Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Hillsborough County

on 04/04/2019

CINS/FINS Rating Profile

Standard 1: Management Accountability	
1.01 Background Screening of Employees/Volunteers	Satisfactory
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Satisfactory
1.05 Analyzing and Reporting Information	Satisfactory
1.06 Client Transportation	Satisfactory
1.07 Outreach Services	Satisfactory

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

Standard 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
2.08 Sexual Orientation, Gender Identity/Expression	Satisfactory

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

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

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

Standard 4: Mental Health/Health Services	
4.01 Healthcare Admission Screening	Satisfactory
4.02 Suicide Prevention	Limited
4.03 Medications	Satisfactory
4.04 Medical/Mental Health Alert Process	Limited
4.05 Episodic/Emergency Care	Satisfactory

Percent of indicators rated Satisfactory:60.00%
Percent of indicators rated Limited:40.00%
Percent of indicators rated Failed:0.00%

Percent of indicators rated Satisfactory:92.86%
Percent of indicators rated Limited:7.14%
Percent of indicators rated Failed:0.00%

Rating Definitions

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

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

Review Team

Members

Marcia Tavares, Lead Reviewer, Consultant-Forefront LLC

Toni DelRegno, Regional QI Monitor, Florida Department of Juvenile Justice

Shad Renick, Residential Director, Sarasota YMCA

Travis Scott, Residential Counselor, CDS Family and Behavioral Health

Mark Shearon, Chief Compliance Manager/ Arnette House, Inc

Persons Interviewed

- [ ] Chief Executive Officer
- [ ] Chief Financial Officer
- [x] Program Coordinator
- [ ] Direct-Care On- Call
- [x] Clinical Director
- [x] Case Manager
- [x] Nurse
- [ ] Executive Director
- [x] Program Director
- [x] Direct- Care Full time
- [ ] Volunteer
- [ ] Counselor Licensed
- [ ] Advocate
- [ ] Chief Operating Officer
- [x] Program Manager
- [ ] Direct-Care Part Time
- [ ] Intern
- [x] Counselor Non- Licensed
- [x] Human Resources

2 Case Managers
1 Program Supervisors
1 Health Care Staff

1 Maintenance Personnel
0 Food Service Personnel

1 Clinical Staff
0 Other

Documents Reviewed

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

3 # Health Records
4 # MH/SA Records
20 # Personnel Records
6 # Training Records
5 # Youth Records (Closed)
8 # Youth Records (Open)
0 # Other

Surveys

3 Youth 3 Direct Care Staff

Observations During Review

- [ ] Intake
- [ ] Program Activities
- [x] Recreation
- [ ] Searches
- [x] Security Video Tapes
- [x] Social Skill Modeling by Staff
- [ ] Medication Administration
- [x] Posting of Abuse Hotline
- [x] Tool Inventory and Storage
- [x] Toxic Item Inventory and Storage
- [ ] Discharge
- [ ] Treatment Team Meetings
- [ ] Youth Movement and Counts
- [x] Staff Interactions with Youth
- [ ] Staff Supervision of Youth
- [x] Facility and Grounds
- [x] First Aid Kit(s)
- [ ] Group
- [x] Meals

Comments

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

Strengths and Innovative Approaches

Rating Narrative

Hillsborough County Department of Children Services is a Hillsborough County operated department that focuses on keeping children, young adults, and families protected and empowered to live safe, healthy lives. Services provided include: Children in Need of Services/Families in Need of Services (CINS/FINS); Child Care; Case Management & Case Staffing; Safe Place; Residential Group Care; and Domestic Violence Respite. The CINS/FINS program for runaway and ungovernable children and their families, offers counseling services to reunite families and prevent runaway behavior, as well as short-term residential respite and shelter. Emergency shelter care is available for dependent, abused, or neglected children. For long-term foster care of adolescent females, there is a pre-independent living group home program. Additionally, there are training classes for parents to improve parenting skills.

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

Personnel

· Patrick Minzie is the new Youth Programs Operation Manager. He provides oversight of the residential programs on campus.

· Sarah Gimming and Arthur Hinton have joined the staff as Residential Service Coordinators who provide direct supervision to the Youth Care Specialists.

· Josephina Fletcher, LCSW is the new Senior Treatment Counselor. She will assist with supervision and oversight duties for both the CINS/FINS and Foster Care Programs.

· Bianca Ross, MA is a new Treatment Counselor, in the CINS/FINS program providing services in the Intensive Case Management Program.

New Programs

Intensive Case Management Program- Intensive Case Management Services (ICMS) are designed for youth ages 6-17 who are chronically truant/runaway/ungovernable, are court involved or are likely to enter the petition process, and may require more intensive and lengthy services. Services to youth shall be provided during traditional and non-traditional business hours in communities, homes and/or schools and shall connect youth and families to a coordinated, comprehensive array of services that meet their ongoing needs.

Peer Mediation-Peer Mediation is a program designed to assist young people in resolving conflicts by increasing communication and reducing potential violent acts and encouraging them to resolve their disputes by developing listening, critical thinking, problem-solving skills, and seeking peaceful resolutions. We have trained five youth in peer mediation and will be providing this opportunity to other youth and staff.

Future Services

Domestic Violence-Civil Citation- Civil Citation/Domestic Violence is a prevention program designed to serve youth ages 7 to 17 who have been served a Civil Citation summons for Domestic Violence. Services provided will be housing, intensive crisis stabilization services to stabilize the youth and the family and begin to resolve issues and family issues, domestic violence groups for the youth and family, and outpatient therapy upon the discharge process to promote ongoing family stabilization.

The Triple P – Positive Parenting Program ® is a parenting and family support system designed to prevent – as well as treat – behavioral and emotional problems in children and teenagers. It aims to prevent problems in the family, school, and community before they arise and to create family environments that encourage children to realize their potential. Triple P is delivered to parents of children up to 12 years, with Teen Triple P for parents of 12 to 16-year-olds. The program can be implemented with parents and youth in a classroom, home or community setting.

Step-Up is a nationally recognized adolescent family violence intervention program designed to address youth violence toward family members. Violent behavior includes threats, intimidation, property destruction, degrading language and physical violence. The goal of Step-Up is for youth to stop violence and abuse toward their family and develop respectful family relationships so that all family members feel safe at home.

Training

Residential Child and Youth Care Professional Certification- The Residential Child and Youth Care Professional Certification Curriculum was developed out of the University of Oklahoma and offers a Youth Care Professional Certification upon completion of the 42-hour curriculum. We are now providing all of the departments' Youth Care Workers the opportunity to be certified as well as staff from other agencies.

Community Connectedness

In an effort to provide comprehensive services to the Community Children's Services is participating with various social service entities and child welfare agencies such as the Cross-Over Committee to address youth who are involved with DCF and DJJ and the Juvenile Justice Board.

Standard 1: Management Accountability

Overview

Narrative

The Hillsborough County Department of Children's Services provides both Residential and Non-Residential CINS/FINS services for youth and their families in Hillsborough County, Florida. The program located at 3110 Clay Mangum Lane, Tampa, Florida is under the leadership of the Hillsborough County Government. The Division Director oversees the residential and non-residential components of the program, including volunteer and outreach initiatives. The shelter is licensed for 22 beds by the Department of Children and Families effective through July 31, 2019. Another shelter houses foster care youth and are licensed for 30 beds, also effective through July 31, 2019. The agency's administrative offices and youth shelters are housed in buildings located on a beautiful, large campus.

The program recently restructured and has designated leadership and management of the CINS/FINS program to the Clinical Director. The Director oversees both the clinical and youth programs component; the latter is under the direct supervision of the Youth Program Operations Manager (YPOM). The YPOM supervises 5 Residential Services Coordinators (RSC). The RSCs are responsible for supervising a total of 24 tier 2 youth child care specialists and 46 tier 1 youth child care specialists. The clinical component consists of 2 senior treatment counselors, a human services supervisor, 4 residential treatment counselors, 5 non-residential treatment counselors and 1 non-residential case manager, 4 RGC case managers, 1 program coordinator, and 2 registered nurses.

The agency maintains key partnerships in the community with major local service providers, as well as, community-based programs and agencies. The agency has key partnerships with the local school system, law enforcement, social services, and cultural and arts programs.

During the QI review, it was observed that the Department of Children's Services policies and procedures do not have signatures of approval, just effective dates, review dates, and expiration dates. Policy Section 1.19 outlines the protocol for the establishment and review of policies and procedures. DCS policies and procedures will be reviewed and revised at least every two to three years or when practices, procedures, legal requirements or regulations change. Within the three-year time frame or as needed, DCS Program Managers or their designees are responsible for reviewing, updating or establishing policies under their area(s) of responsibility. The DCS Program Manager or designee works with their QI Workgroup to prepare a draft of the new or revised procedure. The updated policy is then submitted to the QI Committee Chair who forwards the draft policy to legal for review. If the legal review is completed and no edits are required, the QIC Chair completes the bottom section of the Revised Procedures Coversheet and forwards the policy and coversheet to the Department Director for approval.

1.01 Background Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has multiple written policies and procedures in place for background screening to address all the key elements of this indicator as follows: 3.05, Screening of Employees, reviewed 12/1/16; 3.09, Volunteers. Reviewed 11/30/16; and 3.19, Pre-Employment Assessment, implemented 10/1/2018. The current policy and procedures do not address completion of the Annual Affidavit of Compliance with Good Moral Character Standards (form IG/BSU-006) prior to January 31 each year or re-screening of employees and volunteers every five years.

The agency's policy and procedure for background screening are conducted for all department employees, contracted providers, and volunteers (not under the supervision of staff), mentors, or interns with access to youth. The background screen is completed prior to hiring staff or utilizing the services of applicable volunteers, mentors, or interns. All employees, contractors, and volunteers working in direct and continuing contact with youth undergo a Level II live scan background screening. All employees must also complete a drug test, local law enforcement, and driver's license check prior to hire. The current policy and procedures do not address the completion of the Annual Affidavit of Compliance with Good Moral Character Standards (form IG/BSU-006) or re-screening of employees and volunteers every five years.

A total of thirty-two background screening files were reviewed for 20 new employees, 7 interns/volunteers, and 5-five-year re-screenings completed by the provider since the last QI visit. Nineteen of the 20 new employees had completed background screenings with an eligible rating prior to their hire date. The 5 five-year re-screened employees had completed successful five-year re-screenings on time prior to their five-year cycle anniversary dates. Similarly, the 7 interns/volunteers were successfully background screened prior to their start dates of volunteer service.

The provider completed and submitted its annual Affidavit of Compliance with Good Moral Character Standards (form IG/BSU-006) to the DJJ Background Screening Unit on January 11, 2019.

The agency uses Berke, a pre-employment assessment that uses data-driven insights to predict hiring success. The program has been using the tool since July 2018. The tool measures personality traits and problem-solving skills and compares candidates to job benchmarks that are customized by the agency for direct-care positions. The tool was administered prior to the hiring of four eligible new staff reviewed. As of the date of the onsite visit, the provider did not have a written policy in place for use of the Berke pre-assessment tool with regards to suitability criteria and agency protocol.

One of the new staff, Administrative Specialist, was provisionally hired 2 days prior to receipt of background screening clearance on the basis that her position does not have contact with youth and lack of access to confidential youth records; however, the staff works on the grounds

where youth are housed and per DJJ's background screening policy, employees in non-caretaker's position shall be background screened if they work in or on the grounds of a facility or program where youth are housed or receiving services.

1.02 Provision of an Abuse Free Environment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

It is the policy of the program to adhere to a code of conduct that is addressed in the Six Pillar Attestation policy 3.18. This policy was effective 7/1/18, and addresses all aspects of the indicator in reference to the use of physical abuse, profanity, threats or intimidation and that the youth are not deprived of basic needs.

The policy regarding Child Abuse and Reporting is addressed in three different policies: 1) Employees Involved in Reports of Child Abuse 4.07 (1/15/17); 2) Reporting Criminal Behavior, Child Abuse of Neglect 6.04 (3/1/17); and 3) Abuse Reporting 4.07 (3/1/18). All aspects of the indicator are addressed in these policies.

The policy regarding grievance procedures meets the requirement as addressed in the Client Grievance process 6.07, effective 11/15/17.

The policy for management to address concerns is addressed on the Conflict of Interest and Ethical Conduct policy 1.09 (9/1/18) and covers the policy.

The program provides an environment that is safe, secure and free from abuse. Staff signs the Six Pillars code of conduct and it is located in the electronic personnel file. The Child Abuse Reporting number is posted throughout the facility. There is a grievance box located in each dorm and the supervisors review and respond to each grievance in a timely manner. Incident reports indicate that immediate action is taken when there are incidents involving youth in the facility.

Staff sign the Code of Conduct/Six Pillars Attestation form which is kept in the employee's electronic personnel file. Three employee records were reviewed and found evidence of the attestation forms in the personnel files.

The Florida Abuse Hotline number was observed to be posted in each cottage. It is displayed in both English and Spanish.

All staff are trained in Child Abuse Reporting. Three files were reviewed and all three staff were trained. There was one abuse call made to the abuse hotline within the last 6 months. On 3/2/19 there was an incident report done and it was documented in the facility log book and on an incident report.

The program has an accessible grievance box that is locked and located in each cottage. The grievance documents are reviewed by the Residential Services Coordinator. The grievances address the complaints of the youth involved and provided follow up. There were several grievances that involved physical threats of violence or intimidation. Each was addressed by the Residential Services Coordinator.

Based on surveys completed the following results were received: 3 of 3 youth knew there was an abuse policy; 1 of 2 youth could tell where the hotline number was posted; 3 of 3 youth stated they were able to make an abuse call and that was not prohibited from making a call; 2 of 3 youth felt that the adults were respectful; 3 of 3 youth stated there was no staff who cursed at or threatened youth; 3 of 3 youth felt safe in the facility; 3/3 youth were not denied food, shelter or clothing; and 3 of 3 stated staff provide appropriate care for the youth.

No exceptions were noted for this indicator.

1.03 Incident Reporting

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

It is the policy of the program to report incidents to the CCC within 2 hours of reportable incidents or within 2 hours of first knowledge. The policy Reporting to the Central Communications Center (CCC) effective 8/13/17, addresses this policy.

The Residential Services Coordinator is responsible for ensuring that all CCC reports are completed within the required timeframe. They are also responsible for any and all correspondence required for each incident. Incidents are documented on an incident report form. All CCC Reports are kept in separate binder.

There were 10 incidents reported to CCC within the last 6 months. Of those 10, 1 was not completed within the 2 hour time frame. The program documents incidents on an incident report form. These incidents are kept in two separate binders. One is an Internal Incident Report binder while the other separates the CCC incidents. All but one of the CCC reports was accompanied by a written internal incident report.

In reviewing the 10 CCC calls there were 6 where there was follow up documented via e-mail. For 3 of those calls, no follow up was needed. No follow up was documented for 1 of the three calls that required a follow-up.

Of the 10 in CCC calls, 7 were documented in the log book. There were 3 that were not documented in the program log book.

All of the incident reports were signed by a program supervisor.

1 of the reportable incidents was not called in to CCC within the 2 hour time frame required.

An internal incident report was not found for 1 of the incidents reported to CCC.

1 CCC Report did not have the necessary follow up with CCC documented.

Three CCC Reports were not documented in the program log book.

1.04 Training Requirements

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has two policies that address training. Those policies are Supervisory Training 1.04 effective 12/1/16 (expired 12/1/18), and Required Staff Training 1.09 effective 4/1/19. The policies address new hire training, annual training and supervisory training.

The program has two staff trainers in the agency that are responsible for the training of staff. An extensive training calendar is maintained to address all of the required training. All trainings are documented on training worksheets and kept in separate binders. Training is completed in multiple ways: SkillPro, the Florida Network website, the USF website, and the DCF website. There are also a large number of trainings completed in house by the training staff.

The program has a training manager and training coordinator that oversees the training of all program staff. A training plan is maintained by the program that addresses training goals for first-year employees, annual employees, part-time employees, supervisory training, training for volunteers and interns, and training for administration. The plan is extremely comprehensive.

There were 6 files reviewed for compliance. Three were new staff within their 120 day period, while three files were annual employees. The program did not have an eligible new hire who is a non-licensed mental health clinical shelter staff in need of Suicide Risk Assessment training. All six files were in compliance and well exceeded the total number of training hours. Each file including the in-service staff contained over 120 plus hours of training. For first year staff, all of the training required within the 120 day period was completed with the exception of 1 Universal Precaution training for which the staff is still within the window. The majority of the trainings were completed annually for both new and seasoned staff.

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

At the time of this review, the Supervisory Training policy was out of compliance as a review date was required by 12/1/18 and was not yet completed as of the QI visit.

No exceptions were noted for this indicator.

1.05 Analyzing and Reporting Information

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place (Section: 04.07.02.01.01.0) for Quality Improvement Process that describes procedures for analyzing and reporting information to address all of the key elements of this indicator. The policy was last reviewed on March 1, 2017. In addition to the policy and procedure, the agency has a Quality Improvement Plan (QIP) dated 1/21/2019.

The agency's QIP includes procedures and guidelines for collecting and reviewing several sources of information to identify patterns and trends to include monthly, quarterly, and annually reports. There is an established protocol and structure in place to ensure the implementation of the agency's policies and procedures. The agency collects and reviews several sources of information to identify patterns and trends. The agency compiles all the information collected and enters it into the Division of Children and Youth Services QI Outcome Measure Summary Report. The results are reviewed and distributed through meetings held weekly, monthly, quarterly, and annually. The agency provided the Division of Children and Youth Services QI Outcome Measure Summary Annual Report and meeting minutes for review. The report included high quality

services & programs, customer satisfaction, program utilization, financial responsibility, community connectivity, and employee success. Data is collected regularly and the results are evaluated to identify strengths and weaknesses. The findings are reviewed by management and communicated to staff and stakeholders. Data collected is due to the committee team member and to the committee chair by the 10th and the 15th of the month for each quarter.

Case record reviews of 50% or 15 records (whichever is greater), including all closed cases, are conducted separately on a monthly basis by the residential and non-residential program using a record review tool specific to each program. If a record is not in compliance, the employee receives a corrective action notification to bring the record into compliance. The case record review workgroup will aggregate the results of the review tools to evaluate the effectiveness of services.

The incident review committee meets and reviews incidents, accidents monthly for the previous month. The data is collected and entered in the agency's database and is maintained including the number of incidents and type by program as well as determining patterns and trends. After committee review, the data is presented to the advisory board by the Principal Business Analyst.

Consumer inputs in the QI process may include participation in meetings, surveys, focus groups, treatment planning input, and/or opportunities to review the annual QI report.

The agency utilizes established criteria for evaluating the appropriateness or quality of their services. Key outcome measures are monitored and reported quarterly through Hillsborough County's Dashboard which is posted on the agency's website.

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

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

The agency reports data collected in a variety of reports: 1) Division of Children and Youth Services QI Outcome Measure Summary/Success Scoreboard which reviews data high quality services & programs, contract benchmarks, incidents/accidents, abuse hotline calls, customer satisfaction, grievances, program utilization, financial responsibility, community connectivity, and employee success; 2) Incident and Census Report- tracks and monitors trends in incidents across all programs; and 3) Outcomes and Scorecard Report, a new report this FY that includes high quality services & programs, contract benchmarks, incidents/accidents, customer and employee satisfaction, and chart compliance.

Documentation was provided to support peer reviews are being conducted. Each week the residential program completes peer record reviews and the non-residential program completes peer record reviews on a monthly basis. The results of the peer reviews are discussed at Meeting of the Minds held with the clinical staff. Documentation is maintained on the individual records reviewed as well as a cumulative count quarterly that identifies an overall compliance rate by the program. Per the Outcomes and Scorecard Report or the 1st quarter of the current FY (October-December 2018), the residential program achieved a compliance rate of 91.8% and the non-residential program's compliance rate was 97.9%.

The program maintains a graphical report of incident/accident data that is collected monthly. A report was provided for review for the FY 2018-2019. The report documents the number of incidents occurring daily/monthly and types of incidents by the program. Incident analysis reports are provided to management every two weeks and to the advisory board on a monthly basis. Trends are discussed at the management team meetings. Grievance data is collected and documented on the agency's Success Scoreboard on a quarterly basis.

The program administers client satisfaction surveys for each program. Data is entered into Netmis and reported annually as well as quarterly in the satisfaction results section of the Success Scoreboard as well as on the Outcomes and Scorecard Report. Per the Scorecard Report for the 1st quarter of the current FY (October-December 2018), 94,7% non-residential youth and 81.5% residential youth were satisfied with services received in the program.

Program outcomes/service utilization is monitored by management and reported annually on the Division of Children and Youth Services QI Outcome Measure Summary and also on the Outcomes and Scorecard Report. The current FY-to-date report was reviewed and supported collection of outcomes data quarterly for the CINS/FINS program. Data is collected regularly and the results are evaluated to identify strengths and weaknesses. The findings are reviewed by management and communicated to staff and stakeholders. Data collected is due to the committee team member and to the committee chair by the 10th and the 15th of the month for each quarter.

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

The provider conducts monthly management team meetings and town hall meetings to incorporate communication of analysis of data collected and findings. A review of the agendas and meetings onsite supported this practice.

No exceptions were noted for this indicator.

1.06 Client Transportation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policy in regards to Client Transportation. Use of County Vehicles for Transporting Clients 4.07 effective 3/1/18. The policy addresses that drivers are approved and have a valid Florida Driver's License. However, the policy does not address a third party driver, the names or initials of the driver, date and time, purpose of travel and location. The policy also states that the Operations Manager and Director sign off on single transports; however, it is signed off on by a designated Shift Leader and not the individuals authorized by the policy. A revision was made to the policy during the review indicating a designee can also provide supervisory approval of single youth transport.

Staff and youth report to the control room prior to transporting youth. While in the control room the Shift Leader completes a Request of Authorization for Off Campus Activities. This form documents the youth being transported, the transporter, the date and time of the transport and location. They authorize the transport, which includes single youth transport and provides the staff with the vehicle keys and vehicle to utilize. Once in the van, the staff fill out another form with the mileage. Staff return to the control room upon returning from the transport.

E-mails are also sent to and from the Operations Manager and Clinical Director for authorization of single transport.

The program requires that all staff providing transportation for youth report to the control room prior to transporting youth. A review of the transportation records were reviewed for the review period. The records show that the Shift Leader completes a Request of Authorization for Off Campus Activities. This form documents the youth being transported, the transporter, the date and time of the transport and location. They authorize the transport, which includes single youth transport and provide the staff with the vehicle keys and vehicle to utilize. Once in the van the staff fills out another form with the mileage. Staff return to the control room upon returning from the transport.

An e-mail is also sent to the Operations Manager and Clinical Director to communicate and request single transport. There were several occasions when a third party staff was authorized to go with another staff to provide transportation due to extenuating circumstances.

Under Hillsborough County, the staff is covered under a Self-Insured policy. Twice a year (May and November), driver's license checks are completed for all staff. As for new staff, the driver's license report is reviewed the prior (3) years and there must be no more than (7) points on their record for the staff to be an eligible driver.

No exceptions were noted for this indicator.

1.07 Outreach Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policy that addresses Outreach Services. Policy 4.07 Community Outreach and Partnerships addresses the standard. It indicates that the program attends the DJJ Board and Council meetings along with other community meetings.

The Clinical Director, Operations Manager, and other supervisory staff attend a plethora of community meetings to include JJ Council Meetings, Ad Hoc Committee Meeting for Dually Served Youth, Children's Home Committee, Anti-bullying Advisory Committee, Hillsborough Local Planning Meeting, Community Advisory Board and a Town Hall Meeting. Outreach is mainly completed by the community-based staff and the senior program coordinator (Safe Place). However, other staff members participate in the outreach in providing information about the agency services and attending community meetings.

The program participates in the local DJJ Juvenile Justice Board meetings. There are meeting minutes documented for meetings held on 10/19/18, 11/16/18, 12/21/18, 1/18/19 and 3/22/19. Of those meetings, it can be established through verifying the minutes that the program sent a representative for the meetings held on 11/16/18 and 1/18/19. There was no verification of attendance for 10/19/18 and 12/21/18. The minutes for the 3/22/19 meeting have not been received at this time.

In addition to the DJJ Board, the program also attends an Ad hoc Committee Meeting on Dually Served Youth, Children's Committee Meeting, Anti-bullying Advocacy Meeting, Community Advisory Board, Town Hall meeting and the Hillsborough Local Planning Team.

No exceptions were 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 nonresidential 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 nonresidential services), a more thorough assessment is completed. After all assessments are completed, the assigned counselor develops a case services plan with the family during the initial family session. If the assessment indicates the need for a referral to a more intensive or specialized service such as substance abuse or mental health treatment, the counselor makes the necessary referral for service. After the development of the case service plan, the counselor works with the family to implement the plan. Counselors document progress towards completion of the service plan goals.

The agency maintains a "paperless" non-residential client file system, while the residential program maintains paper files. The system utilizes electronic documents in which each counselor maintains all files on a dedicated drive. Because non-residential counselors work remotely throughout the county, each counselor utilizes a laptop to manage scanned files that are organized in folders.

2.01 Screening and Intake

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a Policy and Procedure 04.07.02.01.06.62 in place regarding Screening and Intake. The policy and procedure was last reviewed 07/01/2018.

Hillsborough County Children's Services, policy states that each youth/family referred to for services shall undergo an initial screening within seven calendar days of referral by a trained staff member using NetMis screening form, either by telephone or on-site.

The policy outlines the screening process which determines eligibility and identifies the youth's presenting issues, legal status, a threat to him/herself or others, medical issues, and other pertinent demographic information.

There were a total of 6 files reviewed for this indicator: 3 residential (2 closed and 1 open) and 3 non-residential files (2 closed and 1 open). All reviewed files met the minimum requirements for this indicator. All of the reviewed files provided the youth and parent/guardians with the availability of services, rights and responsibilities of youth and guardian, parent/guardian Brochure, possible actions occurring through CINS/FINS services, and grievance procedures.

No exceptions were noted for this indicator.

2.02 Needs Assessment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a Policy and Procedure in place regarding the Needs Assessment for Residential and Non-Residential Services. The Policy and Procedure was last reviewed on 09/01/2017.

Hillsborough County Children's Services, residential and non-residential programs policy states that a full bio-psychosocial or needs assessment be initiated by a qualified professional staff on each youth and/or family participating in services.

For both Residential and Non-residential, assessments are completed by Bachelor's or Master's level staff, Needs assessments should include an initial interview with the client and a separate interview with the parent/guardian, therapist should consider all demographics and factors for any specialized treatments, collect any collateral information pertinent to service delivery, needs assessment are reviewed and approved by the Clinical Director or a designee, CINS/FINS Residential Needs Assessments will be initiated within 72 hours of admissions, suicide risk component of the assessment is required and completed during the therapist initial meeting with the client. Non-residential biopsychological needs assessments will be completed within two to three face to face contacts following initial intake, suicide risk component of the assessment is required and completed during therapist's initial meetings with the clients.

There were a total of 6 files reviewed for this indicator: 3 residential (2 closed and 1 open) and 3 non-residential files (2 closed and 1 open). All reviewed files met the minimum requirements for this indicator. Needs Assessments in all of the six reviewed files were initiated within 72hours of admissions. All of the reviewed files were done within 2 to 3 face-to-face contacts after the initial intake or updated if the Needs Assessment was over six months old. All of the reviewed files were conducted by a Bachelor's or Master's level staff member. Two of the six files reviewed

(1 closed residential and 1 open residential) identified a youth with an elevated risk of suicide during the Needs Assessment process.

No exceptions were noted for this indicator.

2.03 Case/Service Plan

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a Policy and Procedure in place regarding Case/Service Plan for Residential and Non-Residential Services. The Policy and Procedure was last reviewed on 02/19/2019.

Hillsborough County Children's Services, policy states that each youth/family receiving services will have a written individualized Service or Treatment Plan that is reviewed and signed by the youth and parent/guardian.

In Residential Services, upon Intake, the Intake Specialist will ask the youth and their parent/guardian to sign an Initial Treatment Plan. That outlines a preliminary goal and specific objectives to successfully complete the goal of Shelter Services. Within 24 hours the assigned therapist will meet with the youth and make telephone contact with the parent/guardian. Once the treatment plan is determined, it will be signed and dated by the youth, therapist, parent/guardian, and Clinical Director. The plan will be reviewed every 14 days with the youth, therapist, and parent/guardian. In Non-Residential Services, the service plan will be completed within two to three face-to-face contracts following the initial intake by the outpatient Therapist. Once the treatment plan is determined, it will be signed and dated by the youth, therapist, and parent/guardian.

There were a total of 6 files reviewed for this indicator: 3 residential (2 closed and 1 open) and 3 non-residential files (2 closed and 1 open). All six files met the minimal requirements for this indicator. The Case Service Plan was developed within 7 working days of Needs Assessment or two to three face to face meetings (non-Residential). Individualized and prioritized need(s) and goal(s) were identified by the Needs Assessment, service type, frequency, and location established, and person(s) responsible. Target date(s) for completion and actual completion dates were documented, signatures of youth, parent/guardians and supervisor provided, initiation date established, and progress reviewed every 14 days (Residential) and 30 days (Non-Residential).

No exceptions were noted for this indicator.

2.04 Case Management and Service Delivery

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a Policy and Procedure in place regarding Case Management and Service Delivery for Residential and Non-Residential Services. The Policy and Procedure was last reviewed on 07/01/2018.

Hillsborough County Children's Services' policy states that each youth/family will receive case management services from the Residential and Non-Residential qualified therapists. Each youth will receive: a minimum of 30 minutes of case management activity; follow up of school related issues; follow up with Law Enforcement Agencies; follow up with Judicial System; referral(s) to other community resources; Case Staffing committee if requested; and discharge planning. Each Non-Residential youth will receive at least one case management activity prior to the termination of the case.

There were a total of 6 files reviewed for this indicator: 3 residential (2 closed and 1 open) and 3 non-residential files (2 closed and 1 open). All of the six files reviewed (2 closed and 1 open residential files and 1 open non-residential and 2 closed non-residential files) met the minimum requirements for this indicator. All reviewed files, were assigned a counselor, referral needs were established based on on-going services, service plan was initiated, youth/family services were monitored, support for families were provided, referrals for case staffing were conducted (if needed), additional services were provided and case termination notes were completed.

None of the six files reviewed warranted counselors to accompany youth/guardian court hearings. The reviewer interviewed one residential counselor and one non-residential counselor regarding 30-60 day follow-up procedure after termination. In residential service delivery, the therapist assigned to the case will conduct the follow-up call and in Non-Residential service delivery, the Administrative Assistant conducts the 30 and 60 day follow up.

No exceptions were noted for this indicator.

2.05 Counseling Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has multiple policies and procedures in place regarding Counseling Services—Individual and family counseling last reviewed 03.01.2018 and group counseling last reviewed 02.10.2018.

The policy and procedure states that the staff is responsible for meeting with clients and families for progress in improving their goals. The youth/family will have one formal individual counseling session per week, group sessions at least five days per week (focus, didactic, therapy and structured). To assist youth in identifying problems, gaining insight into the relationships between their behaviors and attitudes, in getting control of their behaviors, and developing social skills, a childcare staff will be assigned as the primary group leader and will be responsible for group planning and ensure appropriate service delivery. Health education will also be provided in a group session and includes topics to include prevention of communicable diseases, alcohol use, nicotine use, and substance abuse.

There were a total of 6 files reviewed for this indicator: 3 residential (2 closed and 1 open) and 3 non-residential files (2 closed and 1 open). All of the six files reviewed had completed Needs Assessments based on the presenting problems. All six of the six files reviewed met the minimum requirements for this indicator: Initial Case/Service Plan, Case/Service Plan reviewed, case notes maintained for all counseling services provided, on-going internal process that ensures clinical reviews, and youth and family received counseling in accordance with the Service Plan.

In regards to group sessions, the agency documents all group activities in two separate binders: a girl's binder and a boy's binder. Group counseling is provided at least 5 days per week, at least 30 minutes long, and has a clear leader/facilitator with a clear and relevant topic.

No exceptions were noted for this indicator.

2.06 Adjudication/Petitiion Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has multiple draft policies and procedures in place regarding Adjudication/Petition Process—section 04.28-04.33.

The policy states that parents of active CINS/FINS youth may request a case staffing to be convened within seven days (excluding weekends and holidays), when such request is made in writing. The child must exhibit habitual truant, beyond control and runaway behaviors. The seven day letter should include the following: Child's full name, parent's name and return address, presenting issues, description of efforts made and purpose of requesting a Case Staffing Committee meeting (04.28). The provider shall review the case of any family or child if: (1) the family/youth will not participate in service delivery (2) the family/youth is not in agreement with the services or treatment offered (3) the Juvenile Justice or CINS/FINS provider receives a written request from a parent/guardian or any other member of the committee. The case will then be monitored on a 30-60-90 basis (04.29). The Case Staffing Committee shall provide the child and family with a new or revised plan for service that shall contain the following: A statement of the problem, needs of youth, and needs of parent/guardian or legal custodian, measurable objectives, and accountable service providers of staff, time frame of achieving objectives and services and treatment to be provided (4.30). The Case Staff Committee is a standing committee which meets once a month, on the third Thursday, at 9 am. The Case Staffing coordinator or designee will mail a certified letter detailing time and location. The certified letter will be mailed to the family no less than 15 working days prior to the date the family is scheduled to meet. The family will be notified by the case staffing coordinator via telephone within 5 working days (04.31-4.33).

Three files were reviewed for this indicator (2 open and 1 closed). All of the files reviewed met the minimum requirements for this indicator; case staffing was held within 7 days, notification to family no less than 5 working days, notification to the committee no less than 5 working days. 2 of the reviewed files (1 open and 1 closed) had local school representatives and mental health representatives present at the case staffing. In all three files reviewed: the youth and family are provided a new or revised service plan, a written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and lessons, and that the program worked with the circuit court for judicial intervention for the youth/family. The case manager/counselor completes the review summary prior to the court hearing.

The reviewer interviewed a therapist assigned to the cases reviewed and he was able to articulate the program established case staffing committee, regular communication with committee members, internal procedure for case staffing and scheduled committee meetings (every 2nd Tuesday of the month).

No exceptions were noted for this indicator.

2.07 Youth Records

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has multiple policies and procedures in place regarding Youth Records one was last reviewed 04.15.2017 and the other policy is in draft.

All client records are organized and maintained in a clear, consistent, and chronological manner. The case record should be adequate and accurate information. The client file is arranged in 6 specific sections. The client case paper files will be kept in a double-locked room. In Non-Residential Services, the client files are electronic and are arranged in 8 specific sections. These electronic records are stored in an internal network folder that can be accessed by authorized personnel on a “need to know” basis.

All six files reviewed (3 residential and 3 non-residential) met the minimum requirements for this indicator. All records were marked “Confidential”. All three of the residential files reviewed are kept in a secure room or locked in a file cabinet that was marked “confidential”. All records are maintained in a neat and orderly manner. All Non-residential files are maintained electronically. When the youth records are transported off agency grounds, they are housed in a secured lock box requiring combination lock/key.

No exceptions were noted for this indicator.

2.08 Sexual Orientation, Gender Identity/Expression

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy, Section 6, that meets the requirement for Indicator 2.08, Sexual Orientation, Gender Identity, and Gender Expression. The policy was implemented 7/1/2019.

The program seeks to provide a safe environment and therapeutic case planning for all youth regardless of actual or perceived sexual orientation, gender identity, or gender expression. As such, the provider has implemented the following procedures:

1. Youth in the care of the Department Children’s Services (DCS) will be addressed by their preferred name and gender pronouns which aligns with their gender identity.

2. Staff is prohibited from discussing youth’s sexual orientation, gender identity, or gender expression with other youth in services without the documented consent from the youth.

3. All staff, service providers, and volunteers are prohibited from engaging in any form of discrimination or harassment of youth based upon their actual or perceived sexual orientation, gender identity, or gender expression.

4. Staff will report to the CCC all allegations of harassment or abuse by staff or youth based on their actual or perceived sexual orientation, gender identity, or gender expression.

5. Harassment, verbal abuse, or intimidation by staff towards any youth based on the youth’s sexual orientation, gender identity, or gender expression must be reported the DCF Abuse Hotline. 1-800 96 ABUSE (1-800-962-2873)

6. All staff, service providers, and volunteers are prohibited from attempting to change a youth’s sexual orientation, gender identity, or gender expression, including, but not limited to referrals for conversion therapy, or other similar interventions.

7. All staff, service providers, and volunteers who have intentional contact with youth will have knowledge of this policy and the terms referred to within this policy.

8. If youth are in need of specialized support or services relative to their sexual orientation, gender identity, or gender expression, the service provider is required to refer these youth to services, or request assistance from the Florida Network in identifying qualified resources and providers.

9. Areas in which youth reside or are served will have signage indicating the program is a safe space for all youth regardless of actual or perceived sexual orientation, gender identity, and gender expression.

In the residential program:

1. Youth will be identified in the logbook and all public-facing documents by their preferred name and gender pronouns.

2. Youth are to be assigned a room aligning with their gender identity, or the program will provide specific documentation as to why other room assignment was determined to be suitable.

3. All room assignment decisions will be made on a case-by-case basis. Safety and security for each youth will be taken into consideration when making a decision regarding room assignment.

4.Youth will not be housed in isolation solely based on sexual orientation, gender identity, or gender expression.

5. Youth will be provided with hygiene products, undergarments, and clothing that affirms their gender identity or gender expression.

During a tour of the facility, “safe place” rainbow signs were posted on a window near the entry hallway of the cottage and on a board with program information adjacent to the kitchen. The signage signifies that youth are welcome and should feel safe regardless of sexual orientation, gender identity, and gender expression. The program also has printed material entitled I Deserve Respect, Support, and Safety accessible for youth on the counter in the kitchen.

The program did not serve any youth who met the criteria for the indicator; therefore, the reviewer was not able to assess practice with regards to youth preferences and case planning. The 3 new staff received LGBTQ training and documentation showing a review of the SOGIE policy 5.08. A certificate was provided demonstrating in-service staff had also received LGBTQ training and reviewed the SOGIE policy guidelines outlined in FN policy 5.08; however; none of the interns or program volunteers received training related to FN policy 5.08.

There is no exception noted for Indicator 2.08.

Standard 3: Shelter Care

Overview

Rating Narrative

The Hillsborough Children's Services program provides residential care for CINS/FINS youth in Hillsborough County. The shelter environment consists of two CINS/FINS cottages along with a medical building, cafeteria, administration building, and other cottages for services provided to foster care youth. Youth are housed in the cottages which are the newest buildings on the campus. Each cottage offers a home-like environment with a living room, kitchen, and shared bedrooms equipped with individual beds, linens, pillows, and comforters. Bathroom facilities in the cottages are clean and accessible to youth. The grounds are nicely landscaped, clean, and well maintained. The campus provides ample space for recreation and outdoor activities.

Upon admission, youth are receive orientation to the program and a copy of the Client Handbook. Room assignments are determined based on several factors, each of which is documented. The log books are maintained in the cottages and are reviewed by staff. The Behavior Management System is appropriately designed to address compliance and noncompliance of youth. All staff are trained in NAPPI. The agency has a detailed video surveillance system in place that has recently been updated.

The program also serves youth who meet the criteria for Intensive Case Management Services and Domestic Violence respite. It does not currently provide Staff Secure, FYRAC, Domestic Minor Sex Trafficking or Probation Respite services.

3.01 Shelter Envonment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has policies and procedures in place that address the key elements of this indicator and meet all contractual requirements as follows: Safety/Sanitation Inspection (effective 4/1/18) and Residential Youth Living Environment (Section 06.84- dated 8/1/18).

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

The facility is located on a very large 33 acre lot that includes the Admin. Building, Cafeteria, School House, Hair Training Facility, and 8 cottages for youth. There are two CINS/FINS cottages that are used. The cottages are licensed for 22 beds by the Department of Children and Families effective through July 31, 2019. The grounds are very well maintained and it really shows that the staff takes pride in their campus. The two cottages that were viewed were well kept and free of graffiti. All inspections are conducted in a timely manner and within contractual time frames. Youth Activity logs are clearly posted with all required activities throughout the day. Youth are offered a locked room to store all their personal belongings. The facility is equipped with a camera system that stores video for thirty days and was reviewed to ensure bed checks were being completed properly.

All Chemicals are locked up inside the cottages and a MSDS book is available for all chemicals stored. The chemicals are inventoried on a weekly basis and signed off by a Supervisor. Staff schedules are posted and meets all requirements for the Florida Network. Disaster plan is in place. Fire drills are completed on each shift every month with the exception of the overnight shift, and evacuation times are all below the required two minutes. Mock Emergency Drills are held once a quarter but the standard states it is to be once a shift per quarter.

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

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

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

There are no exceptions noted for this indicator.

3.02 Program Orientation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The provider has policies and procedures to address the orientation of youth: Section 09.07 dated 1/15/2019, Residential Youth Orientation and Section 09.08 dated 12/1/2018, Informing Clients Served of their Rights and Responsibilities.

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

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

8) Review of the visitation rights

9) Review of the telephone procedures

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

There were four files reviewed (two open and two closed). Of the four files that were reviewed all of them contained all contractual requirements for program orientation. All of the files had documentation to confirm a comprehensive orientation handbook was provided to the youth and parent/guardian within 24 hours of admission. All youth files confirmed youth were explained the disciplinary process, grievance procedure, emergency disaster procedure, contraband rules, physical facility layout map, room assignment, and suicide prevention alert notification. Signature of youth and/or parent/guardian were found in all files observed. Daily activity schedule was reviewed and abuse hotline telephone number was explained and provided. All forms are clear and easy to read. They were found in section one of the files.

There are no exceptions noted for this indicator.

3.03 Youth Room Assignment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The provider has the following policies and procedures to address youth room assignment: Residential Youth Orientation (Section 09.07 dated 1/15/2019); Sleeping Arrangements (Section 06.58 dated 7/1/2018); and SOGIE (Section 6 dated 7/1/2019).

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

1) Physical characteristics including age, sex, height, weight, and general physical stature, and gang affiliation; history and status;

2) Initial interactions with and observations of the youth and collateral contacts;

3) Separation of younger youth from older and violent youth from non-violent youth;

4) Identification of youth susceptible to victimization (very small youth, youth with developmental disabilities, or very immature youth), presence of medical, mental, or physical disabilities;

5) Suicide risk, sexual aggression, and predatory behavior.

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

There were four files reviewed (two open and two closed). All contractually required forms were reviewed and all youth were appropriately assigned to a room.The section of the intake form that addresses room assignment was completed in all four files. However, gender identification is not addressed in the room assignment section of the intake form.

The agency addresses gender identification during the youth's screening process. The agency uses two forms to capture information for the youth's room assignment (Hillsborough County Checklist and the CINS/FINS Admission Data Form). The forms are signed by the staff

completing the form and a supervisor who reviews them. Alerts for the youth are marked with colored dots on the front of the files and colored dots on the youth alert board in the shelters.

There are no exceptions noted for this Indicator

3.04 Log Books

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

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

The policy and procedure for log-book entries is to document routine daily activities, events and incidents and are reviewed by direct care staff and supervisor staff at the beginning of each shift and documented that the past two shifts are reviewed. All entries are brief and legibly written with dates and times. All recording errors must have a single line drawn through and initialed. The program director or designee are to review the log- books every week. The supervisor log book will also contain a documented weekly review of the log book by the staff manager. The log books are retained for a period of three years. The supervisor's log book will be kept in the supervisor's office, and the staff log books will be kept in the appropriate shelters.

All in coming child care staff are required to read all entries in the appropriate log book since they last worked and document of the log book. Child Care Staff will also document the start and end time of their shift in the staff log book. Each staff member must sign himself/herself in and out for each shift and cannot allow another staff member to enter or exit them from the log book on his/her behalf. Falsification of log book entry attempts to modify, damage or destroy a log book may result in disciplinary actions being taken, up to and including termination of employment.

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

There are no exceptions noted for this Indicator.

3.05 Behavior Management Strategies

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy in place, Section 04.02, Behavior Management System that was last reviewed 2/23/18.

The agency has procedures in place to implement the key elements of the indicator. The agency is currently using a point-based Behavior Management System that is clearly identified in the Client Handbook and is monitored by the RSC daily (when they come on shift) and by the Residential Director monthly.

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

The system is discussed regularly at monthly staff meetings and recommendations are made accordingly. All staff are trained in the system during their initial CINS/FINS training and also receive NAPPI for Behavior Intervention Training in verbal intervention, de-escalation techniques, and physical interventions.

Six staff training files were reviewed, 3 active charts and three inactive charts. All files reflected that staff were trained in NAPPI and the Behavior Management System. No group discipline is enforced and room restrictions are not applied. Youth are offered a wide variety of rewards and incentives to participate in the Behavior Management System. The youth can use their points to shop at the Swap Store or get later bed times.

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

completed.

There are no exceptions noted for this Indicator.

3.06 Staffing and Youth Supervision

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The Provider has multiple written policies in place that address all of the key elements of the indicator for Staffing and Youth Supervision, namely: Section 6.13-Residential Youth Supervision (reviewed 3/1/2018); Section 04.07.02.01.06.12 - Basic Client Supervision (dated 3/1/2018); Section 06.58- Sleeping Arrangements dated 7/1/2018; and Section 04.07.02.01.06.14-Bed Check Policy (reviewed 3/1/2019).

The Provider has written procedures to implement the key elements of the indicator. During waking hours, the minimum ratio for the CINS/FINS Program is one staff per six youth. During sleeping hours the ratio is one staff per twelve youth.

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

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

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

Bed checks are conducted every ten minutes and are documented on the Bed Check Log Forms. This was also confirmation by reviewing three random nights of video coverage. All checks were conducted in accordance with this QI Standard.

There are no exceptions noted for this indicator.

3.07 Special Populations

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The Agency does not serve youth who meet the criteria for Staff Secure, FYRAC, Domestic Minor Sex Trafficking or Probation Respite. A policy and procedures was provided for Intensive Case Management Services (Section 4.36 dated 1/15/19) but none currently for Domestic Violence. It is the policy of the agency to provide Intensive Case Management Services (ICMS) services to youth ages 6-17 who are chronically truant, runaway, ungovernable, are court involved or are likely to enter the petition process, and may require more intensive and lengthy services.

The process begins one of the following ways: a) the Chairperson of the Case Staffing Committee (CSC) receives a seven (7) day letter request from a parent; b) a counselor and or case staffing coordinator can recommend that a parent submit a seven (7) day letter; or c) an emergency situation exists for the child, which if not immediately attended to could result in harm to the child. The Chairperson will assign a Case Manager and/or Therapist to connect youth and families to a coordinated, comprehensive array of services that meet their ongoing needs. The Case Manager and/or Therapist will be assigned to the family within 48 hours of the scheduled CSC meeting. The caseload size for the Case Manager and/or Therapist will be a maximum of fifteen (15) youth to allow for more intensive services.

The dedicated Case Manager and/or Therapist will:

a) Complete a minimum of six (6) direct contacts per month. Direct contact is defined as face to face contact with youth, parent of guardian for a minimum of fifteen (15) minutes per contact

b) Complete a minimum of six (6) collateral contacts per month. Collateral contacts are defined as school, law enforcement, DJJ, other family members, court personal and other service providers who either have provided services or currently providing services to the youth and family or in the acquisition of potential new services for the youth and family for a minimum of ten (10) minutes per contact

c) Develop a comprehensive, individualized service plan inclusive of input from the youth and family to reflect the family's stated goals and needs

d) The plan will include strategies for managing crises, and time frame outlined for goal attainment

e) Provide information to the youth, family and key supports regarding access to and type of services available. This function facilitates access to a range of services, and facilitates the provision of resources to consumers.

The youth and family will be encouraged to participate in a review of their service plan at every 30, 60 and 90 days, as this will promote goal attainment. A supervisor will review and sign the service plan acknowledging the progress of the service plan at each interval. When a referral is made for additional services, it will be developed in consultation with the youth and family.

Three youth files were reviewed for Intensive Case Management, 2 open (intake dates 11/13/18 and 2/13/19) and one closed file (intake date 3/2/18). Documentation was provided to show all three youths were referred by case staffing. All three charts had an entrance Child Behavior Checklists (CBCL); however, it appears one was completed (3/26/18) in excess of the 14 days required from date of intake for youth admitted 3/2/18. The program uses the Achenbach System of Empirically Based Assessment (ASEBA), an assessment approved by the Florida Network. The ASEBA was repeated with one eligible youth within a 90-day time frame; another youth was removed by DCF and consequently discharged prior to the completion of an exit assessment. Case plans in each file demonstrate strength based, trauma informed focus to assist youth/families.

Upon initial review, evidence of contacts made with or on behalf of the youth/family was not readily accessible in the files. The program utilizes Netmis to document visits then print them out and place them in the file. Six (6) collateral and 6 face to face contacts were observed in the month of March for the 2 open cases and explanations of missing direct and/or collateral contacts was observed from copies of emails sent to the Florida Network between January – March 2019.

Four domestic violence (DV) respite case files were reviewed which reflected that the youth had a pending domestic violence charge and did not meet the criteria for secure detention. None of the youth's stays exceeded 21 days and consequently, did not require transition to CINS/FINS or Probation Respite placement. The case plans in the files included treatment goals and objectives that focus on aggression management and to reduce the re-occurrence of violence in the home. Services provided to DV respite youth were observed to be consistent with the general CINS/FINS program requirements.

For youth admitted 3/2/18, the CBCL was completed on 3/26/18 in excess of the 14 days required from the date of intake.

Substantial documentation during the 6 month QI review period demonstrating compliance with providing six (6) collateral and 6 face to face contacts monthly was not observed for 2 youth with intake dates of 11/13/18 and 3/2/18.

3.08 Video Surveillance System

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The Agency has a policy Section 5.18, dated 3/1/2017 for Video Camera Surveillance System, to address the requirements of a video surveillance system.

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

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

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

Reviewer observed video footage of 3 separate dates and times of bed checks. There is a back-up battery pack to operate the system in a power outage. As per the agency's policy, the Facility’s Manager, System’s Coordinator, and supervisory personnel may review recorded video footage. However, the system can only be accessed remotely by the Facility’s Manager and System’s Coordinator. The System’s Coordinator is able to download recorded video footage to a thumb drive/DVD for third party review upon request from program quality improvement and when an investigation is pursued after an allegation.

Supervisory review of the video is conducted a minimum of once every 14 days by the youth program operation's manager who maintains a separate logbook of the video reviews.

There are no exceptions noted for this indicator.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

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

The agency also screens for the presence of acute health issues and the agency's ability to address these existing health issues. Further, the agency has two Registered Nurses permanently on staff to provide health screenings and delivery of medications for youth admitted to the program. Youth admitted to the shelter with prescribed or over the counter medication will surrender those medication to staff during admission. The agency uses the Pyxis Med-Station 4000 cabinet for the storage and delivery of medications. Two registered nurses oversee and distribute the majority of all medications during the week and direct care staff are responsible for the distribution of medication on the weekends. The agency provides medication distribution training delivered by the registered nurses to all direct care staff members, as well as, first aid response, CPR, first aid, fire safety, emergency drills and exercises and training on suicide prevention, observation and intervention techniques.

4.01 Healthcare Admission Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a current policy and procedures in place, 7.07 Health Screening dated 2/15/2019, which addresses healthcare admission screening for all youth placed at the program. The program also provided a Draft copy of policy 7.13 Residential Health Services for review. There is no mention of the daily log for medical referrals in the reviewed policies or draft of policy revision.

During the intake process, a health screening will be conducted by an intake specialist or designee. Information regarding the screening will be documented on the screening form and filed. If at the time of the screening any issues are evident, the manager or designee will contact the nurse on duty for clearance for prescribed medication, chronic conditions, or a referral will be made to an appropriate service provider. Any referral for an outside community resource will be documented in a referral form. The referral form will be attached to the screening form and filed.

Monitor reviewed three randomly selected youth records for the completion of medical screenings at intake. Each reviewed record included a completed medical screening completed by a non-medical intake staff person. Each reviewed screening was conducted on the date of admission as part of the intake process. Each screening was completed on a form entitled the Florida Network of Youth and Family Services CINS/FINS Intake Form. This form documented screenings for substance abuse, suicide risk, and medical history/current physical condition. The physical screening on this form requires documentation of all of the required elements of the indicator including current and chronic medical conditions, current medications, all known allergies, recent injury, or illness, presence of physical distress, and observation of scars, tattoos, or other skin markings. Each of the three reviewed forms were completed in their entirety. (However, when another youth record was reviewed related to another indicator, it was observed the form lacked any markings indicating the screening for chronic conditions was completed on this form in the youth's record making it difficult to ascertain whether the youth had been questioned about these conditions at the time of intake.)

Each of the three records reviewed for this indicator included a nursing review of the Florida Network of Youth and Family Services CINS/FINS Intake Form within three calendar days subsequent to each intake, (typically the following day if the intake did not occur on a Friday) exceeding the five-business day requirement stated in the indicator. Each record reflected the completion of a secondary medical assessment conducted by a registered nurse, utilizing the Nursing Assessment form. This form documents nursing recommendations including youth access to physical examinations by a physician and dental examinations. The form is maintained in each youth record, as well as, in a specified binder containing all completed nursing assessments for each calendar year. None of the three reviewed records documented the need for referral to a medical provider. While none of the reviewed youth were referred for additional medical services and/or appointments, it was noted the facility Voluntary Placement Agreement signed by each of the youth's parent/legal guardian stipulates when needed, the parent/legal guardian is involved with the coordination and scheduling of any follow-up medical appointments.

Reviewed documentation did not indicate the program has procedures in place for necessary follow-up medical care for youth admitted with chronic medical conditions, such as asthma, seizure disorders, or other conditions, other than an alert system ensuring staff are aware of the

conditions and any possible related emergency. In practice, while the program did not produce a daily log documenting all medical referrals, they did present two separate binders, which filed all nursing assessment forms completed for the calendar year 2018 and 2019. These forms documented the nursing recommendations made at the time the nursing assessment was completed. However, there was documentation indicating the youth had subsequently accessed services such as screening for sexually transmitted disease while in the placement upon the recommendations of the nurse.

Additionally, the reviewer spoke with the mental health clinician who presented a referral form the program uses to document community-based referrals for mental health/substance abuse intervention/treatment services. She also selected a random record and found a completed referral form in the record verifying the program does utilize a referral process for mental health and substance abuse services as policy 7.16 mandates.

The reviewed program policies appeared to lack documentation regarding provision of appropriate medical services for youth identified with a chronic illness/condition. Though policy 7.16 states a procedure for medical referral to a primary care physician with the use of a referral form, the interviewed nurse did not seem aware of such a referral process and the associated procedures to follow including the documentation of a referral form. Neither was specific documentation of a referral process and mechanism for necessary follow-up medical care as required and/or needed or parent/guardian involvement in the coordination and scheduling of follow-up medical appointments noted in the written policy.

4.02 Suicide Prevention

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

The agency has a current policy and procedures in place Section 6.09 that addresses suicide prevention and intervention. In conjunction with the policy and procedures the agency has a comprehensive written master plan for healthcare, suicide and mental health services that is dated March 1, 2016.

The procedures articulated in policy 7.16 clarify for staff how and what to do in order to provide the appropriate screening and assessment services and access to needed intervention services for a youth at risk for suicide. Implementing a three-tiered screening and assessment process, the program staff identify youth at risk for suicide and then provides appropriate supervision of the youth until the youth can be evaluated by a licensed mental health professional or a master's level non-licensed clinician working under the supervision of a licensed mental health professional and is determined appropriate for a reduced level of supervision, an enhanced level of supervision, or more intensive community-based psychiatric services. The intake screening involves the intake specialist completing the Florida Network of Youth and Family Services CINS/FINS Intake Form. If the youth responds affirmatively to one of six questions indicating escalated risk for suicide or presents for any reason at risk for suicide, the youth is placed on constant sight and sound observations and a staff documents the youth's activities/behaviors every thirty minutes until the youth can be evaluated by a qualified mental health professional. Subsequent to the assessment of suicide risk, the licensed mental health professional or a master's level non-licensed clinician after consult with a licensed mental health professional can either refer for a Baker Acted admission to a psychiatric facility, place the youth on elevated status which requires staff documentation of youth behavior every ten minutes, or standard supervision. If placed on an elevated status of supervision, the youth cannot be placed on standard supervision without the completion of a documented follow-up assessment of suicide risk by a qualified mental health professional.

A review of four randomly selected records of youth identified during the intake process as at risk for suicide contained the Florida Network of Youth and Family Services CINS/FINS Intake Form. Each of these completed forms documented reasons why the youth was identified as at-risk for suicide. Three of the four reviewed records documented the youth's placement on sight and sound constant supervision with staff observations documented on a precautionary observation log every thirty minutes until the youth could be evaluated by a mental health professional. Review of one youth record found the observation logs absent. This youth was admitted and discharged from the program before a comprehensive assessment of suicide risk by a mental health professional could be completed. Thus, upon initial review, there was no indication the youth's suicide risk had been addressed until the program staff were able to locate the observation logs. The observation logs were located during the review and immediately placed in the youth's record. Each of the remaining three youth were assessed by a mental health professional (one youth) or a master's level non-licensed clinician working under the supervision of a licensed mental health professional (two youth). Subsequent to the assessment of suicide risk two of three youth were placed on elevated status and one youth was placed on standard supervision. A review of the staff observation logs for each youth indicated the staff recorded their observations within the required time frames and supervisory review was conducted on each of the review observation logs as evidenced by the supervisory signature. No youth was placed on standard supervision without completion of a follow-up assessment of suicide risk by a licensed professional or a master's level non-licensed clinician working under the supervision of a licensed mental health professional.

Reviewed four youth records for youth identified during the intake process as at risk for suicide. Review of one youth record found the observation logs absent. This youth was admitted and released from the program before a comprehensive suicide risk assessment could be completed. Thus, there was no indication the youth's suicide risk had been addressed until the program staff were able to locate the observation sheets. Review of the three suicide risk assessments found none of the three had been fully completed as the indicator and program policy requires. All three reviewed assessments lacked documentation indicating the staff completing the assessment had conferred with the facility supervisor as the form requires. Neither did any of the reviewed assessments document notifications, when applicable. Two of the reviewed assessments lacked the reason for the assessment, as well as, information regarding recent behavioral changes or the presence of neuro-vegetative states of depression as required. These two assessments further lacked documentation of recommendations for treatment or follow-up including the recommendation to continue or discontinue constant supervision of the youth. One of these assessments failed to

document the degree of danger the youth presents to self and to assess as to whether the youth was a potential suicide risk. It was noted when the non-licensed clinician completed the suicide risk assessments the youth was removed from precautions without documented notification of the licensed clinician in three applicable instances. Each of these assessments, though devoid of critical information, were reviewed and signed by a licensed clinician either the following day or three days later.

4.03 Medications

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has multiple policies and procedures in place outlining medication administration (Section: 7.04, reviewed 10/26/18); medication storage, access, inventory, disposal (Section:7.01); controlled substance accountability and inventory (Section:7.02); medication documentation (Section:7.03); medication changes (Section:7.05, reviewed 7/1/18); and medication information manual (Section:07.06).

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

The program maintains all youth medications, controlled medications, and over the counter medications in a Pyxis Med-Station 4000 medication cabinet. The program has two site-specific Super Users for the medication station. The program does not store oral medications with injectable and topical medications. The program is required to have a medication refrigerator to store medications which are required to be kept cold.

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

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

The program has a designated medical clinic on site which consists of a reception area, two examination rooms, a consult office often used by the visiting psychiatrist, a storage room, and a medication a small room designated as the medication room. The clinic is secure, accessible only to authorized staff. The program utilizes a Pyxis Med-Station 4000 which serves to securely store, inventory and assist in the timely dispensing of all medications provided to the youth with the exception of medications requiring refrigeration. Refrigerated medications are stored in a designated, locked refrigerator. The temperature requirements of 2-8 degrees Celsius for refrigerated medications and 36-46 degrees Celsius for all other medications are monitored and maintained daily. All medications are stored in the nursing office which is inaccessible to youth unless the youth is accompanied by an authorized staff member. Only designated staff have the User Permissions in the Med-Station to access controlled medications. There are two full-time registered nurses who are identified Super Users of the Pyxis Med-Station and who are the primary dispensers of all medications on weekdays. One nurse works Monday through Friday 6:00 a.m. through 3:00 p.m. and the second nurse works the same days from 11:00 a.m. through 8:00 p.m. When the nurse is on duty, medication processes are conducted by the nurse. After hours and through the weekend other staff who have been trained to access use the Pyxis Med-Station and access medications when the nursing staff is not on site. All medications are perpetually inventoried by the Pyxis Med-Station which automatically accounts for each time the medication is accessed. The nurses complete a shift to shift count with a registered nurse and trained staff authorized to access medications is conducted each day, Monday through Friday. Two trained staff conduct the shift to shift inventories on the weekend. A full inventory is conducted each Monday by the nursing staff. Over the counter medications are counted weekly and documentation of these inventories is maintained.

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

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

There are monthly reviews of medication management practices via Knowledge Portal conducted by the nurse and clinical coordinator.

There are no exceptions noted for this indicator.

4.04 Medical/Mental Health Alert Process

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

The agency has a policy and procedures in place outlining medical information, behavioral concerns, and the mental health communication alert process. The agency also has a separate policy outline the process for special dietary restrictions and communication of the information to staff. Program policy does not reflect the practice in the implementation of the DOT system the program uses as an integral part of their alert system.

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

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

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

A review of three residential youth records was conducted for compliance with the program's alert process. The three records contained appropriate dots on the outside of the youth's residential case record denoting all youth's alerts were identified with corresponding colored dots and concerns are noted regarding precautions concerning medications, medical/mental health conditions. Color coded sheets were observed in the youth records but no dates were written on the sheets indicating when alerts started if other than the assumable intake date. The combination of colored dots on the exterior of the files and informative alert sheets on the interior ensure staff has sufficient information/instruction to recognize/respond to the need for emergency care.

The agency also has a client board in the control room which indicates all youth currently residing at the facility and has colored dots next to the names listed on the board.

Program policy does thoroughly reflect the practice in the implementation of the colored DOT system the program uses as an integral part of their alert system. Neither does program practice comply with written policy and procedures. Specifically, the policy states the staff will place colored dots next to the youth name on the Client Board. The policy states there are red dots to signify suicide risk, blue dots to signify medical/substance abuse issues and yellow dots to signify behavioral issues. A green dot signifies the youth has no issue, which needs to be communicated to staff. A review of the client boards in each of the two cottages where CINS/FINS youth are housed indicated there were no dots assigned to youth, contrary to the alerts documented in the youth records. While there were some dots next to the names of youth on the Client Board in the control room, the dots were not consistent with the assigned alerts of the three CINS/FINS youth reviewed. Additionally, there were black dots to represent youth who are under the age of twelve, a practice not in the current program policy. In addition to the client board, the dot system is to be implemented on youth records with color-coded alert forms in the records. The reviewer found an orange dot is used for substance abuse alerts, contrary to the written policy. Also, there are two different color blue dots and it is unclear to interviewed staff and the reviewer what the two different blue colors signify. The program is unable to provide a key to assist in discerning what dots signify and it is clear the staff are confused rendering the alert system deficient in effectively communicating to staff the special needs of the youth they serve.

4.05 Episodic/Emergency Care

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has policies and procedures in place to address episodic emergency care as follows: Section: 7.15-Medical Emergencies, reviewed 9/20/18 and Section: 07.16- Accompanying Youth During Medical Emergencies and Scheduled Appointments.

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

If youth have an indication of a potentially serious contagious disease the nursing staff will conduct a nursing assessment of the youth. In the event of a need for further assessment the nurse will notify the parent and refer the youth for further examination by a medical doctor for confirmed diagnosis as soon as possible. All youth will be required to have medical clearance from a physician prior to returning to the facility.

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

The agency training staff conduct emergency medical procedure training with staff during their new employee orientation when they are first

hired and then again annually. Every two years, all direct care staff must attend BFA/CPR/AED re-certification training.

A review of three residential youth records were reviewed for youth who required off-site medical services. The youth's records reflected the youth received medical services offsite and obtained medical clearance prior to returning to the center. Parental notification was documented for each youth. The record also reflected the nursing staff reviewed all medical clearance documentation and the discharge instructions were in the youth's record, as well as, the off-site care binder. There was also documentation to support Center (CCC) was contacted as required by the agency's policy.

Each cottage has a knife-for-life in a secure contraband closet in the kitchen. A review of the two cottages confirm the knife-for-life was present on both cottages.

First aid kits are located in each cottage above the refrigerator and and in each transport vehicle. The nursing staff conducts weekly inspections of first aid kits.

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

There are no exceptions noted for this indicator.