



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Hillsborough County

on 03/04/2014

CINS/FINS Rating Profile

Standard 1: Management Accountability

1.01 Background Screening	Satisfactory
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Satisfactory
1.05 Analyzing and Reporting Information	Satisfactory

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

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	Limited
2.02 Psychosocial Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management and Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petition Process	Satisfactory
2.07 Youth Records	Satisfactory

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

Standard 4: Mental Health/Health Services

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

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

Overall Rating Summary

Percent of indicators rated Satisfactory:95.83%
Percent of indicators rated Limited:4.17%
Percent of indicators rated Failed:0.00%

Rating Definitions

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

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

Review Team

Members

Ashley Davies, Lead Reviewer and Consultant, Forefront LLC

Glenn Parkinson, Director, George Harris Youth Shelter

Martha Fitzpatrick, CINS/FINS Director, Children's Home Society Osceola



Tracey Ousley, Regional Coordinator, CDS Interface

Pat McGhee, DJJ, Office of Prevention and Victim Services

Persons Interviewed

- | | | |
|--|--------------------------|-------------------------|
| <input checked="" type="checkbox"/> Program Director | 1 Case Managers | 1 Maintenance Personnel |
| <input checked="" type="checkbox"/> DJJ Monitor | 2 Clinical Staff | 4 Program Supervisors |
| <input type="checkbox"/> DHA or designee | 1 Food Service Personnel | 0 Other |
| <input type="checkbox"/> DMHA or designee | 1 Health Care Staff | |

Documents Reviewed

- | | | |
|---|--|---|
| <input type="checkbox"/> Accreditation Reports | <input checked="" type="checkbox"/> Fire Prevention Plan | <input type="checkbox"/> Vehicle Inspection Reports |
| <input checked="" type="checkbox"/> Affidavit of Good Moral Character | <input checked="" type="checkbox"/> Grievance Process/Records | <input type="checkbox"/> Visitation Logs |
| <input checked="" type="checkbox"/> CCC Reports | <input type="checkbox"/> Key Control Log | <input checked="" type="checkbox"/> Youth Handbook |
| <input type="checkbox"/> Confinement Reports | <input checked="" type="checkbox"/> Logbooks | 4 Health Records |
| <input type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 4 MH/SA Records |
| <input type="checkbox"/> Contract Monitoring Reports | <input type="checkbox"/> PAR Reports | 0 Personnel Records |
| <input type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 0 Training Records/CORE |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 4 Youth Records (Closed) |
| <input type="checkbox"/> Escape Notification/Logs | <input type="checkbox"/> Sick Call Logs | 4 Youth Records (Open) |
| <input type="checkbox"/> Exposure Control Plan | <input type="checkbox"/> Supplemental Contracts | 0 Other |
| <input checked="" type="checkbox"/> Fire Drill Log | <input checked="" type="checkbox"/> Table of Organization | |
| <input checked="" type="checkbox"/> Fire Inspection Report | <input type="checkbox"/> Telephone Logs | |

Surveys

- | | | |
|---------|---------------------|---------|
| 7 Youth | 5 Direct Care Staff | 0 Other |
|---------|---------------------|---------|

Observations During Review

- | | | |
|--|--|--|
| <input type="checkbox"/> Admissions | <input checked="" type="checkbox"/> Posting of Abuse Hotline | <input checked="" type="checkbox"/> Staff Supervision of Youth |
| <input type="checkbox"/> Confinement | <input checked="" type="checkbox"/> Program Activities | <input checked="" type="checkbox"/> Tool Inventory and Storage |
| <input checked="" type="checkbox"/> Facility and Grounds | <input checked="" type="checkbox"/> Recreation | <input checked="" type="checkbox"/> Toxic Item Inventory and Storage |
| <input checked="" type="checkbox"/> First Aid Kit(s) | <input type="checkbox"/> Searches | <input type="checkbox"/> Transition/Exit Conferences |
| <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"/> Sick Call | <input type="checkbox"/> Use of Mechanical Restraints |
| <input checked="" type="checkbox"/> Medical Clinic | <input checked="" type="checkbox"/> Social Skill Modeling by Staff | <input type="checkbox"/> Youth Movement and Counts |
| <input type="checkbox"/> Medication Administration | <input checked="" type="checkbox"/> Staff Interactions with Youth | |

Comments

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

Rating Narrative

Strengths and Innovative Approaches

Rating Narrative

The program is currently in a transition process and the county has placed the shelter in a new division called Children and Youth Services (formerly Family and Aging Services). Due to this change in division they have also received a new Department Director who is in the process of restructuring the program. There are currently several key "acting" positions because the county has not given the program permission to fill the positions. Three key positions that have been affected are the Program Manager, Program Director, and Clinical Director. Currently the "acting" Program Director has been in this position since May 2013 and the "acting" Program Manager has been in the position since August 2013. The "acting" Program Director is also having to fill the role of Clinical Director and Grant Manager. The program has also lost nine other positions, which include childcare worker positions, for different reasons, and they have not been filled. The "acting" Program Director and Program Manager are extremely involved in the program and are working hard to keep things "afloat"; however, being in an "acting" position for such an extended period of time, plus other vital positions being vacant, is putting a strain on both the staff and the operation of the program. The program has struggled with low numbers and low referrals for a period of time. In addition to the vacant positions, some key staff have been out on medical leave the past few months. Two of these key staff both went on medical leave around the same time. These two staff were the intake staff, for the shelter, who were responsible for contacting families and scheduling a time to come in and complete the intake. Due to these staff being out for a period of time, parents calling in with referrals were not called back in a reasonable amount of time to come in and complete the intake. Over the past couple months these two staff members are both now back and are once again completing all intakes. However, due to staffing issues with the non-residential program these two staff members are also having to answer calls for non-residential referrals and help with scheduling and arranging services. The central intake person for the non-residential program went out on medical leave around September 2013 and has been back and forth intermittently, but not on a consistent basis. This has resulted in referrals from call-ins from parents and the JAC not getting answered, as there was no one to call them back. Referrals were coming in, for non-residential, through the out-patient counselors and other agencies and outside sources; however, the program was missing the call-in referrals. At one point there were at least thirty-three messages from call-in referrals that needed to be called back. This situation has recently been rectified, somewhat, when the parent or JAC calls in and no one answers, instead of leaving a message they are instructed to call the "residential central intake" and the two before mentioned staff will take the information and help with scheduling and arranging services.

The "acting" Program Director has implemented a corrective action plan to help keep the program running during this transition time. Non-residential counselors are now required to participate in twenty PR/outreach activities per year to be divided as follows: five per quarter and PR should be done at ten schools and the remaining ten elsewhere. Counselors are also doing presentations with school social workers. Counselors are also now required to conduct at least fifteen counseling sessions per week with a total of sixty sessions per month. The "acting" Program Manager is on the Juvenile Justice Advisory Board and conducts outreach activities and awareness of the program during those meetings.

Some changes have also been implemented in the shelter, during these difficult times, to help keep things running smoother. They have implemented a curriculum from the National Runaway Center, which includes twelve modules, and has helped decrease their runaway rates tremendously. The 1st and 3rd of every month they complete a NAPI debriefing with all staff and look at all critical incidents, what staff did well and what they did not do well. Staff reenact the situations and then discuss them. They go over any new policies or procedures during this time. The treatment counselors now conduct trainings with all childcare staff to focus on common diagnoses seen in the shelter, different behaviors these diagnoses may present, and best practices for handling these types of behaviors.

It should be noted that although the program received all Satisfactory's and one limited rating during this Quality Improvement review, it is strongly recommended that these key, vital, vacant, and "acting" positions be filled immediately. These vacant positions and "acting" roles are placing a strain on program operations and also on program staff, causing them to be overworked and having to take on many different responsibilities, in addition to their own position requirements. Continuing to operate in this manner is resulting in services not being provided to families in need and staff getting "burnt out", which can potentially cause liability issues.

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. At the time of the review the shelter was in a transition process and the county had placed the shelter in a new division called Children and Youth Services (formerly Family and Aging Services). Due to this change in division they have also received a new Department Director who is in the process of restructuring the program. There are currently several key "acting" positions because the county has not given the program permission to fill the positions. Three key positions that have been affected are the Program Manager, Program Director, and Clinical Director. Currently the "acting" Program Director has been in this position since May 2013 and the "acting" Program Manager has been in the position since August 2013. The "acting" Program Director is also having to fill the role of Clinical Director and Grant Manager. The program has also lost nine other positions, which include childcare worker positions, for different reasons, and they have not been filled. Neither the shelter, nor the non-residential program, had any newly hired staff since the last Quality Improvement review. It is strongly recommended that these key, vital, vacant, and "acting" positions be filled immediately. These vacant positions and "acting" roles are placing a strain on program operations and also on program staff, causing them to be overworked and having to take on many different responsibilities, in addition to their own position requirements.

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

1.01 Background Screening

Satisfactory
 Limited
 Failed

Rating Narrative

The program has a detailed policy and procedure in place for screening of all new hires, volunteers, student interns, mentors and frequent visitors. Background screenings are maintained electronically through the Hillsborough County Human Resources Information System. A five year re-screening process is also outlined in the policy.

There were no new employees hired since the last QI Review to consider for this indicator. Four employees were in need of a five year re-screen for this period of review. Of the four, three re-screens were completed prior to the due date. One completed re-screen was received a month late; however, the program had documentation that the process was initiated months prior to the due date but due to problems with fingerprints and time delays with the BSU the completed re-screen was not received on time.

The program completed the Annual Affidavit of Compliance with Good Moral Character Standards on January 23, 2014.

1.02 Provision of an Abuse Free Environment

Satisfactory
 Limited
 Failed

Rating Narrative

The program has written policies and procedures that address incidents of abuse and harassment to youth and staff to secure a safe environment. The program has a tracking system to maintain reports. These systems include the CCC call In-logs, CCC reports and the grievance reports.

Other tools provided and reviewed were: the Program policies and procedures that match DJJ standard for # 1.02, CCC call In-logs, policy for Employees Involved in Reports of Child Abuse, the policy for Informing Clients Served of Their Rights and Responsibilities, grievance policy, and the following binders: CINS Information reports, Fire Safety/Drill Logs, suicide precaution procedures, Preparedness Log, CINS/RGC staff meeting minutes and CCC reports.

There is literature on safety information posted and brochures made available for youth and guests to review. Staff meeting minutes seem to address some form of safety, incidents (bed checks), and offered training's to enhance the skills of the staff.

There was a total of seven (7) grievances that were reviewed of the seven (7) reviewed all were completed with the required signatures. Through a review of reports, management takes the necessary actions in addressing incidents of physical and/or psychological abuse, verbal intimidation, use of profanity, and/or excessive use of force when required.

Staff provided a tour of the facility and the rooms were very warm and conducive to the services/activities provided to the youth. The shelter displays a safe and secure atmosphere.

Program has written policies and procedures that address incidents of abuse and harassment. Program posts literature of safety information throughout the program for youth and any guest to review while on site.

An handbook is provided to the youth at the point of intake to understand their rights and the protocol of the facility. I observed grievance forms which are available on the walls or can be provided at any time by staff.

A total of ten (10) CCC reports were reviewed and all were completed with the necessary information.

1.03 Incident Reporting

Satisfactory

Limited

Failed

Rating Narrative

The program clearly has a system for tracking and documenting incidents. The incidents were documented well and it appears, from the report, the supervisors and program director reviewed the cases very carefully and actions were taken accordingly.

There were ten (10) CCC reports reviewed and completed within the last two months. All ten (10) CCC's were reported within the two (2) hour time frame and documented appropriate actions were taken. The programs policies and procedures were reviewed all matched DJJ indicator 1.03. The program maintains separate binders to capture and track incidents. These binders consist of the CINS Incident reports, the CCC reports, and grievances. All program staff are required to complete training's within the first full year of employment.

1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

There were no new employees in their first year of employment to review for this indicator.

Six employee training files were reviewed for annual training requirements beyond the first year using the fiscal training year of October 2012 through September 2013. Five of the six files had documented training hours that met or exceeded the annual required hours. One employee had 17.5 of the 24 hours required.

Four employees had received Fire Safety Training and two did not.

Five employees were current in their CPR and first aid training and one was not.

All six employees are on track to meet or exceed training hour requirements for the current training year. It was evident that attainment of

training hours has been a priority and increased efforts were noticeable.

1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

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

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

The agency has a QI team that meets weekly to review data being collected and to streamline the process of collecting and analyzing data. Several workgroups have been developed that review trends and patterns related to risk management, operations and programming. The major areas of review are: Case Record Review, Safety and Risk Management, Personnel, Staff Development, Outcomes, Medical, and Nutrition/Food Service. The teams track information on a monthly basis and that information is provided to the QI Committee that produces a Quarterly report. The agency provided copies of quarterly reports for the agency fiscal year starting in October of 2013 through March 2014. The agency provide graphs and tables reflecting topics that includes Client Satisfaction Survey Results; Case Record review; 180 Day Follow up; Incident Reporting; and Stake Holder survey. This information is then shared during management team meetings, all staff meetings, advisory board meetings, NAPPI debriefings, clinical review meetings, case management meetings, and town hall meetings. Corrective action plans are developed and put into effect if needed.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

The Hillsborough County Non-Residential Counseling Program provides non-residential services for youth and their families throughout Hillsborough County. The program's main office is located at the Clay Magnum Campus. The program also has partnerships with agencies to have office space at various community sites in the Tampa area. Primary services delivered include a full range of individual and family Counseling. Since the last Quality Improvement review the program has struggled with low numbers and low referrals, for both residential and non-residential services. There have been three key staff out on medical leave. Two of these staff were the intake staff, for the shelter, who were responsible for contacting families and scheduling a time to come in and complete the intake. The third staff is the central intake person for the non-residential program. This staff member has been on medical leave since September 2013 and has been back and forth intermittently, but not on a consistent basis. With no one available to fulfill the duties of these positions on a consistent basis, it resulted in a period of time when referrals were not being called backed in a reasonable amount of time to come in and complete the intake for the shelter and referrals from call-ins, for non-residential services, from parents and the JAC not getting answered, as there was no one to call them back. Over the past couple months the two intake staff members, for the shelter, are both now back and are once again completing all intakes. However, due to staffing issues continuing with the non-residential program, these two staff members are also having to answers calls for non-residential referrals and help with scheduling and arranging services. It is strongly recommended that staffing issues with the non-residential program be resolved as it is resulting in staff having to take on many different responsibilities, in addition to their own position requirements which can potentially affect services being provided to children and families in need.

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

Out of the four (4) non-residential files three were completed within seven (7) calendar days of referral. One (1) screening was completed after seven (7) days. All four residential screenings were completed the same date as intake.

In all eight cases reviewed, there is consistent documentation that the parents and youth receive service options, client rights and responsibilities, as well as, HIPPA information, and the grievance process.

The program has struggled with low numbers and low referrals, for both residential and non-residential services. There have been three key staff out on medical leave. Two of these staff were the intake staff, for the shelter, who were responsible for contacting families and scheduling a time to come in and complete the intake. The third staff is the central intake person for the non-residential program. This staff member has been on medical leave since September 2013 and has been back and forth intermittently, but not on a consistent basis. With no one available to fulfill the duties of these positions on a consistent basis, it resulted in a period of time when referrals were not being called backed in a reasonable amount of time to come in and complete the intake for the shelter and referrals from call-ins, for non-residential services, from parents and the JAC not getting answered, as there was no one to call them back. There was one point when there was over thirty-three messages left, for non-residential services, that needed to be called back. This issue has been somewhat resolved, when the parent or JAC calls in and no one answers, instead of leaving a message they are instructed to call the "residential central intake" and the residential intake staff will take the information and help with scheduling and arranging services. The two residential intake staff members are recently back from medical leave and working full-time. It is strongly recommended that staffing issues with the non-residential program be resolved as it is resulting in staff having to take on many different responsibilities, in addition to their own position requirements. This staffing issue has resulted in services not being provided to children and families in need during this Quality Improvement review cycle.

2.02 Psychosocial Assessment

Satisfactory

Limited

Failed

Rating Narrative

Of the four non-residential files reviewed, the psychosocial assessments were very detailed. They were each completed within the first two (2) to three (3) face-to-face contacts with the family. They were signed off by the counselor, as well as, supervisor. No suicide ideation noted in these four (4) non-residential files.

Of the four (4) residential files reviewed, one psychosocial was initiated the same date as intake. The remaining three (3) files used psychosocial assessments completed during previous admissions to the program and were dated within the last six (6) weeks to six (6) months. The completed psychosocials were signed off by the counselor, as well as, the supervisor. One of four files reviewed showed a youth to have an elevated risk of suicide. A licensed mental health counselor completed an assessment by the next day as a follow up to this concern.

2.03 Case/Service Plan

Satisfactory

Limited

Failed

Rating Narrative

There were four non-residential files reviewed. Service plans were completed within seven (7) working days of the completion of the psychosocial assessment. Three (3) of the four (4) service plans were completed on the same day as the psychosocial assessments. Each Service plan appeared individualized, noting the person responsible, target dates, date of initiation, as well as, service type and location. Three (3) of the four (4) plans noted the frequency of service Each Service Plan was signed by the counselor, supervisor, client, and parent. Two (2) of the four (4) service plans had late 30 and 60 day reviews by two (2) to four (4) days each. Though the reviews were late by a couple days, there is documentation that the service plans were reviewed and signed by both the youth and parent, as well as, counselor.

All Four (4) residential service plans were completed at intake or within two (2) days. In two (2) files of youth who stayed in the shelter longer, a detailed service plan update was completed prior to the thirty (30) day review due date. The service plans included service type, frequency, location, persons responsible, initiation date, and signatures of all parties (youth, parent, counselor and supervisor). One (1) of the four (4) service plans was missing target dates.

2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

Rating Narrative

In all eight (8) residential and non-residential files reviewed there was clear documentation by the counselor/case manager, in progress notes, of the services provided to support the youth and family, as well as, clearly addressing the outlined service plan goals. Two (2) of the four (4) non-residential files were closed and contained a termination report.

2.05 Counseling Services

Satisfactory

Limited

Failed

Rating Narrative

Each of the four (4) non-residential files reviewed contained progress notes documenting that the youth and families were receiving counseling services according to the service plan. It is evident, by supervisor sign off, that there is an internal process for case review. There is also monthly open and closed file reviews completed by program counselor.

Group counseling binders were reviewed and showed that youth are offered at least five (5) sessions of group per week. Individual and family counseling sessions were also documented in each of the four (4) residential files reviewed.

2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

Rating Narrative

One of the four non-residential files reviewed had Case Staffing involvement. It appears that the referral and screening were completed at the time of Case Staffing. There was documentation provided that the Case Staffing Chair person sent the parents a certified letter informing them of the Case Staffing. The Case Staffing Committee members were provided notification within five (5) working days. There is an extensive list of community providers as part of the Case Staffing Committee.

An additional three files were reviewed for the petition process. A school social worker referred each of the three (3) youth that had Case Staffing involvement. There is documentation that the parents, as well as, the Case Staffing Committee in each case were notified of Case Staffing no less than five (5) working days prior to the staffing. Service plans were not updated for two (2) residential files due to the goals remaining the same. The program does an excellent job of providing the parents with the Case Staffing recommendations either given in person the same day or mailed to the parent the same day of the Case Staffing. The Program appears to have a well working system involving the school system, local providers, as well as, the court, to provide Case Staffing intervention. According to the documentation provided, the Committee meets regularly on a monthly basis.

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

The non-residential files are kept by the program electronically only. Individual log-in access is given to the program counselors. The Residential files are kept locked, in a file cabinet, and confidential in the Shift Leader Building. All files reviewed were consistently organized and marked confidential.

Standard 3: Shelter Care

Overview

Rating Narrative

The Hillsborough County CINS/FINS program is located on a 33 acre campus, which is shared by other programs operated by the county. The grounds consist of numerous different buildings but the primary buildings relating to residential CINS/FINS services include: a boys shelter, a girls shelter, a shift leader building, a recreation building, a modern and professionally designed cafeteria, a gymnasium, a classroom, an administration building, a recreation pavilion, several large recreation fields and a relaxing pond area (fenced) with a gazebo and pier. Currently youth in the shelter are transported to their respective schools if they are within a twelve mile radius of the shelter. Those youth outside the twelve mile radius complete school assignments on a computer in a classroom. The shelter is in the process of hiring a certified teacher so these youth do not have to complete all school work on a computer and can actually attend school on campus.

The shelter recently applied for, and received, a DJJ grant for \$80,000 that lasts seventeen weeks, to provide services to youth. Youth will participate in karate, yoga for self-relaxation and stress, CPR and first aid certification, and tutoring. The program has also implemented an evidenced based software called The Ripple Effect, that helps youth deal with social and emotional issues, as well as, participate in workshops. The program also has the second highest number in the state for processing Domestic Violence Youth.

The programs co-located on the same site as the shelter have proven to be an asset to the shelter during this period of transition, as the shelter is able to utilize staff members from the other programs to help fulfill staffing requirements in the shelter. Due to this, staffing requirements for the boys and girls shelters have been maintained as required since the last Quality Improvement review. However, there are currently numerous vacant childcare worker positions and it is recommended these positions be filled, as soon as possible, so the shelter does not have to rely on staff from the other co-located programs to fill these positions.

3.01 Shelter Environment

Satisfactory

Limited

Failed

Rating Narrative

The Hillsborough County residential CINS/FINS program is located on Clay Magnum Lane in Tampa, Florida on a large 33 acre campus. The program primarily consists of three buildings, a male and a female shelter each with a kitchen and ten beds, and a recreation building. There is also a separate dining facility and a gymnasium. There is a separate building for the Shift Leader where intakes and screenings are conducted. Medications are also stored in this building.

In the living areas, the furnishings were in good repair. The bathrooms and shower areas appeared to be clean. There was no observable graffiti on the walls, doors, or windows. Each youth did have an individual bed with clean covered mattress, pillow, and sufficient linens. There was adequate storage space for each of the youth to keep personal belongings. Lighting was adequate. The program appeared free of insect infestation.

In the recreation building youth are able to play pool, Foosball, and watch TV. There are several covered outdoor recreational areas.

The grounds and landscape are well maintained.

Some DCF youth are initially housed with CINS/FINS and DV youth.

Daily schedule is publicly posted and youth are provided opportunities for voluntary faith-based activities. However, according to a log of faith-based activities no youth has been interested in such activities since early November 2013.

Health and fire inspections were current.

3.02 Program Orientation

Satisfactory

Limited

Failed

Rating Narrative

Intakes are completed by the shift leaders who are housed in a separate building. Each youth signs an acknowledgement form that they have received a program orientation which includes a tour of the facility, program description, rules/resident rights, visitation policy, mail and telephone privileges, abuse hotline information, description of the behavioral management system, client grievance, emergency evacuation procedures, search policy, facility activity schedule, food menu schedule, procedures to access health and mental health care, consequences for violation of rules or property damage, identification of staff and their key roles, room assignments, contraband policy, and a copy of the Client Handbook. This is signed by the youth and parent, and staff completing the orientation.

A review of four (4) CINS/FINS and four (4) Domestic Violence client case files indicated that the orientation checklist was completed the same day as the intake and admission into the shelter.

Youth are not given a separate list of contraband items. However, the 08/2012 Client Handbook states that smoking is prohibited and that associated products such other tobacco products, lighters, matches or other paraphernalia are considered contraband items that will be confiscated and destroyed. Similarly drugs and alcohol, weapons, or gang related materials are prohibited.

There was no indication whether or not cell phones or cameras are prohibited.

The dress code for youth is clearly delineated in the Client Handbook.

3.03 Youth Room Assignment

Satisfactory

Limited

Failed

Rating Narrative

There is a process in place that includes an initial classification of the youth for purposes of room assignment with consideration given to potential safety and security concerns. Room and bed assignment is documented on the Florida Network CINS/FINS Intake Assessment form. Notation is made with regard to the rationale made in the determination of bed assignment. Information is also considered from data provided in the Admission Checklist/Physical Health Screening form.

A review of eight residential case records indicated that in all cases the room assignment was completed at intake. Observations, and rationale, were documented as necessary.

An alert is entered into the the alert system with a colored dot on the outside of the case record, documentation inside the case record in the alert section, documented in log book, and put on white boards with a colored dot in the respective shelter and shift leaders building.

3.04 Log Books

Satisfactory

Limited

Failed

Rating Narrative

The program maintains several log books. There is one log book for the Shift Leaders and another for each of the separate shelters (Male/Female).

The supervisory log book is used to document intakes/discharges, program activities, appointments, safety and security issues, and other client care information.

According to staff, a system of emails is also utilized to communicate and document mental health and medical alerts.

All Log books are highlighted for safety and security issues, as well as, alerts.

All entries are brief and legible in ink. Date and military time is documented in the log book along with the names of the youth and staff involved. No corrections or the use of white out were observed. Supervisory weekly reviews were consistently conducted with recommendations or follow up when indicated.

The oncoming shift leaders consistently documented having reviewed the previous two shifts

The Shift Leader maintains a separate log book that is reviewed by each incoming Shift Leader. This is reviewed weekly by a manager. On each unit there is another Log Book which is maintained by a primary staff person. As a practice, other staff on the unit do not review the previous two shifts, but are given a verbal shift briefing. This log book is not reviewed weekly by a designated person.

Rating Narrative

The shelter's behavioral management system is clearly outlined in the Client Handbook. It is a daily point system designed to promote appropriate prosocial behavior which includes, for example, wake up, appearance and personal hygiene, attending school, leisure skills, chores, attitude (appropriate language, respect toward others), positive peer interaction, and bed times.

There are four levels in the Behavioral Management System: Orientation (first 24 hours), Level 1, Level 2, Level 3. Each Level is earned by the number of points obtained by the youth. Level 1, the highest level with the highest level of earned privileges requires a minimum of 90 points. Level 2 requires 80-89 points. Level 3 requires 0-79 points.

Privileges are determined by each subsequent earned level. Orientation Level only allows for game and phone privileges, whereas on Level 1 youth are able to have off-campus activities, work incentive jobs, athletic center and covered Pavilion privileges, Teen Center, Late Night, and special privileges.

According to staff the behavioral management system is effective, consistent, and fair.

Staff are trained in the behavioral intervention techniques known as NAPPI: Non-Abusive Psychological and Physical Interventions. Ten staff are trainers. All direct service staff receive sixteen (16) hours of initial training in NAPPI and then eight (8) hours of refresher training each subsequent year. NAPPI training is conducted once a month. NAPPI debriefings occur twice a month.

Room restriction is not used. Group discipline is not imposed. Only staff discipline youth.

3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

Rating Narrative

Shift schedules are 6am to 2pm, 2pm to 10pm, and 10pm to 6am. Staff are able to ensure compliance with 1:6 ratio during waking hours and 1:12 during sleeping hours. In addition to the direct care workers, a shift leader works each shift. A Manager is also on duty. A security guard works from 6pm to 6am to ensure that the grounds are secure.

A staff schedule is posted. A review of the staff schedules of the completed staffing pattern indicated that the program consistently maintained staff ratios during awake and sleeping hours. Male and female staff were consistently present as required by the indicator. There is always at least one staff member on duty of the same gender as the youth. If necessary, direct staff are able to be utilized from other programs on the grounds.

The male shelter and grounds are equipped with security surveillance. The female shelter is not equipped with cameras. Staff complete ten minute room checks rather than the required fifteen (15) minutes. A random sample of three bed checks on video on indicated that staff in the male shelter completed the ten minute checks as documented.

3.07 Special Populations

Satisfactory

Limited

Failed

Rating Narrative

The Hillsborough County shelter is not contracted to Staff Secure youth. Nor has the program had any Probation Respite youth in the last six months.

According to staff in the shelter, the program has admitted the second largest number of Domestic Violence (DV) youth in the state. Referrals come from the county JAC and detention center for youth with a pending DV charge.

In a review of four (4) DV case records, the length of stay did not exceed fourteen (14) days. Of the four (4) cases, all had a treatment plan completed at admission. However, this was a photocopied plan that was identical with the exception of dates and signatures, and did not address anything related to domestic violence.

It should be pointed out that goals were put into progress notes when the youth was seen in all four (4) of the cases, that address DV issues during individual sessions.

It was recommended, for all DV youth, that a separate initial treatment plan be developed to address DV issues at intake

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The Hillsborough County program provides screening, counseling and mental health assessment services. The program has childcare specialists that are trained to screen, assess and notify all staff members of conditions and risks of all youth admitted to both residential and non-residential CINS/FINS programs. The agency provides risk screening and identification methods to detect youth referred to their programs with mental health and health related risks. Specifically, the agency utilizes screening and a CINS Intake form to determine eligibility and various screening methods to determine the presence of risks in the youth past mental health status, as well as their current status. The agency also screens for the presence of acute health issues and the agency's ability to address these existing health issues. Further, the agency has a Registered Nurse on staff to provide health screenings within seventy-two (72) hours of a youth being admitted to the program. The agency also uses a general alert board to inform all staff members on each shift of the health and mental health status of all youth in residential youth shelter. Shelter staff assists in the delivery of medications to all youth when needed. The agency provides medication distribution training to all direct care staff members, first aid response, CPR, first aid, fire safety, emergency drills and exercises and training on suicide prevention, observation and intervention techniques.

At the time of the review, the Clinical Director position was vacant and the "acting" Program Director was having to fill this role. The program had seven Treatment Counselor's, two of which are Clinical Social Workers, to provide services to residential and non-residential youth.

4.01 Healthcare Admission Screening

Satisfactory
 Limited
 Failed

Rating Narrative

The program has developed policies and established procedures that address all items in this indicator. At the first contact with a family seeking residential services, an Admissions Checklist/Physical Health Screening Form is completed. It captures information on recent injuries, allergies, medication, exposure to recent illnesses or disease, and the list of chronic conditions listed in this indicator. According to staff, if a medical concern is identified, the family may be required to obtain medical clearance prior to admittance.

At intake, in addition to the information already gathered, the Florida Network CINS/FINS Intake Form is utilized to capture all of the required and additional medical information. Additionally, a front and rear body sketch is used to visually show identifying marks, scars on the body. During the intake process, if a youth has a medical issues or is on medication, the staff notifies the nurse who sees the youth within 72 hours and completes a Medical Assessment and suggests follow-up as needed. Parents/guardians are expected to schedule and transport to all non-emergency medical appointments. All medical appointments are documented and highlighted in the Shift Leader logbook rather than a daily log.

Four residential files and portions of the current Shift Leader Logbook were reviewed. All four files included screenings for the required elements. One youth was identified as having asthma and the outlined procedure was confirmed.

4.02 Suicide Prevention

Satisfactory
 Limited
 Failed

Rating Narrative

The agency has a Suicide Prevention and Intervention Policy that was last reviewed on March 1, 2014. Youth are screened for suicidal concerns during intake using the six questions on the CINS/FINS Intake Assessment Form. If the youth answer yes to any of the six screening questions the youth placed on constant sight and sound supervision until a Treatment Counselor completes a more in-depth assessment. A red dot is also placed next to the youth's name on the client board and on the outside of the youth's file. A red sheet of paper is placed in the client's file to identify the issue of concern. Any youth with risk factors for suicide are referred for a counselor's assessment within twenty-four hours. A Treatment Counselor will assess a youth using the Assessment of Suicide Risk form. Based on the outcome of this assessment the youth will either remain on constant sight and sound supervision, be Backer Acted, or be taken off constant supervision and be placed on an elevated status. A Suicide Risk Assessment Summary is also completed that documents the date and time the youth was placed on suicide precautions and the reason why, a clinical staff review with recommendations, and when the youth was removed from elevated observation status.

The shelter employs three licensed staff and a master's level counselor who is a registered intern. There were four youth files available for review for youth who had been placed on suicide precautions. All four files documented the youth were placed on suicide precautions at intake

due to issues identified during the screening process. All four youth remained on constant sight and sound supervision until assessed by a qualified professional. All youth were seen and assessed, using a suicide risk assessment, within twenty-four hours. All suicide risk assessments were reviewed by a licensed professional prior to any changes in the youth's supervision level. All Youth were placed on an elevated supervision level upon completion of the suicide risk assessment. All four youth had thirty minute observations documented the entire time they were on suicide precautions. The shelter maintains ten-minute observations of the youth while on elevated supervision, this was documented in three of the four files. Any youth on suicide precautions sleeps in the first room in the hallway in the appropriate boys or girls shelter. All changes in supervision levels were documented in the youth's file on the suicide assessment summary form, in all logbooks, and in an email to all staff.

Note: Youth are placed on elevated supervision as a step down from constant supervision. During the time on elevated supervision documentation goes from 30 minutes to every 10 minutes. The 10 minute observations do not have to be maintained the entire time the youth is on elevated supervision, only when youth is in sleeping room, i.e. overnight shift, that youth would be on 10 observations instead of 15 like the other youth.

4.03 Medications

Satisfactory

Limited

Failed

Rating Narrative

The agency has detailed policies related to the delivery of medication to youth admitted to the youth shelter. The agency policies are highly structured and meet the general requirements of the current indicator. The agency had written procedures that addressed the safe and secure storage, access, inventory, disposal and administration of medication in accordance with the DJJ Health Services Manual. The agency has a Registered Nurse overseeing the medication documentation and inventory of the agency's medication process. The program had a list delineated in writing of staff that are designated to have access to secured medications, and limited access to controlled substances.

The agency utilizes a Medication Distribution Record to capture major information related to each youth admitted to the youth shelter on a daily basis. The MDR includes name, date of birth, picture, allergies, side effects, staff initials, youth's full name and initials, staff member initials and name.

All medications in the shelter are stored in a separate, secure area, which is inaccessible to youth. There were no injectable medications on site, or identified as needed for any youth during the time of the review. The shelter has a system in place for refrigeration of medication if needed, however there was no medication that required refrigeration during the time of review. Controlled medications are locked in large metal cabinets behind two (2) locks. One cabinet is designated for controlled/narcotic medications and prescribed medication. This cabinet features metal housing with a locking metal door and individual locks on each slotted shelf that houses a medication. The other cabinet houses over the counter medications.

Shift-to-shift counts and a perpetual inventory is maintained, and documented for controlled medications. Prescribed medications are inventoried by documenting the original amount of medication when the youth enters the shelter and then initialing each time the youth receives a dose. By going back and looking at the starting amount and then subtracting each time the youth receives a dose you can determine the number of pills that should be in the bottle. It was recommend that staff actually write the number of pills left in the bottle, maintain a running perpetual inventory, each time the medication is given to the youth and document this on the MDR. Oral medications are stored separately from topical medications. When both medications are required, each is placed in a baggie or tray to ensure separation. Over the counter medications (OTC) are accessed regularly and are inventoried weekly by the nurse. However, there was no daily perpetual inventory of the OTC medications. Each youth has a separate MDR for each OTC medication and if the youth receives that medication the youth and staff will initial the applicable MDR.

Sharps are secured as required. The agency maintains an inventory of sharps that include nail clippers, shaving razors, wire cutter, tweezers, scissors and a pill cutter. These sharps are inventoried each shift and documented in the shift leader logbook. The nurse conducts a weekly inventory of the sharps as well.

There were four youth files reviewed to verify the medication administration process. The youth's MDR is maintained in the youth's individual file. All MDRs reviewed documented the youth's name, a picture of the youth, allergies, medication the youth was taking with dosage and time to be given, method of administration, staff initials, youth initials, full printed name and signature of each staff member who initialed a dosage. A print –out of side effects in each file for each medication the youth was taking. All MDRs reviewed documented medications were given at the times specified.

Over the counter medications (OTC) are accessed regularly and are inventoried weekly by the nurse. However, there was no daily perpetual inventory of the OTC medications. Each youth has a separate MDR for each OTC medication and if the youth receives that medication the youth and staff will initial the applicable MDR.

4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place for Medical Information, Behavioral Concerns, and Mental Health Communication Alert Process. The policy was last reviewed on March 1, 2014. The shelter uses a colored dot system with a blue dot indicating a medical alert, a yellow dot indicating a behavioral alert, a red dot indicating a mental health alert, and a green dot indicating there is no issue. The appropriate colored dots are placed next to the youth's name on the Client Alert Board in the shift leader building, the alert is documented in the shift leader's logbook and in the shelter logbook, as well as, discussed during the shift briefings and emailed to all staff. In addition, a corresponding color coded paper is placed in the youth's file under section C to coincide with the alert. This form gives staff further information about the specific alert.

A review of four youth files found all alerts were appropriately documented with the colored dot on the front of the file and the appropriate colored sheet inside the file. Alerts documented on the file corresponded with the alerts documented on the Client Alert Board and in all logbooks. Staff interviewed were very knowledgeable of the alert system and were able to articulate the process from the shift briefings to documentation in the logbooks and meanings of the different colored dots on the alert board.

4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

Rating Narrative

The program has established procedures for this indicator. An Episodic Care Logbook is maintained by staff and includes an Episodic and Emergency Care Tracking Form and includes the corresponding Internal Incident Report, the CCC Call-In Log Form if applicable, and progress notes providing updates.

Three incidents were reviewed for this indicator. One youth had a lower leg injury and seen by the program nurse who recommended getting outside medical attention. The parents were notified and transported the youth to the Doctor. Youth was diagnosed with a sprain and given instructions for care. The shelter obtained follow up care instructions and clearance. The CCC was called and the report was not accepted.

The second incident involved a youth who was having trouble breathing. EMS was called and the youth was transported to the hospital. The mother was notified and met the ambulance at the hospital. Youth was diagnosed with a panic attack, dehydration, and strep throat. Youth was not hospitalized and did not return to the program. CCC report was not accepted.

The third incident involved a youth who left school and was hit by a car. She was transported by ambulance and admitted to ICU. The program was notified by law enforcement. The parent was notified and went to the hospital. Ultimately the youth lost several teeth and was diagnosed with a fracture to the skull and the base of her neck. The program staff stayed in touch with the parent and documented numerous follow-ups and additional progress reports. The CCC did not accept the report due to the youth not being considered a DJJ youth and she did not expire as a result of the incident. The youth did not return to the shelter.

Three of the four cases were not listed on the Tracking Log but all the information was maintained in the Episodic Care Log Book.

The program has the knife for life, wire cutters, and first aid kits available and staff are trained in CPR and First Aid.

Additionally the staff participate in quarterly mock emergency drills simulating events such as discovery of a weapon, seizure, hurricane evacuation, and shots fired.

The program does a nice job of keeping all relevant information in a central location.

The program developed an Episodic and Emergency Care Tracking Form but all emergency care incidents are not recorded on it.