Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Hillsborough County

on 04/02/2015

CINS/FINS Rating Profile

Standard 1: Management Accountability	
1.01 Background Screening	Satisfactory
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Limited
1.05 Analyzing and Reporting Information	Satisfactory

Percent of indicators rated Satisfactory:80.00%
Percent of indicators rated Limited:20.00%
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	Satisfactory
2.06 Adjudication/Petitiion Process	Satisfactory
2.07 Youth Records	Satisfactory

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

Standard 3: Shelter Care	
3.01 Shelter Environment	Satisfactory
3.02 Program Orientation	Satisfactory
3.03 Youth Room Assignment	Satisfactory
3.04 Log Books	Satisfactory
3.05 Behavior Management Strategies	Satisfactory
3.06 Staffing and Youth Supervision	Limited
3.07 Special Populations	Satisfactory

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:91.67%
Percent of indicators rated Limited:8.33%
Percent of indicators rated Failed:0.00%

Rating Definitions

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

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

Review Team

Members

Keith D. Carr, Lead Reviewer, FOREFRONT - Florida Network of Youth and Family Services

James Myles, Executive Director, Bethel Community Foundation

Terry Buckley, COO, Family Resources

Glenn Garvey, Operations Review Specialist/Regional Monitor, DJJ

Shad Renick, Residential Director, Sarasota YMCA

Persons Interviewed

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

3 Case Managers
5 Clinical Staff
1 Food Service Personnel
2 Health Care Staff

1 Maintenance Personnel
2 Program Supervisors
7 Other

Documents Reviewed

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

9 Health Records
6 MH/SA Records
7 Personnel Records
11 Training Records/CORE
10 Youth Records (Closed)
11 Youth Records (Open)
4 Other

Surveys

10 Youth | 10 Direct Care Staff | 0 Other

Observations During Review

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

Comments

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

Video camera footage was incosistent for the entire 2 day onsite review process.

No Probation Respite Referrals were submitted in the last 6 months.

Strengths and Innovative Approaches

Rating Narrative

The agency now requires that all Direct Care staff members wear uniforms. These uniforms consist of a Hillsborough County branded polo and khaki pants.

Agency utilizes 2 professional Registered Nurses on campus Mondays-Fridays.

Agency uses a digital scanning system to capture, organize and store Staff member personnel records and non-residential client files.

The agency has access to licensed mental health professionals.

The agency's management is in the process of conducting restructuring in its CINS/FINS and residential group care programming. This reorganzation is a major transition process with multiple steps impacting staff members at all levels. The agency reports that this transition process will take an extended period of time to complete. The agency has multiple goals including professonalization for their staff members. The agency is currently working with an outside consultant on their reorganization and overhaul of the program. The agency will revamp many areas related to its staff, programming operations, and services to youth and families.

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. Division's Director oversees the residential and non-residential components of the program, including the volunteer and outreach initiatives.

The shelter is licensed by the Department of Children and Families. The program's Emergency Disaster Plan has been approved by the Florida Network. The agency administrative offices and youth shelters are housed in buildings co-located on campus can be utilized up to a level three and four hurricane category. The agency maintains key partnerships in the community with major local service providers, as well as community base program and agencies. The agency has key partnerships with the local school system, law enforcement, social services and cultural and arts programs.

The agency does utilize the Florida Network, computer-based trainings and training delivered in house by Hillsborough County staff.

At the time of this QI Review, the agency has multiple vacancies. Per the agencies organizational chart date March 19, 2015, there are an estimated minimum of 13 vacant child care positions and 3 vacant Sr Child Care positions. Interviews conducted with direct care staff members report that staff members are experiencing stress due to the the lack of on-call and part-time staff members positions. Further, current direct care staff reported that current or recent hires are not fully trained prior to being place in the staffing schedule to supervise and work with CINS/FINS Residents. The Lead Reviewer interviewed a recent hire and reported that they had only received two (2) trainings and no job shadowing time prior to being required to work on an overnight shift. Additional staff members reported that the current reorganization has required a work shift change from three (3) - eight (8) hour work shifts to two (2) - twelve (12) work shifts. Staff report that is a major change that has caused many staff to leave or resign and has resulted in having no time during work for any breaks. Staff report that having fewer well trained and experienced direct care staff members has brought down quality level of services being provided to the residents. In addition, staff members report moral is low and has been deeply impacted by the reorganization process.

1.01 Background Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a written policy and procedure that addresses background screening for all new hires and any student interns, mentors, volunteers, and frequent visitors that provide services more than ten hours per month will be screened. The policy was last reviewed March 1, 2014.

There were seven new employees hired since the last annual compliance review of which all seven had a completed background screening completed by their hire date. All seven were eligible and none required an exception be granted. There were no employees required to have a five year rescreening for this review period, however there are six employees that require a five year rescreening prior to the end of the calendar year. The packets have been started on those employees so the shelter can remain in compliance. The program submitted their Annual Affidavit of Compliance with Good Moral Character on January 26, 2015.

The program does not have any volunteers that provide ten or more hours of services per month to the youth that would require a background screening and/or a five year rescreen.

No exceptions noted.

1.02 Provision of an Abuse Free Environment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has written policies and procedures that address verbal abuse, neglect or abuse of clients, and abuse reporting that was last reviewed March 1, 2014. The employee is also required to sign a form upon hire that is titled child abuse/neglect definitions and reporting procedures that include obligation to report, failure to report, and prohibited discipline. A review of personnel files on the seven new hires found that all seven contained a signed copy of the form.

There were ten youth surveyed and all ten indicated that they felt safe and no adults ever threaten them or other youth. One of the ten youth indicated that they had heard a staff curse. There were six staff surveyed and all six indicated that a youth was never denied an abuse call and never observed a co-worker use threats, intimidation or humiliation when interacting with youth. One staff indicated they heard a staff use profanity.

There were no incidents found during the review that indicated that the shelter was not providing a environment that youth, staff and others did not feel safe, secure, and feel any threat of any form of abuse or harassment.

No exceptions noted.

1.03 Incident Reporting

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There were twenty-two (22) reports made to the Central Communications Center (CCC) in the past six months. Ten of the reports were in regard to youth that had absconded from the shelter, two involved vehicle accidents involving program vehicles, four involving contraband, one youth not returning from a home visit, three youth behaviors resulting in their arrest, one complaint against staff and one for improper supervision. There was only one of the twenty-two reports not made within the required two hours of becoming aware of a reportable incident.

There were no incidents found during the review that should have been reported to DJJ CCC and were not.

There was only one of the twenty-two reports not made within the required two hours of becoming aware of a reportable incident

1.04 Training Requirements

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

The training printouts were reviewed for the seven new employees hired since the last annual compliance review. The reviewed documentation had the training hours range from zero hours to twenty-nine and a half hours. There were only two of the seven new hired staff that have received COR/1st Aid training and only two had received suicide prevention training. Five of the seven had received crisis intervention training. There were also four training printouts reviewed for annual training requirements and those hours ranged from forty-three to eighty-four and a half. There was one of the four staff that is out of compliance with their CPR/1st Aid training and only two had completed universal precautions training.

There were only two of the seven new hired staff that have received CPR/1st Aid training and only two had received suicide prevention training. Five of the seven had received crisis intervention training. There was no documentation that indicated any of the new hires received a program orientation, CINS/FINS Core training, Title IV-E procedures, fire safety equipment training, in-service component training, signs and symptoms of mental health and substance abuses, universal precautons, or cultural competency training. There was one of the four staff that is out of compliance with their CPR/1st Aid training and only two had completed universal precautions training. The review of the 2014-2015 annual training plan along with the calendars indicating the date when a training is scheduled to be conducted would indicate that staff would not receive the required training to be in compliance with the various subject areas that new hires and annual requirements of those staff employed beyond one year are identified to receive.

1.05 Analyzing and Reporting Information

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The review of grievances completed by the youth found that there were a total of seven submitted since September 2014, of which six were submitted by one youth. Documentation of satisfaction surveys completed by youth and parents that is completed on Survey Monkey. The results indicated that both the youth and parents had a positive outlook on the shelter. The average for the first two quarters reported on indicated that ninety-one percent of the youth were satisfied with the shelter and ninety-two percent felt safe at the shelter. The review of the case record review for CINS records over the past six months indicated that the average number of files reviewed was seventy percent with a low of fifty percent and a high of one hundred percent. The review of the case record review for RGC records over the past six months indicated that the average number of files reviewed was ninety-five percent with a low of eighty-eight percent and a high of one hundred percent. The fiscal year 2014 quality improvement committee annual report was reviewed which included key highlights, resolution to key highlights, areas in need of improvement and recommendations.

No exceptions noted for this indicator.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

Hillsborough County Children's Services is contracted to provide both shelter and non-residential services for youth and their families in Hillsborough County. The program provides centralized intake and screening twenty-four hours per day, seven days per week, and each day of the year. Trained staff are available at the program site to determine the needs of the family and youth. Upon referral, a screening for eligibility is conducted and the screening is the initiation of the assessment process. Information regarding the youths' presenting problems, living situation, etc. is collected. Upon intake into either program (residential shelter or non-residential services), a more thorough assessment is completed. After all assessments are completed, the assigned counselor develops a case services plan with the family during the initial family session. If the assessment indicates the need for a referral to a more intensive or specialized service such as substance abuse or mental health treatment, the counselor makes the necessary referral for service. After the development of the case service plan, the counselor works with the family to implement the plan. Counselors document progress towards completion of the service plan goals. The agency maintains a "paperless" non-residential client file system, while the residential program maintains paper files. The system utilizes electronic documents in which each counselor maintains all files on a dedicated drive. Because non-residential counselors work remotely throughout the county, each counselor utilizes a laptop to manage scanned files that are organized in folders.

2.01 Screening and Intake

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Program has Screening and Intake policy requring eligibility screening completion within 7 days of referral. Also standard 2.01 policies require documentation and receipt by parent/youth of orientation to program servicws, Rights and Responsibilities and Grievance procedures. Eight(8) client files were reviewed, including three(3) residential and five(5) non-residential. All 8 files included documentation of eligibility screening completed day of referral, clearly within 7-day policy. Additionally, all 8 files included documentation and receipt by parent/youth of program services, Right and Responsibilities, and Grievance procedures. Of particular note is the 28-page Client Handbook that is comprehensive and detailed.

2.02 Needs Assessment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Program policy requires residential clients psychosocial to be completed or attempted within 72 hours of admission. Policy for non-residential requires psychosocioal is completed within first 2-3 contacts. Policy also requires psychosocial review and sign-off by clinical supervisor. Policy also met 2.02 standard requiring suicide assessment for clients with elevated risk of suicide. The 8 files reviewed reflected 2 of 3 residential clients had psychosocials completed witin 72 hours and 3 of 5 non-residential clients completed within 2-3 contacts. The one(1) residential file without a Needs Assessment had no evidence of an attempted psychosocial. The two (2) non-residential files without psychosocials reflected clients that did not return to services after the initial clinical contact. Two(2) of the 8 files were clients with elevated suicide risks and both were referred for and had suicide risk assessments completed by liscensed MH professional.

2.03 Case/Service Plan

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Program policy requires case plan development within 7 days following completion of psychosocial and review of plan every 30 days. Policy also requires case plan issues be driven by psychosocial assessment needs. Additionally, requires service plan include services, responsible parties, target dates, completion dates, initiation date, and signatures by parent, client, counselor and supervisor. Of the 8 files reviewed, 3 of 3 residential files and 3 of 5 non-residential files had case plans, all within 7 days of psychosocial.The two(2) non-residential files without plans represented clients who left services after only one(1) contact with therapist, no psychosocial and therefore no case plan. The 8 filles reviewed had only (3) 30-day reviews completed. The other 5 files were all early closures, including 2 early residential and 3 early non-residential closure Of particular note are the non-residential treatment plans that are comprehensive and needs focused with extensive detailed 30-day reviews.

2.04 Case Management and Service Delivery

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Program written policies for 2.04 minimally address the 11 key indicators of the Case Management and Service Delivery standard. However, review of 8 client files indicate all youth are assigned Counselor/Case manager and that staff person coordinates asssessment of needs and referrral to appropriate services. Files document referrals for substance abuse and medical/psychiatric, including residential theraputic. The files all reflect counselor/case manager coordination and implementation of service plan with youth/family, including referral and follow-up with case staffings recommendations and CINS/FINS Court when necessary. Practice as documented in the files is consistent with key indicators of standard 2.04.

2.05 Counseling Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Program has written policy & procedures that address the key indicators of 2.05, including group counseling in the Shelter and Outpatient individual/family counseling, including representation of youth's presenting problems re: psychosocial, case plan/treatment plan. Review of 3 months(Jan-March) of client group sign-in logs indicate youth participate in educational groups 1-2 X's daily facilitated by Direct Care staff. Review of 5 out-patient clients indicate all records are electronically maintained, including screeening intake to closure. All records are scanned in the program's digital client system. All 5 records were electronically reviewed and were complete, including screening, intake, psychosocial assessment, treatment plan, 30-day goal reviews and discharge. Of particular note was the thorough and comprehensive professionalism evident with documentation of the psychosocials, treatment plans, case note narratives and 30-day goal reviews. Policy and practice are consistent with key indicators of Counseling Services.

2.06 Adjudication/Petitiion Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Program has policies and procedures for standard 2.o6, including parent 7-day notification for case staffing, 15-day letter notification & 5-day phone contact. Policy indicates Case Staffing Comittee is a standing committee that meets monthly on the 3rd Thursday with memo reminders prior to meetings. Policy indicates core members of case staffing team includes not only required DJJ and and School District representative, but also CINS/FINS provider, Hospice, Tampa Housing, PACE and a Youth Advocate prevention organization. Policy also indicates youth/family are provided,immediately following staffing, a copy of new/revised service plan recommendations. policy includes provisions for Case Staffing to recommend CINS petition be filed in Circuit Court for judicial intervention when youth refuses to follow staffing recommendations. Policy also indicates requirement for Case Staffing Coordinator to prepare and submit case summary for CINS Court.

Three(3) case staffing files were reviewed, two(2) initiated by parents and one(1) by School Social Worker. One(1) of 2 parent cases had staffing within 7 days, but the second case had hearing on day 10. Only 1 of 3 cases was noticed outside the 5-day limit, the other 2 were noticed @ 2 & 3 days. Review of Agency sign-in rosters for past 6-months verify policy of participation with attendance @ staffings from 3-8 agencies, including DJJ, School Board, MH, other CINS/FINS provider, Housing Authority, and PACE. In all 3 files, documents present showing copy of staffing recommendations provided family after staffing. In 2 of the 3 cases the process of CINS petitioning with Court was consistent with policy & procedure. 2.06 has policy that covers all elements of the Adjudication/Petition process and practice is consistent with written policy and requirements of the Standard.

2.07 Youth Records

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Agency has several related policies to address the format, organization, storage and security of records. These policies are called confidentiality of client records, organization of client records and entry of information into clinical records, storing/dispostion of client records, client record management and security.

A reveiw of youth records reveals that files are file in a 6-file folder. All files are stamped confidential in the front cover. All paper files are stored securely and are not accessible to clients. Client are easy to access on a routine basis.

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

No exceptions are noted for 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 environement consists of two CINS/FINS cottages along with a nurses building, cafeteria, administration building and other cottages not related to this audit. The grounds are clean, neat and well maintained. There is ample room for the youth and their facilties are in good shape. The youth are appropriately oriented to the program with the review of the Client Handbook. Room assignments are determined based on several factors, each of which is documented. The log books are maintained in the cottages, but staff do not sign in and out consistently and documentation of supervisory reviews is not taking place consistently either. The Behavior Management System is appropriately designed to address compliance and non-compliance of residents. Residents receive rewards for their behavior and the point sheets and documentation for behavior is appropriate. Residents are allowed to attend a "Swap Shop," to purchase items for those that demonstrate appropriate behavior. There is no documenation of training of front line staff or supervisors in the Behavior Management System. Staffing and supervision have a lot of issues in reference to staff signing in and signing out. This leaves questions as to whether or not the program is within ratios.

3.01 Shelter Envonment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The facility has a Policy and Procedure that meets the requirements of the standard. The program has over seventy different policies that corresepond to the standard, which makes it difficult to determine which policies are appropriate or not for the standard. All fire, safety, disaster plan and health standards along with their drills have been completed on time. The facilities are kept clean and in good order. The facility has two cottages for the CINS/FINS youth along with a nurses building, cafeteria and administration building. The cottages house twelve youth with bedrooms, kitchen, bathrooms, a recreation area and work areas. Grievance procedures were posted along with the grievance box. Grievances were followed up on by administration. The daily activity schedule was posted in both cottages.

On the first days of the review the surveillance cameras were not in working order for most of the day. Only one of the cottages has working surveillance cameras at this time. The male cottage or cottage E has four surveillance cameras, while the female cottage does not have any surveillance cameras inside. All other surveillance cameras are exterior.

It is difficult to determine the affectiveness of the key control as staff are not consistently signing in and out. According to the supervisor keys are transferred from one staff to the other when they change shifts.

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3.02 Program Orientation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a Policy and Procedure that meets the standard. The majority of program orientation information is detailed in the Client Handbook. There are two separate areas that address the handbook being given to the youth and family. There were ten files reviewed for compliance for this standard. Of those ten files, four were active files and six were closed files. In one of the ten files the youth refused to sign the orientation paperwork. In one of ten files the parent signed the orientation paperwork the next day and in another the parent signed the majority of the paperwork, but did not sign or date the paperwork. Overall all aspects of the standard were satisfied. Three of the ten files had youth who required suicide alert notifications completed.

There are no exceptions documented for this Program Orientation Assignment indicator.

3.03 Youth Room Assignment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a Policy and Procedure that meets the standards. The room assignment information is contained in the CINS/FINS intake Form in the Client Room Assignment section. Room assignments were made in all six (6) files reviewed. In addition collateral information was gathered in the Admissions Checklist as well as the Admissions Report forms. The purpose for the room assignments was contained in each file.

There are no exceptions documented for this Youth Room Assignment indicator.

3.04 Log Books

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a Policy and Procedure that meets the standard. Entries are legible and signatures from staff are documented in ink. Significant occurrences in reference to safety and security are documented and highlighted in yellow. Residents counts are occurring on a regular basis. Supervisory reviews are not being conducted on a regular basis and recommendations from supervisors are also not occurring regularly. When they are occurring it is difficult to differentiate bewtween staff and their supervisors. Reviews of the previous two shifts is occurring often, but not consistently across the program. Staff are not consistently signing in and out of the log book.

3.05 Behavior Management Strategies

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a Policy and Procedure that meets the standard. The Behavior Management System is detailed in the Client Handbook and addresses positive behavior, accountability, consequences for non-compliance and incentives at orienation. Point sheets are completed daily and the point system is detailed in the Client Handbook as well. There is a white board that indicates the residents level in the cottages. The residents are afforded priviledges based upon their levels that include off-campus activities, game priviledges, phone priviledges, athletic center privildges and late night activities. In addition the Behavior System has a "Swap Shop," that the residents have access to where they can use points earned to purchase items on a bi-weekly basis. The program indicated that staff are trained on shift using "job shadowing." However, there is no documenatation in the training files that indicates that staff have gone through "job shadowing." Supervisors do not have documentation of how to monitor their staff's use of the Behavior Management System either.

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3.06 Staffing and Youth Supervision

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

The program has Policy and Procedure that meets the standard. It is extremely difficult to ascertain if the program is maintaining appropriate ratios. When reviewing the log book some staff have not signed in or signed out making it difficult to determine the ratios held. After reviewing three separate dates in th girls cottage, 2/22/15, 3/3/15 and 3/15/15, the compliance with ratios was not able to be determined. In each case the program indicated that either a floater or supervisor filled in for staff to make the ratios correct. However, it was not able to be determined if and when that staff came to the cottage to fill in as they did not sign in. There were staff on campus, which could be determined, but it was not clear where they worked. There were entries in the log book which stated that staff were transporting residents or returning from somewhere, but they did not sign in at that particular cottage. When the boys cottage was reviewed, three more dates were reviewed in the log book. On 1/11/15, 2/1/15 and 3/6/15, the staff did not sign in or out in the log book making it appear as there was no staff on shift. However, the log book had documentation from a staff member around 7:30 PM that the staff member was in the dorm, but had not signed in. A supervisor interviewed stated that floater staff or supervisory staff sign in elsewhere and then go to the cottages to assist in the ratio. However, this was not able to be determined via documentation. Only that staff was on campus.

Bed checks are conducted every ten minutes as opposed to every fifteen minutes according to documentation. However, with no cameras in the female dorm this could not be verified visually in that cottage. Cameras did not function consistently on a day 1 and day 2 of this onsite program review.

3.07 Special Populations

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a detailed policy on probation respite. The agency has multiple policies that include admissions, discharge -CINS/FINS Shelter Criteria and CINS/FINS Screening Intake Discharge Process.

The reviewer selected a sample of six (6) client files. The agency utilizes a 6 section client file folder and all files are organized as required. A review of the client files indicates that the agency has a practice staffing and programming in place regarding Domestic Violence Special Population assigned to the program. The agency does have domestic violence cases. Of these 6 cases all have assigned evidence of referral documents in the file from the JAC/Detention. Evidence in the file indicates that youth placed in shelter do not exceed a 14 day placement. File documentation states that there are treatment plans in 4 out of 6 resident files. All client files have evidence of Domestice Violence Respite specific treatment plans. In general all DV Respite are consistent with all other general program requirements.

Two (2) out of the six (6) client files reviewed did not have a treatment plan that is specific to addressing domestice violence issues.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The program has policies with an effective date of 3/1/12 and were last reviewed 3/1/14. The review of the policies is past due. The program has a comprehensive master plan that covers most of the requirements in this standard. Other policies cover the remaining required items. Two Treatment Counselors provide counseling services to the CINS youth, one of whom has been employed for 5.5 years and the other for 17 years. The program has a multi-tier system for screening and assessing youth for medical, mental health or substance abuse conditions that need immediate action. A comprehensive alert system is in place to ensure all staff are aware of youth's needs within the required time frames.

The Hillsborough County program provides screening, counseling and mental health assessment services to both residential and non-residential CINS/FINS clients. The Hillsborough County Government has Child Care Specialist staff members are that are trained to screen, assess and notify all staff members of conditions and risks of all youth admitted to both residential and non-residential CINS/FINS programs. The agency provides risk screening and identification methods to detect youth referred to their programs with mental health and health related risks. Specifically, the agency utilizes screening and a CINS Intake form to determine eligibility and various screening methods to determine the presence of risks in the youth past mental health status, as well as their current status.

The agency also screens for the presence for acute health issues and the agency's ability to address these existing health issues. Further, the agency has Registered Nurses permanently on staff to provide health screenings on youth admitted to the program. The Hillsborough County program assists in the delivery of medications to all youth admitted to the youth shelter. The agency operates a detailed medication distribution system that includes direct assistance from two (2) Registered Nurses. Nurses oversee and distribute the majority of all medications during the week. The agency provides medication distribution training delivered by Registered Nurses to all direct care staff members, first aid response, CPR, first aid, fire safety, emergency drills and exercises and training on suicide prevention, observation and intervention techniques.

The agency also uses a general alert board to inform all staff members on each shift of the health and mental health status of all youth in residential youth shelter. The agency also requires all staff to complete emergency training.

4.01 Healthcare Admission Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has policies with an effective date of 3/1/12 and were last reviewed 3/1/14. The program has a comprehensive master plan effective 3/1/12, reviewed 3/1/14, that includes a three tier process for assessment and screening. The review of the policies is past due. The program has a comprehensive master plan that covers most of the requirements in this standard. Other policies cover the remaining required items. Two Treatment Counselors provide counseling services to the CINS youth, one of whom has been employed for 5.5 years and the other for 17 years. The program has a multi-tier system for screening and assessing youth for medical, mental health or substance abuse conditions that need immediate action. A comprehensive alert system is in place to ensure all staff are aware of youth's needs within the required time frames.

The first screening is completed by the Manager or designee completing the Admissions Checklist/Physical Health Screening Form. If issues are identified during this screening, the nurse on duty is contacted by the Manager or designee for action (clearance or referral to appropriate community based resource). The second level of screening is conducted at the time of intake and is completed by the Child Care Specialist using the color dot system to communicate the youth's specific needs to the rest of the staff. The third tier is the psychosocial assessment completed by the youth's Treatment Counselor.

A Senior Child Care Specialist, employed for 12 years, a Treatment Counselor (employed for 17 years) and a Nurse (employed for 3.5 months) were interviewed to determine compliance with the policy and procedure for conducting screening. All were very knowledgeable of the process and validated each other's part in the process. All nine files reviewed had evidence of the admissions checklist/physical health screening form in the file. One of which was used from a previous admission and included additional entries for updating the information.

4.02 Suicide Prevention

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program's comprehensive master plan effective 3/1/12 and reviewed 3/1/14, addresses screening for suicidal issues during the referral process and again at intake (face to face). The youth's counselor conducts a full suicide risk assessment when indicated and completes a safety agreement with all youth. The policy indicates that staff follow program medical alert procedures and CINS/FINS suicide risk response standardized protocol. The policy also states that the youth will be referred for a counselor's assessment (using the Suicide Probability Scale or Child Depression Inventory) within 24 hours when indicated or within 72 hours from Friday evening to Monday evening if no staff is available. The policy establishes three levels of risk: suicidal history - moderate risk; suicidal ideation - high risk; and suicidal behavior - attempts to injure him/herself.

All three staff interviewed confirmed the correct implementation of policies and procedures, which also meet the FL Network's Policy and Procedure Manual for CINS/FINS requirements.

Of the nine files reviewed, six contained evidence of the youth requiring a more indepth assessment and appropriate level of supervision. Observation logs were also found in the applicable files.

No excpetions were noted for the Suicide Prevention Indicator.

4.03 Medications

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a detailed Medication policy that was last updated in March 2014. There are a total of severn (7) documents and work flow and tracking papers related to Medication. These polcies include an Administration of Medication policy; Medication Storage, Access, Inventories and Disposal; Medication Documentation; Types of Medication that will be Accepted into Programs; Controlled Substance Accountability and Inventory;Medication Changes; a Medication Information Manual. All policies indicate that theywere last reviewed in March 1, 2014. A Nurse works from 6AM – 8AM on campus 5 days a week Monday – Friday. Nurses provide training quarterly and on an as needed basis. The program submitted an up to date list of n writing of staff that are designated to have access to secured medications, and limited access to controlled substances.

All medications in the shelter are stored in a separate, secure room in an adjacent cottage. This room has limited access that 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 At the time of this review, there was no medication that required refrigeration during the time of review.

Controlled medications are locked in a large medication cabinet behind two (2) locks. The agency maintains the 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 are now being conducted 2 times per day as a result of the shift change to 2 12-hour shifts per day. Medication counts for Narcotics and a perpetual inventory is maintained, and documented for controlled and prescribed medications. Oral medications are stored separately from topical medications. Shift to shift counts are conducted and documented for controlled substances three (3) times per day once on each shift. Non-controlled is counted on a perpetual basis and when given.

Over the counter (OTC) are accessed regularly and are inventoried weekly by maintaining a perpetual inventory. The agency utilizes a Medication Distribution Log to capture major information related to each youth admitted to the youth shelter on a daily basis. The MDL includes name, date of birth, picture, allergies, side effects, staff initials, youth's full name and initials, staff member initials and name. The format of the MDL is functional and user-friendly.

The majority of the document has typed information to reduce non-legibile writers. Sharps are secured as required. The agency maintains an inventory of three (3) sharps that include nail clippers, shaving razor, wire cutter, tweezers, scissors and a pill cutter.

The agency also maintains several first aid kits that are sealed with break-away tabs. The agency also inventories all creams/ointments; bandages; and miscellaneous that are counted weekly. A 1 page inventory sheet with each of the aforementioned items is listed and counted by the Registered Nurse on a weekly basis. The agency utilizes bio hazard waste disposal bags in each first aid kits and waste bin.

A review of six (6) randomly selected client files indicate that all major requirements for medication documentation are being met. The documents reviewed included medication type, amounts, counts, staff and other related information.

Medication verification is primarilty completed by the Registered Nurses. When nurses are not available, agency staff members verify and confirm medications that enter the youth shelter with the licensed pharmacy that filled the prescription.

The agency has no medication errors related incidents that involve the agency's direct care staff or the Registered Nurse.

The agency has Registered Nurse Practitioners onsite on a daily basis. These Registered Nurses are primarily responsible for overseeing the medication documentation, inventory and training non-licensed direct care staff members of the agency's medication process. Nurses provide training quarterly to staff members and on an as needed basis. The program submitted an up to date list of n writing of staff that are designated to have access to secured medications, and limited access to controlled substances.

The nursing department provides and supplies a Quick Reference Medical Information Book. Agency uses punch packed pills for general over the counter pills. Prescription Drug Reminder information is included. Most common controlled drugs are also provided with expanded information. The six (6) rights are also given.

Agency provides a comprehensive reference source upon hire. Primarily a Senior Child Specialist II staff members are only positions provided training in order to give medication to residents.

All trainees have to take a test. Test results are submitted and a sign sheet is provided to personnel to documented in each staff members' training file. The agency requires that medication training be provided to all employees on an annual basis.

Overall medication process is extremely organized and well executed.

There are inconsistencies in the regular counting of sharps scissors, razors, wire cutters, nail clippers and tweezers for this indicator. The majority of counts found are documented on the AM shift change. There is also no consisting accounting for the disposal of shaving razors.

4.04 Medical/Mental Health Alert Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a comprehensive master plan effective 3/1/12, reviewed 3/1/14 that establishes a policy and procedure for healthcare, suicide and mental health services. The program also has a policy titled: medical information, behavioral concerns, and mental health communication alert process with an effective date of 4/12/13 and review date of 3/1/14. The color dot system is used to communicate issues; red - mental health/suicide precautions, blue for medical/substance abuse issues and yellow for behavioral concerns. Green dots are used to indicate general or no issue. The dots are posted next to their name on the client board and a corresponding colored sheet of paper is placed in the client's file in section "C" to identify the issue of concern. The youth's name is placed in the Log Book and email forwarded to staff indicating that the youth is on an alert status. The youth is placed on sight and sound supervision with the appropriate documentation on the Suicide Precautions-Constant Sight and Sound Supervision Log Form until a more in-depth assessment is conducted by the Treatment Counselor. In terms of medical

needs, medications or has a medical condition which is chronic or could result in a need for treatment, the shift leader notifies/follows up with the nurse on duty and will set up any needed medication dispensing and instructions. Food allergeis are noted on the food allergy sheet, placed in the client file and nurse is notified. The food allergy form is copied and placed in the kitchen mailbox, the clinic mailbox and in the youth's file in the medical section. The shift leader or intake staff will inform the child care workers of any medical conditions which may result in a need for treatment or emergency care.

Staff interviewed confirmed the implementation of the alert notification process as indicated in the policies and procedures. Of the nine files reviewed, five had indication of a need for heightened supervision. Documentation was found in the file to support that the appropriate level of supervision was provided.

No excpetions were noted for the indicator.

4.05 Episodic/Emergency Care

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a comprehensive master plan and policies effective 3/1/12, reviewed 3/1/14 that address first equipment, infectious outbreak and residential health services (which addresses routine required health services and any medical or dental services required due to unexpected illness or injury). Staff interviewed confirmed the implementation of policies and procedures addressing episodic/emergency care, in that, parents are expected to transport the youth when a medical issue arises that is not of an emergent nature. In the event of an emergency, 911 is called. A review of the log book revealed entries by staff communicating the medical needs and/or results of medical appointments and the required follow-ups. Files reviewed contained documentation of communication with the parent regarding the youth's medical condition.

No excpetions were noted for the Episodic Emergency Care Indicator.