicide risk, sexual aggression, and predatory behavior.

The room assignment procedure is implemented during the intake process. A section of the intake form is completed to address the youth's history and exposure to trauma, age, gender, history of violence and aggression, disabilities, physical size, and strength.

There were seven youth files reviewed. The section of the intake form that addresses room assignment was completed in all seven files. However, gender identification is not addressed in the room assignment section of the intake form.

The agency addresses gender identification during the youth's screening process. There were seven youth files reviewed to determine if gender identification had been addressed and three of the four screening documents did include this information. The remaining four did not. It was explained a new screening form was implemented in August 2016 to address gender identification and the four files that did not address it were admitted prior to August 2016.

**Exception:**

Four files reviewed did not address gender identification during the screening process.

**3.04 Log Books**

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place for log-books, to address all of the key elements of this indicator. The policy was last reviewed on March 1, 2014.

The policy and procedure for log-book entries is to document routine daily activities, events and incidents and are reviewed by direct care staff and supervisor staff at the beginning of each shift and documented that the past two shifts are reviewed. All entries are brief and legibly written with dates and times. All recording errors must have a single line drawn through and initialed. The program director or designee are to review the log-books every week.

A review of five log books dated from April 2016 to present contained written entries in ink that was legible and reviewed by direct care staff, supervisors, and program director. There were resident counts occurring on a regular basis. All significant occurrences

were highlighted. Mistakes were marked through with a single line and initialed; however, there were several instances when staff had scribbled through the entire mistake with no initials.

**Exception:**

There were several instances when staff scribbled through a mistake with no initials.

**3.05 Behavior Management Strategies**

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy in place that addresses all of the key elements of the indicator.

The agency has procedures in place to implement the key elements of the indicator.

The Director will ensure that a Behavioral Management System be implemented and monitored for the program. The Behavioral Management System will emphasize positive behavioral support, praise, and encouragement.

The Behavior Management System (BMS) is introduced to the youth during the orientation process and is also explained in the Youth Handbook.

The Residential Coordinators monitor the BMS daily and the Residential Director monitors the BMS on a month basis.

All staff members are trained in Behavior Management during their initial CINS/FINS training and they receive NAPPI (Behavior Intervention Training in verbal intervention, de-escalation techniques, and physical intervention) training.

Three staff training files were reviewed. All files indicate staff were trained in NAPPI and the BMS.

Youth are rewarded by being allowed to attend paid off-campus activities and through extra privileges.

There were no exceptions to this indicator.

**3.06 Staffing and Youth Supervision**

Satisfactory

Limited

Failed

Rating Narrative

The Provider has a written policy in place that addresses all of the key elements of the indicator.

The Provider has written procedures to implement the key elements of the indicator.

During waking hours, the minimum ratio for the CINS/FINS Program is one staff per six

youth. During sleeping hours the ratio is one staff per twelve youth.

When both male and female youth are housed in the same shelter, at least one staff of the same gender staff is assigned at all times.

Currently the staff are scheduled to work twelve hour shifts 6 am-6 pm and 6 pm-6 am. There are at least two staff members per shelter with a maximum of twelve youth.

The agency utilizes two of the cottages on campus as CINS/FINS shelters. The male shelter is staffed with only male staff members and the female shelter is staffed with only female staff members. In the event that there is shortage and a staff member of a different gender has to work in a shelter, a Residential Coordinator will work in the shelter also. There are two Residential Coordinators monitoring the staff and care of the youth on each shift and one floater staff member to be utilized as needed. Shelters are consistently staffed during overnight shifts with two staff members. A review of staff work schedules for the last six months confirmed that staffing ratios are consistently met or exceeded.

Documentation reviewed of bed checks every ten minutes while a youth is in their sleeping room revealed that the checks were being completed as required. However, a random review of the video surveillance system to confirm the checks were being completed revealed some inconsistencies between what was documented and what was recorded on video.

On two of the days reviewed, the check sheets documented bed checks being completed exactly every ten minutes throughout the entire night; however, when reviewing the video there was a two to three minute difference in the times documented throughout the night. The bed checks were not documented in real time.

On another night reviewed, the bed checks were documented every ten minutes throughout the entire night; however, when reviewing the video there were gaps of at least twenty minutes between some of the checks. Since the logs documented checks being completed every ten minutes, this resulted in falsification of bed checks. This was reported to the CCC while on-site. The CCC number is 2016-05966.

#### **Exceptions:**

On two of the days reviewed, the check sheets documented bed checks being completed exactly every ten minutes throughout the entire night; however, when reviewing the video there was a two to three minute difference in the times documented throughout the night. The bed checks were not documented in real time.

On another night reviewed, the bed checks were documented every ten minutes throughout the entire night; however, when reviewing the video there were gaps of at least twenty minutes between some of the checks. Since the logs documented checks being completed every ten minutes, this resulted in falsification of bed checks. This was reported the CCC while on-site. The CCC number is 2016-05966.

### **3.07 Special Populations**

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy on Domestic Violence (DV) referrals called CINS/FINS Screening-Intake-Discharge Process. This policy documents that the agency serves youth referred from the JAC for DV charges. In addition, there is a Scope of Services document attached to the policy outlining the work with DV clients.

Embedded in this same policy on page 2 is a section that discusses Staff Secure youth.

There was no policy relating to serving youth on Probation Respite or Domestic Minor Sex Trafficking.

The agency has procedures embedded in the policy that relates specifically to the handling of DV referrals. The majority of the procedures are detailed in handling the referrals.

There were no specific procedures in handling Staff Secure, Probation Respite, or Domestic Minor Sex Trafficking youth. It only stated that the agency will accept these youth.

There were three DV files reviewed for compliance with the indicator. All three contained evidence that the youth was charged with DV and referred by the JAC or PO. In addition, there was evidence that the treatment plans reflected goals conducive to the presenting problem and that none of the youth stayed beyond twenty-one days. None of the youth reviewed needed to be transferred to an alternate funding source and were discharged appropriately.

For the time frame of this review the agency has not had any Probation Respite, Domestic Minor Sex Trafficking, or Staff Secure youth.

**Exception:**

The policy did not have specific procedures for working with Staff Secure, Probation Respite, or Domestic Minor Sex Trafficking youth.

**3.08 Video Surveillance System**

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place to address the requirements of a video surveillance system.

The agency recently installed a new video surveillance system. There are forty-eight cameras located throughout the campus. Each shelter has four cameras located inside the shelter. All the cameras are visible and there are no cameras located in the bathrooms or sleeping rooms. The system can capture and retain video photographic images including facial recognition. A review of the video surveillance system revealed

**the video does record the date, time, and location. The system stores video footage for thirty days. There is a back-up generator to ensure the cameras still record during a power outage. A supervisory review of video is conducted at least once every fourteen days and noted in a logbook. This a random review of shifts, including the overnight shifts. The agency has signs posted at the entrance of the campus stating that a video surveillance system is in use.**

**There were no exceptions to this indicator.**

## 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. 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 seven and a half months prior to the on-site Quality Improvement Review. 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, as well as, 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 June 8, 2016.

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. The form 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 five residential files reviewed. All five 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 policy in place that acts as a comprehensive plan outlining the agencies approach to working with youth in crisis as it relates to suicide prevention, mental health, healthcare, and substance abuse.

The noted plan is titled "Healthcare, Suicide, and Mental Health Services" and consists of ten pages. The procedures denote three tiers for screening youth at all risk levels and outlines the process for staff to place youth on watch and begin the log sheets. The procedures also denote the three levels of watch for the program: One to One, where a Baker Act assessment is being requested; Constant Sight and Sound, which requires constant supervision with a log notation every thirty minutes; and Elevated Supervision, which requires a log notation every ten minutes. Youth are assessed by clinical staff using the Suicide Assessment form and a determination is made at that point on how to move forward. The files that were reviewed reflected that all of the therapists were licensed. The program is under the supervision of a clinical director who has her PhD.

Upon intake a youth is assessed for suicide risk by utilizing the CINS/FINS Intake Assessment form. If the youth has any positive responses on the first six questions they are placed on Constant Sight and Sound until they can be seen by a therapist. The youth will be monitored by staff on a log denoted for Constant Sight and Sound every thirty minutes. The therapist will conduct a Suicide Assessment and determine whether to remove the youth from watch or place them on an elevated level which is monitored every ten minutes on a separate log sheet. Once the youth is assessed again, the therapist will again determine the next course of action and the youth is either maintained on sight and sound or removed completely. There is a sheet in the files notating the history of the youth's progression through this process. In addition, the program uses a red dot on the front of the file and a red sheet in the third section of the file denoting a youth at suicide risk.

Three files were reviewed and an interview was conducted with the Clinical Director of the program.

The first file reviewed documented the youth was screened and appropriately placed on suicide precautions at intake. The observation log in this file documented on one of the days there were no staff initials for a four hour period. On this same sheet there was no manager or designee signature. According to the last observation log, the youth was removed and placed on elevated supervision at 11:30 pm on 6/8/16; however, according to the note left by the therapist on the risk assessment summary, the youth was removed from Constant Sight and Sound Supervision and placed on Elevated Supervision at 12:45 pm on 6/8/16. This indicates the youth was left on Constant Sight and Sound

Supervision for an additional ten plus hours after having been stepped down. On the Elevated Supervision log sheet from 6/8/16 going into 6/9/16, there is a gap of time between 7:20 am and 8:30 am where there are no notations of checks. The final Elevated Supervision log sheet shows the youth being removed from this status on 6/11/16 at 6:50 pm; however, the risk summary sheet completed by the therapist shows that the youth was removed from Elevated Supervision on 6/11/16 at 2 pm, again indicating that the youth remained on elevated status, after having been removed, for an additional four plus hours.

The second file documented the youth was placed on Constant Sight and Sound supervision at intake. A Suicide Risk Assessment was initiated within twenty-four hours; however, it was never completed or signed. This youth was placed on Elevated supervision on 10/22/16 at 4:30 pm; however, the observation logs for Elevated supervision do not begin until 10/23/16 at 4 pm.

The third file documented the youth was screened at intake on 10/6/16 at 9 am and placed on Constant Sight and Sound supervision. This youth was not seen by a therapist until 10/7/16 at 11 am, which exceeds the twenty-four hour requirement.

#### Exceptions:

The observation log in one file documented on one of the days there were no staff initials for a four hour period. On this same sheet there was no manager or designee signature.

Another observation in this same file documented the youth was removed and placed on elevated supervision at 11:30 pm on 6/8/16; however, according to the note left by the therapist on the risk assessment summary, the youth was removed from Constant Sight and Sound Supervision and placed on Elevated Supervision at 12:45 pm on 6/8/16. This indicates the youth was left on Constant Sight and Sound Supervision for an additional ten plus hours after having been stepped down.

Another Elevated Supervision log sheet from 6/8/16 going into 6/9/16 documented a gap of time between 7:20 am and 8:30 am where there are no notations of checks.

The final Elevated Supervision log sheet shows the youth being removed from this status on 6/11/16 at 6:50 pm; however, the risk summary sheet completed by the therapist shows that the youth was removed from Elevated Supervision on 6/11/16 at 2 pm, again indicating that the youth remained on elevated status, after having been removed, for an additional four plus hours.

In another file a Suicide Risk Assessment was initiated within twenty-four hours; however, it was never completed or signed.

In this same file the youth was placed on Elevated supervision on 10/22/16 at 4:30 pm; however, the observation logs for Elevated supervision do not begin until 10/23/16 at 4 pm.

In the last file the youth was screened at intake on 10/6/16 at 9 am and placed on Constant Sight and Sound supervision. This youth was not seen by a therapist until 10/7/16 at 11 am, which exceeds the twenty-four hour requirement.

#### 4.03 Medications

Satisfactory

Limited

Failed

##### Rating Narrative

The agency has a policy in place for Medication Storage, Access, and Inventory that was last reviewed July 8, 2016.

The policy states that all medications are to be reviewed by the Registered Nurse (RN). Medications are to be stored in the Pyxis Med-station in the Medication Room. Medication access is limited to the RN, Residential Services Coordinator (RSC) and designated trained staff.

Medication inventories are counted at intake and discharge. Controlled substances are counted at the change of shift. This process is documented on the Controlled Substance Accountability Form and may only be modified by the nurse to reflect different shifts. Staff designated to have access to medications, at the end of their shift, will count medication in front of the designated staff coming on shift. Both will initial the accountability sheet. All prescription medications are kept on running count. This is documented on the Medication Distribution Log (MDL) by the nurse on a weekly basis or electronically by Pyxis. Over-the-counter (OTC) medication and the Inventory Supply list is checked on a weekly basis and documented on the Inventory Supplies Form by the nurse.

The agency also has detailed procedures in place for Medication Refusal, Return Waste, and Discovered. There are procedures in place for Medication Errors, Medication Changes, Medication Reports, Infectious Outbreaks, and Medication Education.

The agency provided a list of staff who are trained to supervise the self-administration of medications. There were twenty staff on that list. There were two staff and the Nurses listed as the Primary staff for distributing medications. The Residential Service Coordinators (RSC) are the Secondary staff, with four listed. And the remainder of the list were Child Care Specialist IIs who were trained to distribute medications whenever a RN or RSC is not available to distribute the medications. The two RN's are listed as the Super Users of the Pyxis Med-Station.

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. There is an RN on-site Monday through Friday from 6:00am till 8:00pm. There is also an on-call schedule, so an RN can be contacted and come in if needed during overnight hours or weekends. Direct care staff are responsible for distributing medications on the weekends.

The RNs train all staff two times a year on the medication administration process, using the Pyxis Med-Station, and also CPR refresher. This training lasts four to five hours each time. In addition, the RNs train all newly hired staff on the medication administration process and CPR/first aid.

At the time of the on-site review, the shelter had been using the Pyxis Med-Station for

approximately seven and a half months. All medication is stored in the Pyxis Med-Station, including over-the-counter (OTC) medications which are stored in the bottom two bins of the Med-Station. If an RN is on-site they will verify all new medications with the parent at admission and then enter the medication into the Pyxis Med-Station. If an RN is not on-site when a new youth is admitted to the shelter with medication the RSC will verify the medication and then enter it into the Pyxis Med-Station.

The RN reported there have been no major discrepancies with the Pyxis Med-Station. There have been minor discrepancies, mainly involving staff entering the wrong number when inventorying medications. These discrepancies were easily fixed and cleared out within twenty-four hours.

The RNs complete a weekly inventory of all medications on-site every Monday. An RN along with a staff complete the shift-to-shift inventories of controlled medications both shifts Monday through Friday. On the weekends, the direct care staff are responsible for doing the shift-to-shift inventories with another staff member. There was inconsistent documentation of these shift-to-shift inventories being documented over the weekends. An inventory of the medication is completed every time it is given and a perpetual inventory is maintained. Hard copies of all inventories are maintained in a binder in the medication room.

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.

The RNs print-out or save several reports from the Knowledge Portal. A Discrepancy Audit Detail report and an All Profile Overrides report is printed out and reviewed every week. A Summary by Transaction Type report is saved to the CareFusion database monthly. Due to how large this report is the agency has chosen to save this report instead of printing it each month. Instead an Inventory report is printed out each week for all medication in the Pyxis Med-Station.

There were two youth in the shelter currently on medications. These files as well as three additional closed files were reviewed to verify the medication administration process. The youth's Medication Distribution Record (MDR) is maintained in the youth's individual file after release. For the current youth, the MDR is maintained in a binder in the medication room. 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's 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, involving a youth not receiving a prescribed medication or receiving a wrong dosage of a medication, in the last six months.

**Exception:**

There was inconsistent documentation of shift-to-shift inventories of controlled medications being completed on the weekend shifts when no RN is present.

**4.04 Medical/Mental Health Alert Process**

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy in place for the Mental Health Communication Alert Process. The policy was last reviewed on March 1, 2014.

The program has a color dot system that is used to communicate alerts with red indicating suicidal/mental health issues, blue indicating medical/substance abuse issues, and yellow indicating behavioral issues. Dots appear next to the youth's name on the client boards, corresponding color stickers are placed on the front of the youth's file, and corresponding color sheets are placed inside the youth's file.

There were five youth files reviewed, two open and three closed. All alerts identified during the intake and screening process were documented on the applicable color-coded sheets inside the youth's file. These alerts also corresponded with alerts documented on the alert board in the staff command center, which all staff review when coming onto shift.

However, the color-coded dots documented on the front of the youth's file did not always correspond with the alert sheets located inside the file and the alert board. Staff reported this was because the same file is used each time the youth is admitted to the shelter. So the alert dots on the front of the file represent the youth's first initial stay in the shelter and not necessarily the current stay.

Out of the five files reviewed, two of the files had alerts on the front of the file that did not correspond to alerts located inside the file. Both of these youth had previously been admitted to the shelter so those alerts reflected the previous admission. It was noted that the alert board in the staff command center and the color-coded sheets inside the youth's file were accurate and only documented the youth's current alerts.

Out of the five files reviewed, two of the files had alerts on the front of the file that did not correspond to alerts located inside the file.

**4.05 Episodic/Emergency Care**

Satisfactory

Limited

Failed

Rating Narrative

The agency has 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 nine 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.

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 to replenish items as needed. In addition, each first aid kit is replaced at the beginning of every month. 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.

A review of training files revealed staff are trained on emergency medical procedures annually.

There were no exceptions to this indicator.