



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Hillsborough County

on 04/04/2018

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	Satisfactory
3.07 Special Populations	Satisfactory
3.08 Video Surveillance System	Satisfactory

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

Standard 2: Intervention and Case Management

2.01 Screening and Intake	Satisfactory
2.02 Needs Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management and Service Delivery	Satisfactory
2.05 Counseling Services	Limited
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	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%

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

Marcia Tavares, Lead Reviewer, Consultant Forefront LLC

Mary Joyce Ackerman, Case Manager, Thaise Educational and Exposure Tours Inc.

Diane Lindsay, Program Manager, Tampa Housing Authority

Stephanie Lobzun, Regional Monitor, Department of Juvenile Justice

Joe Mabry, Residential Supervisor, Family Resources St. Petersburg



Constance Shaw, Navigator, Bethel Community Foundation Inc.

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 type="checkbox"/> Program Manager |
| <input checked="" type="checkbox"/> Program Coordinator | <input checked="" type="checkbox"/> Direct- Care Full time | <input type="checkbox"/> Direct-Care Part Time |
| <input type="checkbox"/> Direct-Care On- Call | <input type="checkbox"/> Volunteer | <input type="checkbox"/> Intern |
| <input checked="" type="checkbox"/> Clinical Director | <input 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 | | |
| 0 Case Managers | 0 Maintenance Personnel | 0 Clinical Staff |
| 0 Program Supervisors | 0 Food Service Personnel | 0 Other |
| 0 Health Care Staff | | |

Documents Reviewed

- | | | |
|---|--|--|
| <input type="checkbox"/> Accreditation Reports | <input checked="" type="checkbox"/> Fire Prevention Plan | <input 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 | 3 # 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 | 48 # Personnel Records |
| <input type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 4 # Training Records |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 12 # Youth Records (Closed) |
| <input checked="" type="checkbox"/> Fire Inspection Report | <input type="checkbox"/> Telephone Logs | 5 # Youth Records (Open) |
| <input type="checkbox"/> Exposure Control Plan | <input checked="" type="checkbox"/> Supplemental Contracts | 0 # Other |

Surveys

3 Youth 3 Direct Care Staff

Observations During Review

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

Comments

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

Rating Narrative

Strengths and Innovative Approaches

Rating Narrative

Hillsborough County Department of Children Services manages a wide range of residential and non-residential services for at-risk children and parents, Head Start, the Child Care Licensing office and Parent Education classes. For emotionally handicapped youth, there are day care and residential treatment services designed to modify the behavior of emotionally dysfunctional children. The CINS/FINS program for runaway and ungovernable children and their families, offers counseling services to reunite families and prevent runaway behavior, as well as short-term residential respite and shelter. Emergency shelter care is available for dependent, abused, or neglected children. For long-term foster care of adolescent females, there is a pre-independent living group home program. Additionally, there are training classes for parents to improve parenting skills.

The following is a list of program highlights demonstrating the provider's endeavors and accomplishments during the past year:

- The Department of Children's Services is participating in a system of care study to establish an effective standard of care in the County. It is the goal of the Department of Children's Services (DCS) to be more effective and more efficient in providing services to youth and families.
- The Department of Children's Services (DCS) was invited for the third year to serve as education learning lab for the University of South Florida's Institute of Translational Research Masters and Doctorate level scholars. The scholars assist the DCS in developing programs and systems that enhance its effectiveness in working with adolescents. Two scholars from the program will be on-site this summer.
- The two nurses as members of the Florida Public Health Association (FPHA), Harden both wrote an essay for the FPHA quarterly newsletter and attended a luncheon with the FPHA chair members on January 18th.
- The provider hired a new Treatment Counselor as the Independent Living and Transitional Specialist. The new staff developed a formalized independent living program which provides information and experiential learning opportunities to all of the foster care youth who enter the program. Curriculums have been developed for youth ages 12 to 13, 14 to 15, and 16 to 17. The formalized Independent Living Program together with the After Care Program and other clinical services has provided the youth being served on the campus with a seamless system of care.
- The new Senior Treatment Counselor is a LCSW who will assist with supervision and oversight duties for both the CINS/FINS and Foster Care Programs.
- Another new Treatment Counselor will be the CINS/FINS non-residential therapist serving the Brandon area.
- Staff and youth are harvesting produce from the Hydroponic Garden. The harvested produce will be incorporated in culinary training by Dining Services. Each cottage has been introduced in how to care and cultivate the garden.
- 3 Staff were trained as Residential Child and Youth Care Professionals resulting in (5) Trained Instructors for Children's Services.
- Conservation LED lighting conversions for the campus gym and cottages D-F have been completed.

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 for 20 beds (12 beds for CINS/FINS) by the Department of Children and Families effective through July 31, 2018. Another shelter houses foster care youth and is licensed for 30 beds, also effective through July 31, 2018. The agency's administrative offices and youth shelters are housed in buildings located on a beautiful, large campus.

The provider is in the process of restructuring and has designated leadership and management of the CINS/FINS program to the Clinical Director. The Director oversees both the clinical and residential component; the latter is under the supervision of a Manager of Youth Program Operation (MYPO). The MYPO supervises 3 Residential Services Coordinator (RSC), 24 Senior Child Care Specialists, and 26 Child Care Specialists. The clinical component consists of 3 Senior Treatment Counselors, 6 Residential Treatment Counselors, 6 Non-residential Treatment Counselors, 2 RGC Treatment Counselors, 2 Case Managers, 1 Education Advocate, and 2 registered nurses.

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.

During the QI review, it was observed that the Department of Children's Services policies and procedures do not have signatures of approval, just effective dates, review dates and expiration dates. The provider indicated that the Department of Children's Services is responsible for establishing and revising policies and procedures which are submitted to the QI Committee prior to approval.

1.01 Background Screening

Satisfactory
 Limited
 Failed

Rating Narrative

The agency has written policies and procedures in place for background screening to address all the key elements of this indicator. Policy Section 04.07.02.01.03.05 addresses the screening of volunteer, mentors, and interns and Section 2, policy 12 addresses the screening of employees. The policies were last reviewed in March 2014.

The agency's policy and procedure for background screening is conducted for all department employees, contracted provider, and volunteers, mentors, or interns with access to youth. The background screen is completed prior to hiring staff or utilizing the services of a volunteer, mentors, or intern. All employees and volunteers working in direct and continuing contact with youth undergo a Level II live scan background screening and are re-screened every five years. All employees must also complete a drug test, local law enforcement, and driver's license check prior to hire. The annual Affidavit of Compliance with Good Moral Character Standards (form IG/BSU-006) is completed by the program annually and sent to the DJJ Background Screening Unit by January 31st of each year.

A total of thirty-six new employees and twelve five-year re-screenings completed by the provider since the QI visit were reviewed. All thirty-six new employees had completed background screenings with an eligible rating prior to their hire date. The twelve five-year re-screened employees had completed successful five-year re-screenings on time prior to their five-year cycle anniversary dates. There were no eligible volunteers who provided service during the review period.

The provider completed and submitted its annual Affidavit of Compliance with Good Moral Character Standards (form IG/BSU-006) to the DJJ Background Screening Unit on January 17, 2018.

No exceptions noted.

1.02 Provision of an Abuse Free Environment

Satisfactory
 Limited
 Failed

Rating Narrative

The Agency has several policies in place for the provision of an abuse free environment: Youth Protection (Section 04.07.02.01.06.03); Neglect or Abuse of Clients (Section 04.07.02.01.06.02); Rights and Responsibilities (Section 04.07.02.01.06.21); Client Grievance Process (Section 04.07.02.01.06.07); Abuse Reporting (Section 04.07.02.01.06.18); and Reporting Child Abuse (Section 04.07.02.01.06.43). The policies were last reviewed on March 1, 2014.

The policy and procedure for neglect or abuse requires all program staff to adhere 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 Statute, is to report such knowledge to the Florida Abuse Hotline. Upon hire, new staff is required to sign acknowledgement of receipt of the agency's neglect or abuse policy. All staff receives orientation training that covers staff expectations and conduct as well as child abuse training. It is the General Manager II or designee's responsibility to take immediate action and investigate any incidents of abuse and/or excessive use of force. All incidents of suspected neglect or abuse will be reported to the abuse hotline and CCC as applicable. Documentation of calls made to the hotline will be maintained and noted in the progress notes for applicable youth. Youth also receive information about their rights and responsibilities, including right to report an abuse and file grievances during intake. The program has an accessible and responsive grievance process for all youth to provide feedback and address complaints, and take immediate action to address incidents of abuse, abandonment, or neglect. The agency has procedure for clients to address complaints and make grievance forms and boxes accessible to youth.

The agency provided an example of staff acknowledging the code of conduct and employee handbook. Upon request, the HR Administrative Assistant provided documentation of disciplinary action taken against 2 staff due to their conduct/ behavior towards youth.

During the tour of the facility, the abuse hotline numbers were observed to be posted in the clients' living area. Reviewer identified 2 residential youth whose progress notes indicated the abuse hotline was called due to allegation of non-institutional abuse. The Clinical Director also provided CCC incident reports documenting calls made for 2 non-residential youth regarding allegations of abuse. The Director also stated that the agency has a database for documenting calls made to the abuse hotline and CCC for residential clients; however, upon initial review, the database only listed calls related to foster care youth.

Twelve (12) grievances reported during the review period were reviewed (6 against staff, 4 against other youth, and 1 about food served). All were resolved in a timely manner and resolution was acknowledged by the youth.

The three youth surveyed indicated knowledge about the abuse hotline number and location of the number in the facility. Per the responses, none of the three youth were stopped from calling the abuse hotline and two of the three youth stated they made attempts to call the hotline. The two staff surveyed acknowledged receiving training on child abuse reporting and have made calls to the Florida Abuse Hotline.

Exceptions:

As required by QI indicator 1.02, the provider's current grievance policy does not state that direct care staff should not handle complaint/grievance documents, unless assistance is requested by the youth.

The program does not appear to have a system in place to track all of the abuse hotline calls made for CINS/FINS youth.

1.03 Incident Reporting

Satisfactory

Limited

Failed

Rating Narrative

The agency policy includes sub-policies entitled "Reporting to the Central Communications Center" (Section 04.07.02.01.06.85) and "Incident Report" (matches DJJ standard # 1.03). The first sub-policy was effective 8/13/2012 and reviewed 3/1/2014 and the second sub-policy was effective 3/1/2012 and reviewed 3/2/2014. There is no documentation reflecting the person who last reviewed the policy. The first sub-policy states that any severe or serious incident that involves the staff and/or clients of the Child & Family Counseling Program is to be reported to the Central Communications Center (CCC) of the Department of Juvenile Justice (DJJ). All reportable incidents will be called in within two (2) hours of their occurrence even if all information is not available. A definition was provided as what would be characterized as a reportable incident and the CCC information was outlined. The second sub-policy states that the purpose is to report all pertinent information concerning any unusual incident involving their clients or staff and to assure appropriate review of all such incidents to afford appropriate and necessary proactive corrective action in an effort to prevent future recurrences.

Under the CCC policy, all reportable incidents will be made to the CCC within (2) hours of the incident by the manager or shift leader or within (2) hours of the affected facility, office or program learning of the incident. All incidents are to be made by telephone unless additional information is requested by the CCC duty officer via fax or email. If it is not possible for staff to adhere to the (2) hour time frame, the personnel in charge will provide an explanation to the CCC duty officer. An additional list of reportable incidents was documented including suicide attempts, life threatening/endangering injury, and employee arrests.

Under the Incident Report policy, it states that is the responsibility of the Department employee who first becomes aware of the incident must complete the incident report on all observed or reportable incidents. Other staff who are present or who have knowledge of the incident will complete a report. All incident reports are to be properly completed and documented by the end of their work shift or prior to leaving the facility. These reports are to be immediately forwarded to the supervisor for review and investigation, if warranted. Incidents should be referenced in the program log and a copy of the incident report placed in the Incident Report Logbook. The client(s) involved or witnessing the incident may be requested to independently write a statement about the incident. They are to do this without staff or other client input or assistance. These statements shall be included with all staff reports. The supervisor on duty will then complete a Supervisory Summary Report on all incidents involving: injury to client or staff requiring medical attention; anytime law enforcement is called; destruction of property; sexual acting out; and suicidal gesturing or attempts. The Clinical Director or on-call Treatment Counselor should be contacted. A sample Incident Report, Manager Summary, and CCC Call-In Log was provided for review.

The incident reports reviewed from October 2017 to date, and the corresponding forms, were completed providing details of the incidents. In the review of internal incidents, it was not found that any non-reported incidents should have been reported to the CCC. A total of 26 calls were reported and accepted by CCC during the review period. Of the 26 calls, 7 were medically related, 13 were for absconded youth, 5 were related to program disruption, and 1 was due to youth's behavior. Twenty-three of the 26 calls were reported during the 2 hour timeframe.

The logbooks and CCC reports reflected follow-up communication with CCC via email when additional information was needed or when representatives requested status updates regarding a youth. The staff documents the incidents in the program logs which are kept at the command center. All incidents are documented on the incident reporting forms and reflect being reviewed and signed by the Clinical Director.

Exception:

Three of the 26 CCC calls for the review period were not reported during the 2 hour timeframe for the following dates: 10/17/17 incident was reported on 10/19/17; 10/31/17 abscond incident; and 2/1/18 abscond incident.

1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

The agency policy included three separate sub-policies entitled, "Supervisory Training – Section 04.07.02.01.01.11", "Required Staff Training – Section 04.07.02.01.01.09", and "Training Coordinator – Section 04.07.02.01.01.08". The effective date of the policy is 3/1/2012 and was reviewed 3/1/2014. The reviewer was not documented on the policy document.

The procedure reflects that all CINS/FINS employees must complete (80) hours of training during their first year of service including the following. In addition, all personnel must have a minimum of forty (40) hours of staff development training each calendar year. Mandatory training includes:

1. County Orientation
2. Suicide Prevention and Suicide Awareness
3. Positive Behavior Management
4. Non-Abusive Psychological & Physical Intervention (NAPPI)
5. Cognitive Stages of Child & Adolescent
6. Identification of a & Reporting Abuse
7. Substance Abuse Prevention/Signs & Symptoms of Mental Health and Substance Abuse Issues including dual diagnosis
8. Core Training/CINS-FINS CORE Training

A total of (4) staff training files/binders were reviewed, including an outpatient clinical staff, two (2) senior child care specialists, and a clinical residential staff member who was hired since the last review. For one (1) of the staff training files (the clinical residential employee), documentation/sign-in sheets was not found indicating that the Program Orientation was not completed within the first 120 days. The Training Coordinator informed peer reviewer that it was discovered that this training was missed and it was completed during the QI review on 4/5/18. The Training Coordinator explained that emergency procedures take place with the Program Orientation and occurs every June in preparation for hurricane season. The Training Coordinator explained that all direct care staff receives the NAPPI training which satisfies the Managing Aggressive Behavior and Behavior Management indicators. The employees learn how to formulate positive relationships with the youth, intervention skills, and de-escalation techniques. A copy of the youth's point sheet which reflects how they earn points on each level (i.e. waking up on time, completing their chores) was placed in the training binders to reflect the Behavior Management training. One of the staff did not complete the Youth Development training although they completed other training including working with foster children and trauma-informed care. Two of the four staff exceeded the 80 hours of training required annually and the other two staff were on target for completing the hours required.

The training binders were neatly maintained inclusive of a tracking sheet of all trainings, certificates of completions, pre/post-tests, and other proof of completion. The employee's training binders reflect that they are meeting their training hours requirement.

Exceptions:

The policy does not reflect all of the training requirements including the Confidentiality and Universal Precautions trainings within (120) days of hire and other trainings within the first year of employment inclusive of the DJJ-SkillPro Learning Management trainings.

One of the first year direct care staff (DOH 6/26/17) had not yet completed Understanding Youth Development training that is required during the first 120 days of hire.

Consultation forms between clinical director and clinical residential staff member was reviewed but documentation that (20) hours of training and supervised experience in assessing suicide risk was not found. Clinical Director indicated that she was not aware of the policy.

1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place (Section: 04.07.02.01.01.0) for Quality Improvement Process that describes procedures for analyzing and reporting information to address all of the key elements of this indicator. The policy was last reviewed on March 1, 2017. In addition to the policy and procedure, the agency has a Quality Improvement Plan (QIP) dated 12/1/2014.

The agency's QIP includes procedures and guidelines for collecting and reviewing several sources of information to identify patterns and trends to include monthly, quarterly, and annually reports. There is an established protocol and structure in place to ensure implementation of the agency's policies and procedures. Data is collected regularly and the results are evaluated 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.

A review of the agency's current QIP was conducted during the QI review. The plan outlines the responsibility of the management team, QI Coordinator, QI Committees, and QI Workgroups in the collection, review, and analysis of QI data to determine compliance with established standards. Per the QIP, specific workgroups are established for the following activities: monthly peer review; safety and risk management; personnel and staff development; and outcomes (including analysis of satisfaction surveys).

Email documentation was provided to support some peer reviews are being conducted. Per interview with the Senior Treatment Counselor, each week the residential program completes an average of 5 and the non-residential program completes an average of 10 peer record reviews. The results of the peer reviews are discussed at Meeting of the Minds held with the clinical staff. Besides the email correspondence, there was no formal documentation of the total number of peer records reviewed monthly/quarterly or documentation of corrective actions or trends identified as a result of the peer reviews.

The program maintains a graphical report of incident/accident data that is collected monthly. Two reports were provided for review: 1) year-end incident report for January-December 2017, and 2) current FY to date incident reports (October 2017- March 2018). The report documents the number of incidents occurring daily/monthly and types of incidents by program. Incident analysis reports are provided to management every two weeks and to the advisory board on a monthly basis. Trends are discussed at the management team meetings. Grievance data is collected and documented on the agency's Success Scoreboard on a quarterly basis.

The program administers client satisfaction surveys on an annual basis and maintains information of the satisfaction rate in the satisfaction results section of the Success Scoreboard. A copy of the Score Board for the FY October 2017-present was provided for review showing 85% satisfaction.

Program outcomes/service utilization is monitored by management and reported annually on the Division of Children and Youth Services QI Outcome Measure Summary. The current FY-to-date report was reviewed and supported collection of outcomes data quarterly for the CINS/FINS program.

NetMIS data reports received from the Florida Network are sent to the agency's ED and Clinical Director and is posted in the Administration office. The reports are reviewed at clinical staff meetings.

The provider conducts monthly management team meetings and maintains minutes that support communication of analysis of data collected and findings with management. Similar meetings were not observed to be held frequently with direct care staff.

Exceptions:

There were no formal aggregated reports maintained for peer record reviews.

Although there is evidence of discussion of some of the data collected among management, staff meetings with direct care staff were not regularly conducted to include communication of findings with staff.

1.06 Client Transportation

Satisfactory

Limited

Failed

Rating Narrative

The agency has a Client Transportation policy that was made effective 3/1/12 and last reviewed 3/1/16. However, there is no documented

signature of the person who reviewed the policy.

The procedures of this standard include but were not limited to the following:

1. Vehicles will be operated in a safe manner at all times and obey all traffic laws.
2. All vehicles transporting clients will be equipped with a fire extinguisher and a first aid kit.
3. Drivers must be approved by the Division to drive client(s) in Division approved vehicles.

The procedures reflect that staff should avoid situations that put youth or staff in danger or real or perceived harm, or allegations of inappropriate conduct by either staff or youth. They indicated that the best practice is to have a 3rd party in the vehicle for prevention of any of the above mentioned events. The procedure documented that the supervisor or managerial personnel would consider the clients' history, evaluation, and recent behavior if a 3rd party is not available to transport and they would provide their approval for a single transport.

The agency's Program Administrative Assistant/Personnel Specialist stated that under Hillsborough County the staff is covered under a Self-Insured policy. A copy of the certificate was provided for review. Twice a year (May and November), driver's license checks are completed for all staff. As for new staff, the driver's license report is reviewed the prior (3) years and there must be no more than (7) points on their record for the staff to be an eligible driver. There may be a review if the staff acquires points during their employment. According to the Resident Services Coordinator, all staff is approved to utilize the agency vehicles. Everyone is required to attend AAA training for vehicular safety.

The vehicle logs were reviewed. Some information was found to be missing on some of the log entries (i.e. full date including year, odometer readings, time in/out); however, the forms included all of the required elements of the indicator. The Resident Services Coordinator confirmed that there are (8) vehicles in the fleet and the logs were not being properly maintained under a former staff member that resulted in the incomplete documentation. However, measures are being taken to remedy the above mentioned issue.

Exception:

There were log entries reviewed that did not consistently document all of the necessary information such as full date including year, odometer readings, and time in/out.

1.07 Outreach Services

Satisfactory

Limited

Failed

Rating Narrative

The agency policy (Section 04.07.02.01.04.02) was made effective 3/1/2012 and has a review date of 3/1/2014. The goal is to increase public awareness of the needs of the troubled youth in Hillsborough County who are at-risk of running away, becoming habitually truant, or who are beyond the control of their parents or guardians. The policy document did not indicate who authorized the last policy review.

The agency will provide outreach information, referrals and services to community members and stakeholders. They will attend and participate in community committees, workgroups and planning teams focused on youth issues and needs, which may include, but is not limited to:

- Juvenile Justice Board and Executive Board
- Juvenile Justice Task Force
- Local Planning Team
- Case Staffing Committee and truancy reduction groups
- Florida Network Resource and Planning Committee

Per the Clinical Director, outreach is mainly completed by the community based staff and the senior program coordinator (Safe Place). However, other staff members participate in the outreach in providing information about the agency services and attending community meetings. The agency's outreach binder was reviewed which reflected regular attendance at the Juvenile Justice Executive Circuit Advisory Board and DJJ Public Advisory Board Meetings held every other month, respectively. Agendas, brochures, notes and flyers gathered from the meetings were reviewed. A NetMIS report was reviewed which reflected from 4/30/17 – 4/30/18 all of the outreach that was completed in the community. Some included visits to local schools, community centers, mental health centers, fire departments, and other community partners. Several outreach forms were presented to show future scheduled outreach events including a university match-up event, resource fair and family fun day. The agency provided a copy of a flyer that advertised their recent community fair that occurred in March which hosted community agencies and had almost (400) attendees. They provided a binder with a spreadsheet which listed community partners and copies of their interagency agreements. Some of the interagency agreements include colleges & universities, a hospital's mobile unit, and a church. A recent agreement was signed November 2017 which allows the agency to use an office at the location in the community to provide CINS/FINS services.

There are 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 Services to eligible youth in Hillsborough County. The CINS/FINS Screening –Intake Discharge Process has an Effective Date of 3/1/2012 and a Review Date of 3/1/2014.

Hillsborough County has an eleven-page document that has detailed procedures for Screening for both Shelter and Non-Residential. The policy outlines the screening process which determines eligibility and identifies the youth's presenting issues, legal status, a threat to him/herself or others, medical issues, and other pertinent demographic information.

Three residential files were reviewed for one open and two closed files. All three residential files included the screening and intake form completed within the required time frames. All files contained information regarding the presenting issue and eligibility for services, Rights and Responsibilities of youth and parents/guardians, parent and/or guardian brochure, and the grievance process.

Three non-residential files were viewed for 2 closed and 1 is open file. All three non-residential files included the eligibility screening within 7 calendar days of referral.

Three youth and parent/guardians received the following in writing: available service options, right and responsibilities of youth and parents/guardians and the parent/ guardian brochures.

Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, and CINS adjudication) are included in the parent brochure provided to all 6 parent/guardian.

No exceptions to this indicator.

2.02 Needs Assessment

Satisfactory
 Limited
 Failed

Rating Narrative

The agency has a Policy and Procedure in place regarding the Needs Assessment for Shelter and Non-Residential Services. The Policy and Procedure was last reviewed on June 8, 2016 and is a 5-page document.

The Policy and Procedure outlines the process for youth and families to engage in appropriate services. The criteria that is to be followed by the other programs includes time frames for the Needs Assessment and all other needed Assessments and Staff levels. For residential youth, the Needs Assessment is initiated within 72 hours.

Non-Residential staff can meet with the client and family more than one session to complete the Needs Assessment but tries to complete it within the first three face-to-face contacts. 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.

There were three residential files reviewed for one open and two closed files. The Needs Assessment was initiated within the 72 hour time frame in all three residential files reviewed and was conducted by a Masters level staff and signed by a Supervisor.

Two of the three files were identified with suicide alerts and completed Suicide Risk Assessments were completed.

Three non-residential files were viewed for 2 closed and 1 open file. The Needs Assessment was initiated within 2 to 3 face to face contacts after the initial intake in the three youth files that includes a supervisor's review signature upon completion. The three youth files have Needs Assessments that were conducted by a Bachelor or Masters level staff. One youth was identified with an elevated suicide risk and the youth was referred for an assessment of suicide risk conducted by a licensed mental health professional.

There were no exceptions to this indicator.

2.03 Case/Service Plan

Satisfactory

Limited

Failed

Rating Narrative

The agency has Policies and Procedures in place for the development of the Service Plan, and was reviewed on June 8, 2016.

The procedures indicate that the Service Plan is to be conducted by a qualified professional staff on each youth and/or family participating in services and is initiated (or attempted) within 72 hours of admission for Shelter care youths. Non-Residential Case Plans are to be completed within two to three face-to-face contacts following the initial intake. The Service Plans are created with the participation of the youth and parents/guardian. The Service Plan development is consistent with both residential and non-residential youth and is in compliance with the agency's policies and procedures.

There were three residential files reviewed for one open and two closed files. The Case Plans are developed within a timely manner and are in compliance, with the exception of one file reviewed. The one closed file did not have the Initial Case Plan (Individualized Treatment Plan) completed at time of Intake. The other two files reviewed had completed Case Plans in the specified time frame.

Three non-residential files were viewed for 2 closed and 1 is open file. Three non-residential youth files had Case Plans implemented within 7 working days of the completion of the Needs Assessment. The three case/service plans included Individualized and prioritized needs and goals identified by the Needs Assessment. Two of the three case plans were signed by all parties including the youth, parent, counselor, and supervisor.

The program's case plan used includes all of the required elements of the indicator as follows: service type, frequency, and location of services; persons responsible; target and completion dates; signature of youth, parent, counselor, and supervisor; and date the plan was initiated.

Three applicable youth files have reviews for progress/revised by counselor and parent every 30 days for the first three months.

Exceptions:

One of the residential files did not have the signature of the parent or guardian. There was no case note or indication on the plan as to why the parent's signature was not obtained.

On one of the three residential files reviewed, there was a blank Initial Treatment Plan form not completed at the Initial Intake by the Intake Staff but a treatment Plan was completed by the Youth's Counselor at their first meeting.

The parent did not sign the case plan in one of the three non-residential cases reviewed. Reviewer was informed by the LCSW supervisor that the parent was present for the meeting with the counselor but did not sign the case plan because her child was not present.

2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

Rating Narrative

The agency has a clearly defined Case Management and Service Delivery policy that was last reviewed 3/1/2018.

The provider will provide case management services for each youth and family admitted to the program. Per the procedures, each youth will receive a minimum of 30 minutes of case management activity a week. Services included are: an assigned Counselor, development of the Service Plan and providing the services appropriately needed to assist the youth and their family such as coordination of services with schools, law enforcement, judicial system, and community agencies. Prior to discharge, families will be given referrals for additional services as needed.

Three Residential files were reviewed for one open and two closed files. Each file had an assigned Counselor who completed the Needs Assessment and developed the Service Plan. The initial contact is made by the Counselor and is noted in the youth's file and is completed within the appropriate time frames. Service Delivery is conducted once the Service Plan is completed. Youth and family received appropriate referrals according to needs identified on the Service Plan. The service delivery involves meeting with the youth and families and attending Judicial Court hearings and any other case management needed.

Three non-residential files were viewed for 2 closed and 1 open file. Three non-residential youth files were assigned a counselor/case manager. Two applicable youth had established referral needs and referrals to services were coordinated based upon the ongoing assessment of the youth/family problems. There was demonstrated coordination of service plan implementation, monitoring of youth/family progress in services, and provision of support for families in the three files reviewed. None of the three youth needed out of home placement or referrals to the case staffing. One of the youth was referred for additional services. One youth file provided case termination notes and two youth files provided follow up 30 days of exit.

There were no exceptions for this indicator.

2.05 Counseling Services

Satisfactory

Limited

Failed

Rating Narrative

The Agency has policies and procedures in place for Individual and Family Counseling Services that was last reviewed 3/1/2018. The agency also has a policy and procedures in place outlining the process for group counseling and health education. The policy was last reviewed on March 2, 2016.

The procedure states that the staff is responsible for meeting with clients and families for progress in improving their goals. Staff have specific time frames and specific number of times they meet to interact and engage the youth and family in services before the case is closed. The policy indicates the program will conduct group session at a minimum of five days per week. The program will use four different type of groups – focus, didactic, therapy and structured, to assist youth in identifying problems and gaining insight into the relationships between their behaviors and attitudes, in getting control of their behaviors, and developing social skills. A child care staff will be assigned as the primary group leader and will be responsible for group planning and ensure appropriate service delivery. Health education will also be provided in a group session and includes topics to include prevention of communicable diseases, alcohol use, nicotine use, and substance abuse.

Three residential files were reviewed for one open and two closed files. The three files reviewed included documentation of individual/family counseling. None of the youth had group counseling sessions. The youth's specific needs and issues were addressed during the allotted individual counseling sessions. Case notes indicated the individual session topic and the sessions were well documented. The Agency's Supervisor signed all of the applicable forms indicating that services were provided.

Three non-residential files were viewed for 2 closed and 1 open file. The three youth files are addressed presenting problems in the Needs Assessment, Initial case/service plan and case/service plan reviews. Case notes were maintained for all counseling services provided and documented the youth's progress. All three youth files showed an ongoing internal process that ensured clinical reviews of case records and staff performance. There was documentation in the files that the youth and families received counseling services in accordance with the case/service plan including individual/family counseling.

A review of the program's activity schedule does not indicate the specific date and times group sessions are taught; however, an interview with the training coordinator indicated group sessions are held during house meetings, which is indicated on the program's activity schedule between 6:15 p.m. and 7:00 p.m. A review of the program's log books and a group calendar indicate youth are receiving groups daily. A review of group curricula indicates the program conducts Young Men's Group with the boys at the program. There was documentation to support the class occurred six times during the review period.

The program child care staff conduct group sessions based on the seven dimensions of health and wellness daily. The staff put together a monthly calendar indicating what life skill will be taught that day of the month; however, there was a lack of documentation to support the child

care staff were conducting the classes because they were not consistently completing sign-in sheets. A review of documentation confirms nursing staff are consistently providing monthly health education groups to the youth on topics such as diets, nutrition, substance abuse, nicotine, hygiene, sex education, weather appropriate clothing, and wound cleaning.

Exception:

There was a lack of documentation to support the child care staff were conducting groups at least five days a week due to the lack of sign-in sheets for the groups conducted. For example, for March 2018 the staff put out a calendar indicating a group was going to occur every day for thirty-one days; however, there were only five sign-in sheets reflecting groups occurred in the month.

2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

Rating Narrative

The policy is currently comprised of (5) different sub-policies that are currently being reviewed for approval. They are as follows:

- Case Staffing Revised and Reviewed Service Plans (Section 04.07.02.01.06.77) – effective date is 3/1/2018 and scheduled to be reviewed on 3/1/2021 – The Case Staffing Committee will provide the child and family with a new or revised plan for service that shall contain goals and objectives determined with the client and family.
- Case Staffing Committee (Supercedes 1/23/07, 3/2012, 8/2016) – effective date is 3/1/2018 and scheduled to be reviewed 3/1/2020 – The Hillsborough County Case Staffing Committee is the standing committee. The committee members consist of a representative from the Department of Children Services, Child and Family Counseling Program, the Child in Need of Services and Family in Need of Services contract provider for Department of Juvenile Justice, and a representative from the school district of Hillsborough County School District. Each representative should be present at all case staffings. In truancy cases, a representative from the school, often the school social worker, is in attendance.
- Scheduling/Arranging Case Staffing Meetings for the Family (Section 04.07.02.01.06.76) – effective date is 3/1/2018 and scheduled to be reviewed on 3/1/2020 – The Case Staffing Committee is a standing committee scheduled to meet once a month on the second Tuesday at 9am at the Department of Children's Services Administration located at 3191 Clay Magnum Lane, Tampa, FL 33618.
- Notifying Child/Family of Recommendations Made by the Case Staffing Committee – effective date is 3/1/2018 and is scheduled to be reviewed on 3/1/2021 – The committee will provide the parent(s)/guardian with a written report outlining the recommendations and the reasons for the committee recommendations within (7) days of the case staffing meeting.
- Referrals Made to CINS/FINS – Case Staffing Process – effective date is 3/1/2018 and is scheduled to be reviewed on 3/1/2021 – The CINS/FINS provider shall be responsible for addressing habitual truancy, lockout youth from his or her home, ungovernable and runaway youth when all other services have been exhausted.

The case staffing committee is comprised of core members who include member representatives from community agencies serving youth and families within the county. Upon receipt of a referral/request for services, the CINS/FINS provider Case Staffing coordinator shall conduct a screening to determine eligibility for services. A certified letter is mailed to the family no less than 15 working days prior to the date the family is scheduled to meet with the Case Staffing Committee. A resource panel is developed to attend as many as possible of the Case Staffing Committee meetings.

There were 3 case staffing files that were reviewed for youth admitted 5/16/17, 10/17/17, and 11/6/17. One case was initiated by the parent with a 7-day letter, another was initiated with the school social worker, and the third was referred by a staff member of Child and Family Counseling. All files indicated that the family and committee members were notified of the staffing no less than 5 working days. The case staffing committee included a local school district representative, DJJ representative, and other community members, including representatives from Pace Center for Girls and the Youth Advocate Program. The files included plans for services and outlined recommendations for services provided to the parent/guardian and signatures of their receipt of their copy. The program has an established case staffing committee in which they meet monthly and has an internal procedure and process.

There are no exceptions to this indicator.

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

The provider has policies and procedures regarding Youth Records to maintain confidentiality and privacy for the youth and family in both Residential and Non-Residential programs. The policies are: Organization of Client Records (reviewed 3/1/2014) and Confidentiality of Client

Records (reviewed 3/1/2014).

All client records are organized and maintained in a clear, consistent, and chronological order. Only clinical services staff who have received HIPAA training are authorized to file documents and have access to the clinical file. The chart is arranged in sections to ensure uniformity in all of the records. All files will be marked confidential. Residential files will be kept in a double-locked room, except when in use by the counselor. Non-residential client files are electronic from the initial screening through the course of treatment, discharge, and storage. These electronic records are stored in an internal network folder that can be accessed by authorized personnel on a need to know basis.

Three residential files were reviewed for one open and two closed files. All files were marked confidential which was visible on the front. Youth files are kept in a secure locked area only accessible by authorized staff. Residential files are usually not transported off the premises and staff are knowledgeable that if files must be transported off the premises they must be transported in a locked, opaque container.

Three non-residential files were viewed for 2 closed and 1 open file. All three files were marked confidential. Non-residential youth records are maintained electronically. When the youth records are transported off of the premises, they are housed in a secured lock box. Some boxes are accessed by a key and some are accessed by a combination lock. Each counselor has his/or her individual lock box. All files reviewed were orderly and neat.

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 for services provided to foster care youth. Youth are housed in the cottages which are the newest buildings on the campus. Each cottage offers a home-like environment with a living room, kitchen, and shared bedrooms equipped with individual beds, linens, pillows, and comforters. Bathroom facilities in the cottages are clean and accessible to youth. The grounds are nicely landscaped, clean, and well maintained. The campus provides ample space for recreation and outdoor activities.

Upon admission, youth receive orientation to the program and a copy 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 noncompliance of youth. All staff are 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 over 20 policies in place that address the key elements of this QI Indicator. The policies are contained in Section 04.07.02.01 and were last reviewed during the period March-August 2014.

A review of the procedures were conducted to ensure adherence with QI Indicator 3.01 in regards to facility and site maintenance, fire safety and health hazards, and youth engagement. The program ensures that Health and Fire Safety Inspections are current, furnishings are in good repair, the program is free of insect infestation, grounds are well maintained, bathrooms and showers are clean and functional, and individual youth beds are provided with fitted sheets on mattresses, pillow cases, and blankets. Youth's valuables are kept secured. Lighting is adequate in all areas of the building.

During the tour of the facility the Reviewer observed the shelter environments to be safe, clean, neat and well maintained. The program provides structured daily programming to engage youth in activities that foster health, social, emotional, intellectual and physical development. The furnishings are in good repair. The program is free of insect infestation. The grounds are landscaped and well maintained. There is no graffiti on walls. The lighting is adequate for tasks that need to be performed. The agency installed a special lighting system to dim the lights at night to ensure youth are not awakened during bed checks. Exterior areas are free of debris and hazards. Dumpster and garbage cans all have lids. All agency vehicles were locked and are equipped with the required safety equipment. All buildings are locked from the outside and can only be accessed by staff members with electronic cards.

The following required items are posted: Detailed map and egress plans are posted throughout the facilities, general client rules, grievance policy and forms, abuse hotline info, DJJ incident reporting number and emergency numbers.

All chemicals are approved inventoried and secured. The washer/dryer areas are operational and lint collector is clean. Each youth has their own bed with clean covered mattress, pillow, and sufficient linens and blanket. All youth have locked closets in their rooms that can only be accessed by staff in their bedrooms.

The agency has a current DCF Child Care License. Annual Fire Inspections are current; last completion dates were 6/30/17 and 7/10/17. The agency completes a minimum of 1 fire drill per month, per shift in 2 minutes or less. One emergency drill per quarter is also completed. All annual fire safety equipment inspections are current 7/12/2017. The agency has a current Residential Group Inspection and Food Service Inspection from the Dept. of Health Expiration date 9/30/2018.

All food is stored and marked properly cold or in the pantry. Refrigerators and freezers are clean.

The daily routine and monthly activities schedule are posted where youth and staff members can see it. Youth are scheduled to engage in meaningful, structured activities; education; recreation (at least 1 hour daily); counseling services; and life and social skill training. Idle time is minimal. Youth are provided the opportunity to participate in faith based activities and are not penalized if they do not want to participate.

Exceptions:

One of the boy's bathrooms has mold on the shower ceiling and wall.

Evacuation Map does not show the location a person is standing within the environment while looking at the map.

3.02 Program Orientation

Satisfactory

Limited

Failed

Rating Narrative

The provider has the following policies and procedures to address the orientation of youth: Section 04.07.02.01.06.08, Residential Youth Orientation, last reviewed 3/1/2014; and Section 04.07.02.01.06.21, Informing Clients Served of their Rights and Responsibilities, last reviewed 3/1/2014.

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: program's purpose, goals and expectations; facility tour; introductions; room assignment (based upon assessment of youth needs, risk factors, current milieu factors, and safety and security concerns); and review of daily program schedule. The youth and parent/guardian will also be issued a program handbook to read. If the intake staff member determines the youth and parent/guardian are not able to read/comprehend the handbook in the written format, the entire handbook will be read to the youth or parent/guardian. During the orientation process, the intake staff member will verbally review, at minimum the following information with the youth and parent/guardian: Identification of key staff and roles; information about what conditions represent a crisis or emergency at their residential program; how to proceed in case of an emergency/crisis; what staff to ask/seek help from (suicide prevention); and a review of the emergency evacuation procedures (disaster preparedness).

Upon Intake, each consumer/client is provided a client handbook that contains a written description of their rights, including the program's grievance policy and procedure form. The information is presented in a clear concise manner and is available in both English and Spanish and will be translated into other languages as needed. The General Manager of each program is responsible for arranging translation for persons unable to communicate in English or Spanish. Each Program will also post the Department of Children & Families (DCF) "Your rights while receiving services" poster in common areas where they are easily seen.

Confirmation of the agency's implementation of program orientation was observed by reviewer in 4 youth files, 2 open files and 2 closed files. All of the files had documentation to confirm a comprehensive orientation handbook was provided to the youth and parent/guardian within 24 hours of admission. All youth files confirmed youth were explained the disciplinary process, grievance procedure, emergency disaster procedure, contraband rules, physical facility layout map, room assignment, and suicide prevention alert notification. Signature of youth and parent/guardian were found in all files observed. Daily activity schedule was reviewed and abuse hotline telephone number was explained and provided.

No exceptions.

3.03 Youth Room Assignment

Satisfactory

Limited

Failed

Rating Narrative

The provider has the following policies and procedures to address Youth Room Assignment: Section 04.07.01.06.58 - Sleeping Arrangements, last reviewed 3/1/2014, and Section 04.07.02.01.06.08- Residential Youth Orientation, last reviewed 3/1/2014.

Program staff will make every effort to separate/or segregate dangerous youth from those who are not. Program action based on youth classification will be documented on CINS/FINS Intake Form. When placing a youth in a multi-occupancy room, the following must be taken into consideration: physical characteristics including age, sex, height, weight, general physical stature, and gang affiliation. In addition, a review of available information about youth's history and status, initial interactions with observation of the youth, and collateral contacts will be documented. Younger youth is separated from older and violent youth. Room assignment also considers youth susceptible to victimization, presence of medical, mental, or physical disabilities as well as identifying suicide risk sexual aggression and predatory behavior.

Confirmation of the agency's implementation of program orientation was observed by reviewer in 4 youth files, 2 open files and 2 closed files. All of the files had documentation of youth who were assigned rooms based on a review of the youth's history and exposure to trauma, youth's age, and gender, history of violence, disabilities, physical stature/size, gang affiliation, suicide risk, sexually aggressive or reactive behavior. Alerts were documented, collateral contracts were reviewed and initial interactions and observations were considered.

Exception:

Intake form did not ask youth their gender identification for room assignments.

3.04 Log Books

Satisfactory

Limited

Failed

Rating Narrative

The provider has a policy and procedure Section 04.07.02.01.06.86 for Log Books that was last reviewed 3/1/2014.

Entries in the log books must be made in ink with no erasures or white out. All recording errors are struck through with a single line and "void" written by error. The staff person must initial and date the correction made. Entries in the log book that include time-sensitive information, critical alerts, or other information that could impact the health or safety of one or more youth will be highlighted. Entries in the log book will be brief and clearly written, printed as needed if there are issues with penmanship, and will include the date and time of the event, incident, etc. the names of the youth/staff involved, additional pertinent information, and the name/signature of the person making the entry. The supervisor log book shall contain documentation, that at a minimum, a review of the two shifts by the incoming shift leader was completed. The supervisor log book will also contain a documented weekly review of the log book by the staff manager. The log books are retained for a period of three years. The supervisor's log book will be kept in the supervisor's office, and the staff log books will be kept in the appropriate shelters. All incoming child care staff are required to read all entries in the appropriate log book since they last worked and document of the log book. Child Care Staff will also document the start and end time of their shift in the staff log book. Each staff member must sign himself/herself in and out for each shift and cannot allow another staff member to enter or exit them from the log book on his/her behalf. Falsification of log book entry attempts to modify, damage or destroy a log book may result in disciplinary actions being taken, up to and including termination of employment.

A process is in place to document daily activities, events, and other major occurrences which include safety and security issues. All entries are brief and legibly written in ink without erasures and white out areas. Incidents are clearly documented including youth and staff involved with date, and signature. Recording errors are struck through with a clear line, staff initials and date. Supervisor reviews are conducted at least weekly, dated, and signed. Comments, requirements, corrections or follow up are noted. Supervisor and all staff review the log book of the previous two shifts. Supervision and resident counts are documented. Visitation and home visits are documented.

Exception:

Program procedure mentions their logbooks should be retained for three years while the FN policy requires seven years.

3.05 Behavior Management Strategies

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy in place, Section 04.07.02.01.06.60 - Behavior Management System that was last reviewed 3/1/2014.

The Division Director will ensure that a Behavioral Management System be developed, implemented and monitored for each program. The Behavioral Management System will emphasize positive behavioral support, praise and encouragement. The Residential Group Care Program implements two separate Behavior Management Systems. The Behavioral Management System will address the following; rules for youth, systems for documenting youth behavior, methods for rewarding youth behavior, methods for disciplining youth behavior, and methods for protecting youth or others when a youth is out of control and their behavior is likely to endanger themselves, other persons or property. The Point/Level System uses positive reinforcement of pro-social behaviors by awarding points for appropriate behavior in order to help reinforce youth's development of healthy, responsible, safe behaviors and greater independence. The Point/Level System also helps foster accountability and compliances with program rules and expectations, protection of individual rights, and the security and safety of youth and staff. A new point sheet is started daily, giving youth the opportunity to earn points in four main areas; Healthy and Responsible Behavior, Appropriate Interactions with others, Education and Safety.

A Behavior Management Strategy is in place and includes a detailed written description and is explained to the youth and parent/guardian during orientation. This was evidenced in the reviewing of 4 youth files. The BMS is designed to encourage the youth to encourage the youth to comply with the rules of the program, influence positive behavior and increase accountability. The BMS uses a wide variety of awards and incentives to encourage participation and completion of the program as evidenced by the Environmental Wellness Activity Calendar consisting of special activities. Level 1 youth earn by exhibiting preferred behavior. There are appropriate BMS consequences and sanctions used by the program which are determined by Supervisor based on the nature of the inappropriate behavior. The program's BMS minimizes the separation of youth from general population. It is documented staff receive BMS Training during their formal initial Orientation Training. Supervisors are trained to give feedback to staff members for proper implementation of the BMS. In general the program's BMS promotes order, safety, security, respect, fairness and protection of the client's rights.

No exceptions.

3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

Rating Narrative

The Provider has multiple written policies in place that address all of the key elements of the indicator for Staffing and Youth Supervision, namely: Section 6.13-Residential Youth Supervision (reviewed 3/1/2018); Section 04.07.02.01.06.12 - Basic Client Supervision (reviewed

3/1/2014); and Section 04.07.02.01.06.39-Shift Coverage in Residential Programs (reviewed 3/1/2014).

All Child Care Staff shall maintain constant sight and sound supervision of all youth assigned to them at all times unless in a youth's "Teen/Normalcy" Plan that they are allowed unsupervised/alone time, or have off campus privileges. The following system allows for managing the movement and identifying the location of each youth at all times. Formal mandatory counts will be conducted at each shift change, off campus activities, when youth return home/or runaway, bed checks, and at meals. These counts are noted in the shelter logs. Informal counts will be conducted throughout the day especially with on campus activities. Emergency counts will be conducted during emergency evacuations such as fire drill, hurricanes, etc. Staff will follow the emergency procedure.

On walks, Child Care staff may take an appropriate number of youth (1:5 and 1:4 in crowded places), who are qualified to off-campus on walks. After giving the Residential Services Coordinator or designee the route, the group will walk after getting the RSC's approval, and document departure time and estimated return time.

One same gender staff will be responsible for knowing the whereabouts of all youth. Staff will have direct visual contact with each youth every 10 minutes. Staff should alter the times they check on youth, so a pattern is not set.

A process is in place to ensure adequate safety and security of youth and staff. Program does have a written policy in place that meets the general ratio as required by the Florida Administrative code of 1 staff to 6 youth during awake hours and 1 staff to 12 youth during sleeping hours. As per the staff schedules there are 2 staff persons on duty every night in each cottage gender specific to the cottage the staff members are working in. Staff schedules are posted in the Command Center and in the office of each cottage. There is a phone list of staff members to contact in the event that a staff member calls out. The agency is equipped with functioning surveillance cameras well throughout the public areas of each cottage that records and stores 30 days of footage. Reviewer did observe video footage going back as far as 3/7/18. Agency's policy requires observance of youth while asleep every 10 minutes. This was observed by reviewer through recorded video footage of bed checks. Agency usually meets the gender specific guidelines in terms of staffing.

No exception to this indicator.

3.07 Special Populations

Satisfactory

Limited

Failed

Rating Narrative

The policy of the agency reflected the intake and admission process that was made effective 3/1/16 and has a review date of 6/8/18. The policy stated that a youth/family will complete an initial screening within 7 calendar days of referral by a trained staff member using the NetMIS screening form, either by telephone or on-site. A Domestic Violence Policy was reviewed (Section 04.07.02.01.06.62) but it was not documented who completed the last review.

The procedure outlined states that a trained staff member will screen each child and family completing the Florida Network approved NetMIS screening form, to determine the eligibility presenting problems and referrals to other programs or services. The procedure process further outlined a pre-admission process for the youth entering shelter and other orientation/intake procedures.

One staff secured file was reviewed that outlined that an in-depth assessment was completed with the client and parent and service planning was conducted. A weekly point sheet was used to document the client's daily activities, including waking up, attending school, chores, and bedtime, reflecting constant staff monitoring. The Clinical Director provided a spreadsheet entitled, "Day & Evening Shift" to show coverage of the cottages on a 24 hour shift. In addition, the agency was able to present a cottage logbook which showed that the staff documented the client's whereabouts and location.

Three domestic violence respite case files were reviewed which reflected that the youth had a pending domestic violence charge but did not meet the criteria for secure detention (one youth was a lockout and one youth was on probation). One of the domestic violence respite case files reflected that youth's stay exceeded 21 days. Clinical Director explained that she granted approval for extended stay as the parent was not able to pick him up due to unforeseeable circumstances. The case files did not document any transition to CINS/FINS or Probation Respite placement. However, other aftercare recommendations were outlined in the discharge summary. One case file was closed the night prior and the progress notes were not updated to reflect transitional services. The case plan was found in the files to implement treatment goals and objectives to focus on aggression management and to reduce the reoccurrence of violence in the home. There was indication in the case file of other CINS/FINS guidelines and requirements. The agency stated that no Probation Respite or Domestic Minor Sex Trafficking youth were served since the last review.

Exception:

The policy and procedures do not reflect the Florida Network Special Populations standards inclusive of Staff Secure, Domestic Minor Sex Trafficking, and Probation Respite.

3.08 Video Surveillance System

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place, Section 5.18 Video Camera Surveillance System, to address the requirements of a video surveillance system.

Recording devices enhance the ability of DCS to protect youth and employees. Surveillance cameras record images and may aid in the completion of thorough and timely investigation of abuse and neglect allegations, and other legal, criminal, or policy violations. Video monitoring for security purposes will be conducted in a professional, ethical, and legal manner. Use of security cameras shall be limited to public areas. Cameras are never placed in private areas used for dressing and self-care. Security cameras will not be used as a substitute for direct supervision. Audio recordings shall be prohibited unless permitted by law and specifically authorized by the Department Director. Facilities Manager is responsible for oversight of installation, maintenance and use of security cameras. Facilities Manager will consistently monitor cameras to ensure the repair/replacement of defective cameras and ensure system meets all requirements of Florida Network. Video recorded image is retained for thirty days.

Supervisory review of video footage is conducted a minimum of once every 14 days by Systems Coordinator and noted in log book. The reviews assess the activities of the facility and include a review of random samples of overnight shifts and other live views. Recorded images that do not document specific incidents shall be kept confidential and automatically overwrites images every 30 days.

The agency has a video surveillance system in operation 24 hours a day, 7 days a week. There is a written notice posted at the entrances to the campus and on buildings throughout the campus. The Facilities Manager informed this reviewer there are 97 cameras throughout the campus. This reviewer did not see all of the cameras. However, cameras were observed with the naked eye in many common areas in cottages and outside public areas. Cameras were not observed in any bathrooms, bedrooms or anywhere that invade the privacy of the clients. This reviewer observed recorded video footage in which you could see photographic images including facial recognition.

Reviewer observed video footage of 3 separate dates and times on March 7th, March 23rd and March 30th of bed checks. There is a back-up battery pack to operate the system in a power outage. As per the agencies policy the Facility's Manager, System's Coordinator and supervisory personnel may review recorded video footage. However, the system can only be accessed mobile by the Facility's Manager and System's Coordinator. This reviewer observed the binder in which the System's Coordinator documented dates and times of their once a week random review of recorded bed check observation and day time activities. The System's Coordinator is able to download recorded video footage to a thumb drive/DVD for third party review upon request from program quality improvement and when an investigation is pursued after an allegation.

Exception:

There were 2 dates 3/14/18 and 3/17/18 reviewer requested to view in reference to suicide observations. The request to review this footage was to determine if observations were completed. Another reviewer reported pre-printed suicide observation times in a youth's file. The days in question were within the past 30 days and could not be reviewed due to being lost after System's Coordinator reviewed footage of another incident.

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 and assess youth admitted to both residential and non-residential CINS/FINS programs. Specifically, the agency utilizes the screening and CINS/FINS Intake form to determine eligibility and various screening methods to determine the presence of risks in the youth's past and present mental health status. Staff on duty at the time of admission immediately identifies youth who are admitted with special needs and risks, such as risk of suicide, mental health, substance abuse, physical health, or security risk factors, etc. The Clinical Director and Residential Services Coordinator are notified immediately if risks and/alerts are present and recommendations regarding placement and supervision are provided to the direct care staff.

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 and delivery of medications for youth admitted to the program. Youth admitted to the shelter with prescribed or over the counter medication will surrender those medication to staff during admission. The agency uses the Pyxis Med-Station 4000 cabinet for the storage and delivery of medications. 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 and procedures in place which addresses healthcare admission screening for all youth placed at the program. The policy and procedures follow the Florida Network of Youth and Family Services quality improvement standards. The agency's policy and procedures was last reviewed on June 8, 2016; however, there is no signature of the individual who reviewed and approved the policy.

The agency uses a CINS/FINS intake form completed by the intake specialist at the time of the youth's admission and the intake form addresses the youth's healthcare needs at admission. The form specifically gathers information on the following youth medical needs; current injury, current illness, current health conditions, any recent hospitalizations, medications, mental health disorders, allergies, dietary restrictions, and specific physical health conditions. If the intake form indicates a youth is admitted with a chronic medical condition the Nurse is notified immediately and the youth is seen by the nursing staff. Each youth who enters the program has a nursing assessment completed by a registered nurse. The nursing assessment is maintained in the youth's official record and in a nursing assessment binder.

A review of three youth residential records was conducted for the completion of a healthcare admission screening at the time of admission. All three records contained a completed CINS/FINS intake form and a nursing assessment. The intake form and the nursing assessment screened each youth for current medications, existing medical conditions, allergies, recent injuries or illness, observation for evidence of illness, injury, pain, or physical distress, and observation of presence of scars, tattoos, or other skin markings. One of the three reviewed youth records indicated the youth had a current chronic health condition. One of the three reviewed youth records indicated the youth had a current illness which needed to be treated. The nursing staff coordinated with the youth's parent/guardian to ensure the youth received medical care for the current illness. The youth's record also contained documentation of the nurses' referral for medical services and contained documentation of the treatment received by the youth. All three reviewed youth residential records revealed all youth were screened for currently prescribed medications; however, only two of the three youth were applicable for taking medications upon admission.

No exceptions noted.

4.02 Suicide Prevention

Satisfactory Limited Failed

Rating Narrative

The agency has a current policy and procedures in place addressing suicide prevention and intervention and this policy was reviewed on March 1, 2014. In conjunction with the policy and procedures the agency has a comprehensive written master plan for healthcare, suicide and mental health services and the plan was reviewed on March 8, 2016. Neither the plan nor the policy has a current signature of who reviewed and approved them. The policy and plan follows the Florida Network of Youth and Family Services quality improvement standards.

The agency's procedure provides specific guidelines for staff to use when dealing with suicidal children, particularly until the situation can be assessed by a clinical professional. The program's written master plan indicates the program uses a multi-tier process for assessing and screening youth for medical, mental health and substance abuse conditions.

The plan indicates youth are screened at all risk levels and outlines the process for staff to place youth at risk of suicide on precautionary observations. The plan further indicates when a youth is placed on precautions an observation log is started and the youth's behaviors are to be observed and logged every thirty minutes. The plan further clarifies youth are to be put on one to one supervision when a youth is in the Baker Act process and when clinical professionals place a youth on elevated supervision the youths' behaviors are to be observed and documented every ten minutes.

The written plan indicates clinical staff are to complete an Assessment of Suicide Risk on youth who are at risk for suicide and then conduct a follow-up assessment, if necessary.

Upon a youth's admission to the program they are screened using the CINS/FINS intake forms. If the youth has any positive responses on the six suicide questions they are placed on precautionary observation until they can be seen by a clinician. The youth's behaviors will be monitored by staff every thirty minutes and documented on a precautionary observation log at the time of observation. Youth at risk for suicide are maintained on precautionary observations until a clinician completes an Assessment of Suicide Risk and places them on standard supervision or elevated supervision. If the youth is placed on elevated supervision they are monitored by staff every ten minutes and their behaviors are documented on an elevated supervision log. A youth on elevated supervision can only be stepped down from that status when the clinician completes a follow-up assessment and places the youth on standard supervision. The agency uses a red dot on the front of each record and a red sheet in the mental health section of the record to indicate a youth is at risk of suicide.

A review of three youth residential records indicated each youth was screened for suicide risk using the CINS/FINS intake form. All three youth records indicated all the youth were at risk for suicide and all three youth were placed on precautionary observation by the screener and an observation log was started. All three youth were seen by a clinical professional and had an Assessment of Suicide Risk (ASR) completed and the clinician elevated all three youth to elevated supervision upon completion of the ASR. Each youth was maintained on elevated supervision until a clinician completed a follow-up assessment and placed the youth on standard supervision. All three records contained precautionary observation logs, and elevated supervision logs; however, all three records reflect staff did not document the youth's behaviors on the precautionary logs and/or elevated supervision logs correctly.

Exceptions:

The observed logs for one youth record indicated there were three thirty-minute precautionary observations not documented on the precautionary log as required by the program's policy and procedures. One reviewed youth residential record indicated the youth was placed on precautionary observation and there were no thirty-minute observations of the youth's behavior from 2:30 a.m. to 5:30 a.m. A review of the record further revealed the youth was placed on elevated status on March 13, 2018 at 7:00 p.m.; however, the staff continued to monitor the youth at precautionary levels instead of elevated levels until he was released from all suicidal observations on March 17, 2018 at 3:31 p.m. Therefore, the youth was not monitored in accordance with the recommendations of the clinical professional and was observed every thirty minutes instead of every ten minutes. Two of the nine reviewed observation logs contained pre-written times but did not have any observations or staff initials. The Department's Central Communication Center was contacted in regards to the pre-filled out times. Dispatcher Chad indicated the incident was not reportable due to the fact the staff had not initialed the log indicating an observation was made at the times pre-filled out and there was no way to validate checks were conducted due to the video system being down.

One reviewed youth residential records indicated the youth was placed on precautionary observations on March 13, 2018 at 12:00 a.m. The record contains a precautionary observation log indicating the youth was observed every thirty minutes until 6:00 a.m. but there is no record of thirty minute observations between 6:30 a.m. and 4:13 p.m. when the youth was placed on elevated status. The record further does not reflect any staff suicidal observations of the youth were made from 4:13 p.m. until 6:40 p.m. The same youth record reflects the elevated status began at 4:13 p.m. but the elevated log does not indicate staff observed the youth at ten minute intervals until 6:40 p.m.

4.03 Medications

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy and procedures in place outlining medication administration and the policy was last reviewed on October 26, 2016. The agency also has a policy and procedure outlining medication refusal, return waste and discovery and the policy was last reviewed on June 1, 2016. The agency also has another policy outlining medication access, storage, inventory and disposal and this policy was last reviewed on September 14, 2016. The agency also has a policy and procedure addressing medication errors and another policy and procedure which address medication changes. Both policies were last reviewed on July 1, 2016. The agency also has a policy and procedures addressing the medication information manual and another policy and procedure addressing medication education. Both policies were last reviewed on March 1, 2012. The agency also has a policy and procedures which outlines the process for medication reports and the policy was last reviewed on February 1, 2016. All the agency policy and procedures for medications follow the Florida Network of Youth and Family Services quality improvement standards.

The program's policy is to have nursing staff to act as the primary administer of medications to youth, when they are on-site. The program has a list of individuals who have been trained to provide medications to the youth in the nurse's absence. The program's policy requires all medication refusals be documented with an 'R' on the medication administration record (MAR) and the reason for the refusal is also required to be written on the MAR form.

The program maintains all youth medications, controlled medications, and over the counter medications in a Pyxis Med-Station 4000 medication

cabinet. The program has two site-specific Super Users for the medication station. The program does not store oral medications with injectable and topical medications. The program is required to have a medication refrigerator to store medications which are required to be kept cold.

The program is required to maintain a perpetual inventory with a running balance for controlled medications, and a weekly inventory for over-the-counter, sharps and syringes medications.

The program has a bio-medical disposal license through the department of health and disposes of all medications and sharps through a bio-medical disposal company.

The agency has a designated medical clinic for examination and assessments of youth for medical purposes. The medical clinical consists of a nursing office, two medical examination rooms, and a medication administration room. The agency has two registered nurses who work in the facility and they are on-site Monday through Friday. One nurse works from 6:00 a.m. to 3:00 p.m. and the other nurse works from 11:00 a.m. to 8:00 p.m. Both nurses have clear and active licenses in the State of Florida.

The agency has a Pyxis Med-Station 4000, which is used for the distribution of medications to the youth. The medication station is maintained in a locked medication room located within the locked medical clinic. Youth do not have access to the medication room unless they are accompanied by program staff. The program has two super users for the medication station and they are the program's two registered nurses. The program maintains narcotics, controlled medications and over-the-counter medications in the medication station. The program maintains oral medications separate from injectable and topical medications.

The program maintains a locked refrigerator in the medication room for the storage of medications which require refrigeration. A review of temperature logs for the six months prior to the review indicated the nursing staff maintains the refrigerator between thirty-six and forty-six degrees Fahrenheit. The nursing staff indicated the program has not had any medications which required refrigeration during the review period.

The RNs complete a weekly inventory of all medications on-site every Monday, and there was documentation to support these inventories for the entire review period. An RN along with a staff complete the shift-to-shift inventories of controlled medications on 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. An inventory of the medication is completed every time it is given to a youth and a perpetual inventory is maintained in the Pyxis Med-Station. Hard copies of all inventories are maintained in a binder in the medication room.

The agency's registered nurses train all non-licensed staff to assist youth with self-administration of medications. The agency provided the team with a list of non-licensed staff who can assist youth with self-administration of medication. The list consists of one Residential Services Coordinator and fourteen Child Care Specialist IIs.

The nursing staff maintains all syringes and sharps in a black cabinet in the locked medication room in the locked medical clinical. At the time of the review the program did not have any syringes on-site. A review of inventory sheets confirmed nursing staff conduct weekly inventories of the sharps and syringes and the nurses conduct the inventory every Monday.

A review of Medication Distribution Records (MARs) are used to document the distribution of all medications by licensed and non-licensed staff. Three youth residential records were reviewed and two were applicable for medication administration. Both records contained medication distribution records for each medication the youth was prescribed. All MARs were filled out with all required information and were correctly filled out when medications were distributed to each youth. Only one of the two youth was applicable for non-licensed staff medication administration. The one records contained MAR forms which indicated the staff and youth both signed the MAR form when the youth received the medication from the Pyxis Med-Station.

The nursing staff reviews medication management practices from reports from the Pyxis Med-Station reports. A review of documentation for the six months prior to the review supported the nursing staff prints and reviews the following reports monthly from the Pyxis Med-Station: weekly controlled substances report, weekly count report, and overrides weekly report.

Nursing staff are responsible for the verification of all youth medication. An interview with the nursing staff indicated the nurses use many ways to verify youth medications and they can verify the medications by contacting the distributing pharmacy, Lexi-comp on-line tool in the Pyxis Med-Station, pharmacy book, and based on the nurses' professional knowledge of medications. The interview with the nurse further indicated all medication discrepancies are cleared at the end of each shift.

No exceptions noted.

4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy and procedures in place outlining medical information, behavioral concerns, and the mental health communication alert

process. The agency also has a separate policy outline the process for special dietary restrictions and communication of the information to staff. Both policies were last reviewed on March 1, 2014; however, there is no signature on the policies indicating their approval. The agency policy and procedures for medical and mental health alert follow the Florida Network of Youth and Family Services quality improvement standards.

The program uses a colored dots system which indicates if a youth has medical concerns, behavioral concerns, mental health concerns, substance abuse concerns, or no concerns at all. The program uses a blue dot to indicate medical concerns, yellow dot to indicate behavioral concerns, red dot to indicate mental health concerns, orange dot to indicate substance abuse concerns and a green dot to indicate no concerns. The program also ensures a corresponding colored sheet is placed in all youth records to denote specific information about each alert type. The agency also maintains a client board in their command center which indicates all youth currently residing at the facility and has corresponding color dots next to their names indicating each youth's specific alerts/concerns.

The program also has the shift leader send an email to all childcare workers, shift leaders, counselors, managers, general managers, nursing staff, and if needed the cafeteria manager to detail to detail client medical, mental health and behavioral needs and concerns. The shift leader also maintains a medical, behavioral, and mental health alert binder which also details each client's medical, mental health and behavioral needs and concerns. The shift leader uses the alert binder to brief the child care specialist at the beginning of their shift. Furthermore, the shift leader will log each youth's medical, mental health and behavioral concerns in the manager's log book.

The program's nursing staff is required to provide written guidance to the cafeteria staff using the agencies special dietary restrictions form for any youth who require special diets for medical, dental and/or religious beliefs.

A review of one open and two closed youth residential records were reviewed for compliance with the program's alert process. The two closed records contained appropriate dots on the outside of the youth's residential case record denoting all youth's alerts and concerns. Both records also contained corresponding colored sheets inside the case records which documented the specific information concerning each alert.

The one open record also contained the appropriate dots on the outside of the youth's residential case record and contained corresponding colored sheets inside the case record, which documented the specific information concerning each alert. A review of the program's client board indicated the youth had only one dot and not two, which is what should have been indicated on the board.

A review of the program's log book maintained by the shift leader indicated all three youth were entered in the log book upon their admission. All three log book entries documented each youth's specific alerts and/or concerns. A review of all three youth records contained a copy of the shift leader's email to all required staff informing them of each youth's admission, and informed them of each youth's alert and/or concerns.

Three youth residential records were reviewed for dietary special restrictions and only one record was applicable for dietary restrictions. The one applicable record contained a copy of a completed special dietary restrictions form completed by the nursing staff and there was documentation the form was forwarded to dietary staff.

Exceptions:

The agency's policy needs to be updated to reflect the usage of the orange dot and orange communication sheet for substance abuse concerns.

One youth's required a blue and yellow dot to be put on the program's client board; however, there was only a yellow dot and not a blue dot.

4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy and procedures in place outlining the provisions of emergency medical, dental, mental health and substance abuse services. The agency uses a comprehensive master plan outlining the agencies procedures for emergent services for healthcare, suicide, and mental health concerns. The plan was last reviewed on June 8, 2016. The agency also has a policy and procedures in place for substance abuse, crisis and intervention emergency procedures. This plan was last reviewed on September 1, 2017. The agency also has a policy and procedures outlining the provisions for first aid equipment. The policy was last reviewed on September 30, 2016. The agency also has a policy and procedures outlining how the program will minimize or prevent the outbreak of infectious conditions and disorders amongst the youth and staff. The policy was last reviewed in October 2016. The agency policy and procedures for episodic/emergency care follow the Florida Network of Youth and Family Services quality improvement standards.

The agency uses four separate policy and procedures to address youth episodic and emergency care. All four policies provide staff with specific guidelines to use when a youth is suspected of having a medical, mental health, substance abuse, and crisis intervention emergency.

All off-site emergency care is documented in the nursing off-site care binder and episodic log book. All instances of off-site emergency care are reported to the Department of Juvenile Justice Central Communication Center (CCC). Upon each youth's return from off-site care medical clearance is reviewed and verified by nursing staff and all discharge documentation is maintained in each youth's record. When a youth is required to be taken off-site the parent/guardian is notified.

If youth have an indication of a potentially serious contagious disease the nursing staff will conduct a nursing assessment of the youth. In the

event of a need for further assessment the nurse will notify the parent and refer the youth for further examination by a medical doctor for confirmed diagnosis as soon as possible. All youth will be required to have medical clearance from a physician prior to returning to the facility.

Nursing staff are required to maintain, organize and stock all agency first aid kits. First aid supplies will be monitored for quality control and replenished as needed by the nursing staff.

The agency training staff conduct emergency medical procedure training with staff during their new employee orientation when they are first hired and then again annually.

A review of three youth residential records indicated only one youth required off-site medical services. The one record indicated the youth was assessed by nursing staff and was referred out for medical care. The youth was not in need of emergency services; therefore, the youth's parent/guardian was contacted to take the youth to seek medical clearance. The youth's record reflected the youth was taken by their parent/guardian for medical services and received medical clearance and medication for the condition prior to returning to the center. The record also reflected the nursing staff reviewed all medical clearance documentation and the discharge instructions were in the youth's record, as well as, the off-site care binder.

The agency did have six youth who required emergency off-site services during the review period. All six youth were assessed by nursing staff and there was documentation of the emergency services in the program's off-site care binder. There was also documentation to support all six instances of off-site services were called in to the Department's Central Communication Center (CCC), as required by the agency's policy.

The program maintains two knife-for-life instruments and they are maintained in the supervisor's office on the boys' cottage, and in the chemical closet on the girls' cottage. A review of the two cottages confirm the knife-for-life were present on both cottages.

The program nursing staff conducts weekly inspections of first aid kits and the reviewer could confirm nursing staff has conducted their inspections for the entire review period.

A review of four staff training records confirm three of four staff have completed training on emergency medical procedures at the time of hire and/or annually thereafter. The one staff who was missing the training completed the training on the second day of the review.

No exceptions noted.