Risk Measures and Departure Conditions Aggregate Report - 2008

In late 2007 a plan to collect and report risk measures was taken to the Provider Support Team. The most common risk behaviors by children and adolescents in treatment home placement were identified for data collection. Medication errors were also selected for data collection, including prescribing errors, dispensing errors, and administration errors. By collecting and analyzing all risk measure data, treatment homes can review where the risks are occurring and determine opportunities for improvements.

In partnership with the Provider Support Team, the Planning and Evaluation Unit of the Division of Child and Family Services (DCFS) developed a tool to collect the identified risk measures (See Attachment A). Through the Provider Support Team, the Nevada Youth Care Providers meetings and email communication, treatment home providers were informed of the plan to collect and report these identified risk measures.

In early 2008 risk measure collection began. Initially, risk measures were collected quarterly. In October 2008, the collection schedule changed to a monthly reporting of risk measures. In addition, departure conditions were added in September 2008. Collecting and reporting risk measures and later departure conditions was done voluntarily; however, full provider participation was encouraged in order to better ensure the completeness of the data.

Treatment home providers who participated in providing risk measures data are to be commended for their willingness to share this very important information. Treatment home providers that collect and monitor risk data are more likely to support the structures and processes that ensure the safety, permanency and well-being of children and adolescents in their homes.

This report is an analysis of risk measures collected from January 2008 though December 2008 with the exception of DCFS treatment homes, which began to collect and report risk measures in July 2008, at the beginning of the state fiscal year. New treatment homes opened during the year and when they began to serve children, they were added to the list of participating agencies and invited to participate in this initiative. A list of treatment home agencies and their level of participation in this initiative can be found in Attachment B.

As previously mentioned, providers were encouraged to submit information regularly but their participation was voluntary. As a result, not all providers submitted information all the time. Some providers did not submit any information; some submitted partial information. Because of this, there is not a total number of children served or a total bed capacity on which to compare any of the risk measure incidences. There is no certainty that the risk measures or departure conditions represent a true count of incidences. There is also missing information which impacts interpretation of the data. Although these issues lead to data limitations, the information is still useful and can be used to identify areas for program improvement. This effort represents a first step in collecting, analyzing and reporting data from treatment home providers.

Program Information

Providers were asked to submit a bed capacity count. The average bed capacity was 32.45 per agency, ranging from 0 to 225 beds. Providers were asked to submit risk measures and departure conditions. Forty-one agencies out of a total of 43 participated in the collection of risk measures and departure conditions.

Risk Measures

Four areas of risk were selected for reporting. These high-risk areas were determined to be the most salient and, when monitored, could be used for risk prevention. The four risk areas were:

- Suicide
- Medication errors
- AWOL (runaways)
- Safety holds

Suicide

Treatment home providers were asked to track and report incidents of attempted and completed suicides. There were a total of 6 treatment homes that reported incidents of attempted suicide. Attempted suicide was defined as a potentially self-injurious behavior with a nonfatal outcome, for which there is evidence that the person had the intent to kill himself or herself but was rescued or thwarted, or changed his or her mind after taking initial action. There were no reports of completed suicides. Agencies reporting a suicide attempt were:

Agape
Golla Home
Maple Star Rural
My Home
Northern Nevada Child and Adolescent Services (DCFS-NNCAS) Family Learning Homes
Southern Nevada Child and Adolescent Services (DCFS-SNCAS) Oasis Treatment Homes

There were a total of 14 reports of suicide attempt with the following descriptive information:

- 10 were female and 4 were male.
- Average age was 14.93 with an age range of 13 to 17 years.
- 6 were Caucasian, 6 were of mixed race and 2 were African American.
- None were of Hispanic origin.

Clinical and suicide attempt information:

- The 3 most frequent diagnoses were Bipolar Disorder, Mood Disorder and Posttraumatic Stress Disorder.
- Average CASII score was 22.86, ranging from a score of 20 to 27; the mean CASII level was 4.57 (See Attachment C).
- Suicide means reported were 3 incidents of using a knife to harm oneself, 2 incidents of wrist cutting, 2 incidents of attempted hanging, and 7 incidents using

"other" means, to include suicide ideation, threatening to burn house, and scratching at self.

- All 14 children and adolescents with incidents were reported as having previous suicide attempts.
- Following the suicide attempts, 6 were admitted to a psychiatric hospital, 2 resulted in emergency hospital medical procedures, and 6 were categorized as "other" to include youth placed on 15-minute checks.
- In all incidents, agencies implemented a suicide protocol.

Highlights:

- All 6 agencies that reported a suicide attempt have a suicide protocol in place.

Opportunities for improvement:

- Ensure that all provider agencies have a suicide protocol and that treatment home parents and staff are trained to implement it.
- Ensure a complete suicide history of each child and adolescent is shared with providers as early in the pre-placement process as possible.
- In collaboration with Nevada Youth Care Providers, continue to provide treatment agencies with information about available training opportunities.

Medication Errors

Treatment home providers were asked to track and report medication errors. To track medication errors, a definition was needed that clearly stated what constitutes an error. The following definition was used from the U.S. Pharmacopoeia:

> "A medication error is any preventable event that may cause or lead to inappropriate medication use or client harm while the medication is in the control of the health care professional, client, or consumer. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing; order communication; product labeling, packaging, and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use" (U.S. Pharmacopeia, 1997).

Using this definition, 15 treatment home providers reported 192 medication errors over one 12-month reporting cycle. Medication errors may occur at the point of prescribing, documenting, dispensing, administering, and monitoring (U.S. Pharmacopeia, 2000).

Treatment homes reporting medication errors were:

Boys Town
Briarwood North
DCFS-NNCAS Family Learning Homes
DCFS-SNCAS Oasis
Eagle Quest
EEE
Hand Up Homes
Maple Star North
Maple Star Rural
Maple Star South
R House
REM Carson
Saint Jude's Ranch
Sankofa
Transitions

The 192 incidents of medication errors reflect the following descriptive information:

- 65.6% (126) were male and 24% (46) were female; 10.4% (20) were missing gender information.
- Average age was 14.29 with an age range of 6 to 19 years.
- 78.6% (151) were Caucasian, 9.9% (19) were African-American, 1% (2) were Native Hawaiian/Other Pacific Islander, 6.8% (13) were of mixed race and 3.6% (7) were of unknown race or the report was missing information about the child or adolescent's race.
- 10.9% (21) were of Hispanic origin.

Clinical and medication error information:

- The 3 most frequent diagnoses were Impulse Control Disorder, Adjustment Disorder and Posttraumatic Stress Disorder.
- Average CASII score was 22.51, ranging from a score of 17 to 27; the mean CASII level was 4.43.
- Type of medication error (See Attachment D for type of medication error definitions)
    - 3.1% (6) prescribing errors
    - 53.1% (102) omission errors
    - 6.3% (12) wrong time errors
    - 16.7% (32) unauthorized drug administration errors
    - 1% (2) improper dose errors
    - 1% (2) wrong dose form errors
    - 6.8% (13) compliance errors
    - 10.4% (20) other medication errors
    - 1.5% (3) were missing information
- 68.2% (131) of the medication errors were with psychotropic medication, 30.7% (59) were non-psychotropic medication errors, and 1% (2) did not indicate either a psychotropic or non-psychotropic medication error.
- More than 20% (39) of the medication errors reported occurred on Saturday. The lowest occurrence of medication errors were on Thursday (18 errors or 9.4%) and Sunday (20 errors or 10.4%).
- The most common time of day for errors was 8:00 am with 28 of the 192 errors occurring at this time (or 14.6%). Twelve percent (23 errors) occurred at 8:00 pm and the third most common time for errors was at 12:00 pm (17 errors or 8.9%).
- Medication error outcome (See Attachment D for outcome error definitions)
    - 26% (50) were circumstances or events that had the capacity to cause error.
    - 7.3% (14) were errors that occurred but did not reach the client.
    - 60.9% (117) were errors that occurred that reached the client but did not cause the client harm.
    - 2.1% (4) were errors that reached the client and required monitoring to confirm that it resulted in no harm to the client and/or required intervention to preclude harm.
    - 2.6% (5) were errors that may have contributed to or resulted in temporary harm to the client and required intervention.
    - 1% (2) were missing information.

Highlights:

- The high rate of medication errors (20%) on Saturday could be due to children being on weekend passes when dispensing medication may be overlooked or forgotten.

Opportunities for improvement:

- Medication errors can be improved by focusing on omission errors and unauthorized drug administration errors.
- By reviewing the circumstances surrounding an error, providers may be able to identify procedural changes needed to minimize further errors. A common contributing factor to medication errors is distractions (U.S. Pharmacopeia, 2000). The person responsible for the medication error can be informed of the error and receive education or training. A positive action is to ask the person responsible for the medication error to identify how he or she would correct the error in the future.
- Ensure the use of medication logs in each child's treatment home agency record and that each log is reviewed for quality assurance by someone other than the person who administered the medication.

AWOLs – Child or adolescent absent for more than 24 hours

Treatment home providers were asked to track and report the number of children or adolescents absent for more than 24 hours (AWOLs). A total of 26 treatment home providers reported 183 incidents of child or adolescent runaway/absences of more than 24 hours. Providers reporting child or adolescent absences of more than 24 hours are listed below:

Agape
Boys Town
Briarwood North
Briarwood South
DCFS-NNCAS Family Learning Homes
DCFS-SNCAS Oasis
Eagle Quest
EEE
Foundation for the Stars
Golla Home
Kids First
Maple Star North
Maple Star Rural
Maple Star South
Mountain Circle
My Home
New Beginnings
REM
Rite of Passage
SAFY
Saint Jude's Ranch
Shaw Homes
Transitions
Trinity
Ujima
Unity Village

The 183 incidents of child and adolescent absence of more than 24 hours reflect the following descriptive information:

- 60.1% (110) were female and 39.9% (73) were male.
- Average age was 15.65 with an age range of 8 to 20 years.
- 51.4% (94) were Caucasian, 29.5% (54) were African-American, 6% (11) were American Indian/Alaskan Native, 1.1% (2) were Native Hawaiian/Other Pacific Islander, 9.8% (18) were of mixed race, and 2.1% (4) were unknown or missing information.
- 12% (22) were of Hispanic origin.

Clinical and AWOL information:

- The most frequent diagnoses were Adjustment Disorder, Bipolar Disorder, Oppositional Defiant, and Depressive Disorder.
- Average CASII score was 22.46, ranging from a score of 7 to 30; the mean CASII level was 4.38.
- Average length of absence was 10.34 days with a range of 1 to 122 days.
- 80.3% (147) of children and adolescents absent for more than 24 hours had a history of AWOL, 17.5% (32) did not have a history of AWOL, and 2.2% (4) were missing data about a history of AWOL.
- Type of supervision at AWOL
    - 33.9% (62) left from school or work
    - 13.1% (24) left from treatment home at night – staff asleep
    - 24% (44) left from treatment home at night – staff awake
    - 26.8% (49) were other
    - 2.2% (4) were missing information
- Behavior during AWOL
    - 7.1% (13) substance abuse
    - 4.4% (8) criminal activity
    - .5% (1) sexual misconduct
    - 9.8% (18) assaultive to others
    - 1.6% (3) victim
    - 6% (11) sexual activity
    - 52.5% (96) unknown
    - 18% (33) missing information
- Outcome
    - 32.8% (60) returned to treatment home within 72 hours
    - 41.5% (76) absent indefinitely – did not return to treatment home
    - 3.8% (7) returned through juvenile detention
    - 7.1% (13) found with family
    - 12.6% (23) other
    - 2.1% (4) missing information

Highlights:

- Although more males tend to be in treatment for behavioral and emotional disturbance, it appears that females run away more often than males.
- 20.8% (38) of all AWOLs reported were African-American females.
- Over 80% of the children and adolescents who ran away had a history of AWOL.
- Nearly 33% of AWOL children and adolescents returned to the treatment home within 72 hours.

Opportunities for improvement:

- Focus on AWOL prevention at night; nearly a quarter of AWOLs occurred with night staff awake.
- Ensure a complete AWOL history of each child and adolescent is shared with providers as early in the pre-placement process as possible.
- Ensure there is feedback to the home from which the child ran away when the child is found. This may provide some “closure” to children who remain in the home from which the child ran away.

- Focus on developing protocols regarding supervision between the school and the treatment home.
- Develop a protocol for children and adolescents who threaten to run away. The protocol would include the creation of a safety plan that provides appropriate alternatives to the runaway behavior.
- Develop a crisis plan at admission for children that have a known history of AWOL.

Safety Holds

Treatment home providers were asked to track and report on safety holds used on children and adolescents. A safety hold is a method of restricting a child's freedom of movement for his/her safety or for the safety of others. The following 16 treatment home providers reported a total of 154 incidents of safety holds:

Agape	Olive Crest
DCFS-NNCAS Adolescent Treatment Center	Reagan Home
DCFS-NNCAS Family Learning Homes	REM
DCFS-SNCAS Oasis	Rite of Passage
Eagle Quest	SAFY
Koinonia	Saint Jude's Ranch
Maple Star North	Sankofa
Maple Star South	Trinity

Treatment home providers use a variety of safety hold models. Below is a list of the different models that were reported and the percent each model was used:

- 50.6% (78) Conflict Prevention and Response Training (CPART or CPAR)
- 22.7% (35) Jireh Escort/Jireh Standing/Jireh Seated
- 15.6% (24) Crisis Prevention Institute **(**CPI**)**
- 4.5% (7) David Mandt System
- 3.2% (5) Reactive Attachment Hold (RAD Hold)
- 1.9% (3) Therapeutic Crisis Intervention **(**TCI**)**
- .6% (1) Bear Hug
- .6% (1) Interim Control Position

Fourteen treatment home providers report that they do not use any type of safety hold. They are:

Briarwood North	My Home
Briarwood South	R House
EEE	Shaw
Foundation for the Stars	Transitions
Golla Home	Ujima
Maple Star Rural	Unity Village
Mountain Circle	Visions

The 154 reports of the use of safety holds reflect the following descriptive information:

- 66.2% (102) were male and 33.8% (52) were female.
- Average age was 12.59 with an age range of 6 to 18 years.

- 66.9% (103) were Caucasian, 26% (40) were African-American, .6% (1) were American Indian/Alaskan Native, and 6.5% (10) were of mixed race.
- 3.9% (6) were of Hispanic origin.

Clinical and Safety Hold Information:

- The 3 most frequent diagnoses were Bipolar Disorder, Adjustment Disorder and Mood Disorder.
- 77.3% (119) of children and adolescents had a safety hold used on them previously.
- Average length of safety holds was 10.94 minutes, ranging from 30 seconds to 50 minutes.
- Type of supervision prior to use of safety hold
    - 31.8% (49) Group – 4 or more
    - 53.9% (83) One-on-one
    - 5.2% (8) Line of sight
    - 8.4% (13) Other
    - .6% (1) missing information
- Injury report
    - 20.1% (31) Client injured
    - 1.3% (2) Staff injured
    - 1.9% (3) Peer injured
    - 76% (117) No one injured
    - .6% (1) missing information

Highlights:

- Most children and adolescents placed in safety holds had previous episodes of safety holds.

Opportunities for improvement:

- Slightly over 20% of children and adolescents in safety holds were injured as a result. This suggested the need to reduce the use of restraint as much as possible in treatment homes.
- Ensure a complete safety hold history of each child and adolescent is shared with providers as early in the pre-placement process as possible.
- Explore training treatment home parents and staff on Aggression Replacement Training. Aggression Replacement Training (ART) is a multimodal psycho-educational intervention designed to alter the behavior of chronically aggressive adolescents and young children. The goal of ART is to improve social skill competence, anger control, and moral reasoning (OJJDP Model Program's Guide).
- Research and implement best practices in safety holds to include de-escalation techniques in order to reduce its use and to increase safety outcomes.
- Ensure that provider agencies receive ongoing and regular training in best practices in safety holds and de-escalation techniques.

Departure Conditions

Treatment home providers were asked to track and report departure conditions on children and adolescents discharged from services beginning September 2008. A

departure (or discharge) means either a child is discharged from a treatment home agency or a child is discharged from one treatment home and admitted to another treatment home within the same agency. Therefore, providers may have reported more than one admission and departure for the same child throughout the reporting period. Information on departure conditions represents six months of data collected from September 2008 through February 2009. The following list of 30 treatment home providers reported a total of 351 departures:

Agape	Maple Star North
Boys Town	Maple Star Rural
Briarwood North	Mountain Circle
Briarwood South	My Home
DCFS-NNCAS Adolescent Treatment Center	New Beginnings
DCFS-NNCAS Family Learning Homes	Olive Crest
DCFS-SNCAS Oasis	Reagan Home
Eagle Quest	Rite of Passage
EEE	SAFY
Foundation for the Stars	Saint Jude's Ranch
Golla Home	Shaw Homes
Hand Up Homes	Transitions
Hope Healthcare Services	Ujima
Koinonia	Unity Village
London Family Services	Visions

The 351 departures reflect the following descriptive information.

- 63.8% (224) were male and 36.2% (127) were female.
- Average age was 14.9 with an age range of .85 to 22.39 years.
- 56.4% (198) were Caucasian, 30.5% (107) were African-American, 4.3% (15) were American Indian/Alaskan Native, .6% (2) were Asian, .9% (3) were Native Hawaiian/Other Pacific Islander, 7.1% (25) were of mixed race, and .3% (1) were missing information.
- 9.7% (34) were of Hispanic origin.
- Custody Status
    - 43.9% (154) were in child welfare custody
    - 27.6% (97) were in parental custody and on probation
    - 13.1% (46) were in custody of youth parole
    - 1.4% (5) were in Tribal custody
    - 13.4% (47) were in parental custody
    - .6% (2) were missing custody information
- 88.3% (310) were Medicaid or SCHIP recipients

Clinical and departure information:

- The 5 most frequent diagnoses at admission were Adjustment Disorder, Bipolar Disorder, Depressive Disorder, Attention Deficit Hyperactivity Disorder, and Mood Disorder.
- The average CASII composite score at admission was 22.64, with an average level of intensity of 4.38.
- The average CASII composite score at discharge was 21.80, with an average level of intensity of 4.19.

- Reason for departure
  - 27.1% (95) were reunified
  - 4.6% (16) were adopted
  - 4% (14) were placed with a relative
  - 2% (7) were placed in independent living
  - 1.1% (4) were emancipated
  - 6.3% (22) were placed in a less restrictive setting
  - 17.9% (63) were placed in a more restrictive environment
  - 17.4% (61) were AWOL (runaway) from placement
  - 1.1% (4) were placed in a private mental health facility
  - 11.7% (41) were removed by placing agency
  - 2.6% (9) were admitted to another home within the same agency
  - 3.4% (12) were other responses
  - .9% (3) were missing information
- Setting child/adolescent will live – The Restrictiveness of Living Environment Scale (ROLES) (Hawkins, Almeida, Fabry & Reitz, 1992) resulted in an average score of 10.19, which equals the restrictiveness score of a regular foster home.
  - 4% (14) independent living by self
  - 2.6% (9) independent living with friend
  - 3.4% (12) home of natural parents for an 18 year old
  - 27.4% (96) home of natural parents for a child
  - 7.7% (27) home of relative
  - 3.1% (11) adoptive home
  - .6% (2) home of a family friend
  - 2% (7) supervised independent living
  - 2.8% (10) regular foster care
  - 2.8% (10) special foster care
  - .3% (1) individual home emergency shelter
  - 4.6% (16) family-based treatment home
  - 5.7% (20) group treatment home
  - 2% (7) group emergency shelter
  - 8% (28) residential treatment center
  - 2.3% (8) wilderness camp (24-hour, year round)
  - .3% (1) medical hospital
  - .9% (3) drug-alcohol rehabilitation center
  - .9% (3) intensive treatment center
  - 3.7% (13) youth correction center
  - 5.7% (20) county detention center
  - 2% (7) state and private mental hospital
  - .9% (3) jail
  - 6.6% (23) missing information
- 35.6% (125) completed treatment.
- Who recommended departure
  - 9.7% (34) provider agency
  - 6.8% (24) child welfare case manager
  - 16% (56) parole/probation officer
  - 1.7% (6) parent
  - .6% (2) relative guardian
  - 2.8% (10) judge or hearing master

- 5.4% (19) child's mental health practitioner
- 39.3% (138) child and family team
- 14.2% (50) other
- 3.4% (12) missing information

Highlights:

- A total of 41% of children were in parental custody.
- 36.8% of children and adolescents achieved or returned to a permanent placement upon discharge (reunified, adopted, relative placement and emancipation).
- The ROLES score of 10.19 for all discharged children and adolescents is equal to the restrictiveness of a regular foster home. The ROLES score for family-based treatment homes is 13 and for group homes is 14. This may indicate that, upon discharge from a family-based or group treatment home, children tended to be placed in a less restrictive environment.
- Upon departure, 53.6% of children and adolescents were going to a less restrictive setting to live.
- Upon departure, 35.6% of children and adolescents had completed services in the treatment home.
- 39.3% of discharges from treatment homes were recommended by Child and Family Teams.
- Of the 122 children and adolescents who completed treatment, 69.7% (85) of the discharges were recommended by the Child and Family Team.

Opportunities for improvement:

- 17.4% of reasons for discharge were due to AWOL from placement; this information, combined with the 41.5% (76) of children and adolescents who were absent indefinitely as presented in the AWOL measures, indicates a serious safety and permanency issue for children and adolescents in out-of-home placement.
- Adjustment disorder was the most frequent diagnosis found among children and adolescents. Although a serious diagnosis, adjustment disorder lasts for no longer than 6 months unless the stressor or its consequences persist (American Psychiatric Association, 2000). A persistent adjustment disorder may meet criteria for another more severe diagnosis. Children and adolescents requiring an out-of-home placement in a treatment home have a serious emotional disturbance requiring intensive and comprehensive treatment which is not typical of children diagnosed with an adjustment disorder. Diagnoses for children and adolescents must be appropriate to the treatment they are receiving; therefore providers may need to revisit these diagnoses for children and adolescents who are placed in their programs in order to better address their needs.

Summary

This report reflects a first attempt to collect, analyze and report on identified risk measures and departure conditions for treatment home providers. There are substantial opportunities for improvement, even though there were data limitations due to missing information, inconsistent reporting, and a lack of participation by some provider agencies. One of the primary opportunities for improvement will be in the reporting of identified risk measures and departure conditions. Provider agencies will soon have contracts with DCFS and county child welfare agencies for specialized

room and board. Contracts with provider agencies will include performance and quality assurance monitoring and evaluation by DCFS. Submission of risk measures and departure conditions data will be a requirement of the contracts.

With accurate and consistent data, more meaningful conclusions can be drawn. Knowing that the number of reported incidents of each risk measure is drawn from the population of children and adolescents served by all treatment home providers allows for generalizations, benchmarking and data trending. Based on the data collected, some areas of improvement can be addressed. Those areas include:

- Provider agencies will have a suicide protocol.
- Provider agencies will ensure that treatment home parents and staff are trained to implement the suicide protocol.
- The Provider Support Team, in collaboration with Nevada Youth Care Providers, will continue to provide treatment agencies with information about available training opportunities.
- Provider agencies will have medication error policies that target positive actions steps when an error occurs.
- Provider agencies will maintain medication logs in children's treatment home agency records and implement medication log reviews by someone who does not administer the medication.
- Provider agencies will have policies or protocols that address AWOL behaviors, including a section on the prevention of AWOLs when children and adolescents threaten to runaway and a section on crisis planning.
- Explore options for training treatment home parents and staff on Aggression Replacement Training.
- The Provider Support Team will research best practices in safety holds and de-escalation techniques.
- Provider agencies will participate in and convene, when indicated, Child and Family Teams in order to fully advocate for the treatment planning needs, including discharge planning, of the child in their treatment program.

In partnership with the Provider Support Team, the Planning and Evaluation Unit will prioritize areas for program improvement and develop an action plan for implementation.

References

American Academy of Child and Adolescent Psychiatry. (2007). *Child and adolescent service intensity instrument: User's manual version 3.0.* Washington, DC: Author.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., Text Revision). Washington, DC: Author.

Hawkins, R. P., Almeida, M. C., Fabry, B., & Reitz, A. L. (1992). A scale to measure restrictiveness of living environments for troubled children and youths. *Hospital and Community Psychiatry, 43,* 54-58.

Office of Juvenile Justice and Delinquency Prevention's Model Programs Guide. *Model program's guide version 2.5.* Retrieved April 27, 2009 from http://www.dsgonline.com/mpg2.5/TitleV_MPG_Table_Ind_Rec.asp?ID=292

U.S. Pharmacopeia. (2000, December). *USP Medmarx data analyzed – first annual report provided.* Retrieved April 28, 2009 from http://www.usp.org/audiences/volunteers/members/private/memos/2000-12.html

U.S. Pharmacopeia. (1997, January). *Definition of medication errors.* Retrieved April 28, 2009 from http://www.usp.org/hqi/practitionerPrograms/newsletters/qualityReview/qr571997-01-01e.html

Nevada DCFS Performance and Quality Improvement

Monthly Data Collection for High Risk Areas in Children's Mental Health Community Treatment Homes

Program: _____ **Month ending:** _____

1. What were the total number of youth served in treatment homes this month? _____

2. Bed capacity as of the last day of this month? _____

If more than 10 incidents occur in any area, please provide information on an additional sheet of paper or insert additional rows as needed in the excel spreadsheet.

Nevada DCFS Performance and Quality Improvement
Monthly Data Collection for High Risk Areas in Children's Mental Health Community Treatment Homes

Risk Measure #1: Suicide – Completed Suicides and Attempts

How many incidents of attempted and/or completed suicide occurred this month?

#	Date of Incident (mm/dd/yy)	Gender (M or F)	Age	[1]Race	[2]Ethnicity	Primary DSM IV Diagnosis Code	CASII Score	CASII Level	[3]Completed(C) or [4]Attempt(A)	[5]Suicide Means	History of Previous Attempt (Y/N)	[6]Outcome	Was a suicide prevention protocol used? (Y/N)	Date(s) staff present had Suicide Prevention training (AB 507) (mm/dd/yy)
EXAMPLE Format for Data Entry	mm/dd/yy	F	16	2	N	313.89	20	4	A	1	N	1	Y	mm/dd/yy
1														
2														
3														
4														
5														
6														
7														
8														
9														
10														

[1]Race	
1= White/Caucasian	5= Native Hawaiian/Other Pacific Islander
2= Black/African American	6= Mixed
3= American Indian/Alaska Native	7= Unknown
4= Asian	

[2]Ethnicity
H= Hispanic
N= Non-Hispanic

[4]Suicide Means	
1= Overdose	4= Wrist Cutting
2= Gun	5= Hanging
3= Knife	6= Other (describe below)

[5]Suicide Outcomes
1= Psychiatric hospital admission
2= Emergency hospital and medical procedures
3= Death
4= Other (describe below)

[3]**Completed suicide or death by suicide**: Death from injury, including poisoning or suffocation, where there is evidence that the injury was self-inflicted and intended to cause death.

[4]**Suicide attempt**: A potentially self-injurious behavior with a nonfatal outcome, for which there is evidence that the person had the intent to kill himself or herself but was rescued or thwarted, or changed his or her mind after taking initial action. A suicide attempt may or may not result in injuries.

Suicide Means: Other Please Describe:	Suicide Outcome: Other Please Describe:

Nevada DCFS Performance and Quality Improvement

Monthly Data Collection for High Risk Areas in Children's Mental Health Community Treatment Homes

Risk Measure #2: Medication Errors

How many medication errors occurred this month?

"A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing; order communication; product labeling, packaging, and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use." (Reprinted with permission from US Pharmocopeia)

#	Date (mm/dd/yy)	Gender (M or F)	Age	[1]Race	[2]Ethnicity	Primary DSM IV Diagnosis Code	CASII Score	CASII Level	[3]Type of med error	Psychotropic or Non-psychotropic med (P or N)	Time of Med Error (hr:min AM or PM)	[4]Outcome	Date(s) staff present had Medication Administration training (AB 507) (mm/dd/yy)
EXAMPLE Format for Data Entry	**mm/dd/yy**	**M**	**14**	**1**	**H**	**313.89**	**14**	**2**	**2**	**p**	**2:00 PM**	**2**	**mm/dd/yy**
1													
2													
3													
4													
5													
6													
7													
8													
9													
10													

[1]Race	
1= White/Caucasian	5= Native Hawaiian/Other Pacific Islander
2= Black/African American	6= Mixed
3= American Indian/Alaska Native	7= Unknown
4= Asian	

[2]Ethnicity
H= Hispanic
N= Non-Hispanic

Nevada DCFS Performance and Quality Improvement
Monthly Data Collection for High Risk Areas in Children's Mental Health Community Treatment Homes

Risk Measure #3: AWOL's – Youth absent for more than 24 hours

How many incidents of AWOL occurred this month?

#	Date of Incident (mm/dd/yy)	Gender (M or F)	Age	Race[1]	Ethnicity[2]	Primary DSM IV Diagnosis Code	CASII Score	CASII Level	Length of Absence in Days	Time of AWOL (hr:min AM or PM)	History of AWOL? (Y/N)	Type of Supervision at AWOL[3]	Behavior During AWOL[4]	Outcome[5]
EXAMPLE Format for Data Entry	04/07/08	M	12	5	H	313.89	23	4	2	2:00 AM	Y	2	7	1
1														
2														
3														
4														
5														
6														
7														
8														
9														
10														

[1]Race	
1= White/Caucasian	5= Native Hawaiian/Other Pacific Islander
2= Black/African American	6= Mixed
3= American Indian/Alaska Native	7= Unknown
4= Asian	

[2]Ethnicity
H= Hispanic
N= Non-Hispanic

[3]Type of Supervision at AWOL
1= Left from school or work
2= Left from tx home at night-staff asleep
3= Left from tx home at night-awake staff
4= Other (describe below)

[4]Behavior During AWOL
1= Substance abuse
2= Criminal activity
3= Sexual misconduct
4= Assaultive to others
5= Victim
6= Sexual activity
7= Unknown

[5]Outcome of AWOL
1= Returned to tx home within 72 hrs
2= Absent indefinitely
3= Returned through juvenile detention
4= Found with family
5= Other (describe below)

Type of Supervision at AWOL: Other please describe:

Outcome of AWOL: Other please describe:

Nevada DCFS Performance and Quality Improvement

Monthly Data Collection for High Risk Areas in Children's Mental Health Community Treatment Homes

Risk Measure #4: Safety Holds

A safety hold is one method of restricting a youth's freedom of movement for the youth's safety or for the safety of others.

How many safety holds occurred this month? _____ **Model of Safety Hold used:** _____

#	Date of incident (mm/dd/yy)	Gender (M or F)	Age	[1]Race	[2]Ethnicity	Primary DSM IV Diagnosis Code	CASII Score	CASII Level	Previous Safety Holds (Y/N)	Length of Safety Hold in Minutes	Time Safety Hold occurred (hr:min AM or PM)	[3]Type of supervision prior to use of Safety Hold	[4]Injury Report	Date(s) staff present received Safety Hold training? (AB 507) (mm/dd/yy)
EXAMPLE Format for Data Entry	mm/dd/yy	M	17	6	N	309.9	25	5	Y	25	4:00 PM	1	4	mm/dd/yy
1														
2														
3														
4														
5														
6														
7														
8														
9														
10														

[1]Race	
1= White/Caucasian	5= Native Hawaiian/Other Pacific Islander
2= Black/African American	6= Mixed
3= American Indian/Alaska Native	7= Unknown
4= Asian	

[2]Ethnicity
H= Hispanic
N= Non-Hispanic

[4]Injury Report
1= Client injured
2= Staff injured
3= Peer injured
4= No one injured

[3]Type of Supervision
1= Group--4 or more
2= One-on-one
3= Line of sight
4= Other (describe below)

Type of supervision prior to safety hold. For "Other", Please Describe Here:

ATTACHMENT B

	PROVIDER NAME	# of Provider Reporting Periods	# of Provider Reports Submitted	% of Reports Completed
1.	Agape	6	6	100%
2.	Apple Grove	6	6	100%
3.	DCFS Adolescent Treatment Center	4*	4	100%
4.	DCFS Family Learning Homes	4*	4	100%
5.	DCFS Oasis	4*	4	100%
6.	Briarwood - North	6	6	100%
7.	Briarwood - South	6	6	100%
8.	Eagle Quest of Nevada	6	6	100%
9.	Evans Electrifying Enterprises	6	6	100%
10.	Father Flanagan's Boys Town	6	6	100%
11.	Foundation for the Stars	6	6	100%
12.	Fresh Start Services	6	0	0%
13.	Golla Home	6	6	100%
14.	Hand Up Homes	6	6	100%
15.	Hope Healthcare Services, Inc.	6	6	100%
16.	Kathy's House	6	6	100%
17.	Kids First	6	2	33%
18.	Koinonia	6	6	100%
19.	Las Vegas Home Health –Our Kids Home	6	6	100%
20.	London Family & Children's Services	6	6	100%
21.	Maple Star Nevada - North	6	6	100%
22.	Maple Star Nevada – Rural	6	6	100%
23.	Maple Star Nevada – South	6	3	50%
24.	Mountain Circle Family Services	6	6	100%
25.	My Home	6	6	100%
26.	New Beginnings	6	5	83%
27.	Olive Crest Foster Family Agency	6	5	83%
28.	REM Nevada (Carson)	6	6	100%
29.	REM Nevada (Las Vegas)	6	6	100%
30.	R House Community Treatment Center	6	6	100%
31.	Reagan Home	6	6	100%
32.	Rite of Passage	6	6	100%
33.	Rivendel Independent Living	6	0	0%
34.	SAFY	6	6	100%
35.	Sankofa Group	6	6	100%
36.	Shaw Foster Homes, Inc.	6	6	100%
37.	St. Jude's Ranch for Children	6	6	100%
38.	Transitions	5*	5	100%
39.	Trinity Youth Services	6	3	50%
40.	Unity Village	6	6	100%
41.	Visions Treatment Home	3*	3	100%
42.	Ujima Youth Services	6	4	66%
43.	Unity Family Services	6	5	83%

* Agency was new in service or invited to report later in the data collection process.

Child and Adolescent Service Intensity Instrument

The Child and Adolescent Service Intensity Instrument (CASII) is used to determine the needed level of service intensity for an individual child and family (American Academy of Child and Adolescent Psychiatry, 2007).

The following is the American Academy of Child and Adolescent Psychiatry CASII Level of Service Intensity Composite Score Table (p.51).

Level	Description	Score
Zero	Basic Services for Prevention and Maintenance	7-9
One	Recovery Maintenance and Health Management	10-13
Two	Outpatient Services	14-16
Three	Intensive Outpatient Services	17-19
Four	Intensive Integrated Services Without 24-Hour Psychiatric Monitoring	20-22
Five	Non-Secure, 24-Hour Psychiatric Monitoring	23-27
Six	Secure, 24-Hour Psychiatric Management	28+

Type of Medication Error-Definitions[1]	
1= Prescribing Error	Incorrect drug selection (based on indication, contraindications, known allergies, existing drug therapy and other factors), dose, dosage form, quantity, route, concentration, rate of administration, or instructions for use of a drug product ordered or authorized by physician (or other legitimate prescriber); illegible prescriptions or medication orders that lead to errors that reach the patient.
2= Omission Error	The failure to administer an ordered dose to the patient before the next scheduled dose, if any.
3= Wrong Time Error	Administration of medication outside a predefined time interval from its scheduled administration time (medication should be given within plus or minus one hour of time ordered).
4= Unauthorized Drug Administration Error	Administration to the patient of medication not authorized by a legitimate prescriber for the patient.
5= Improper Dose Error	Administration to the patient of a dose that is greater or less than the amount ordered by the prescriber or administration of duplicate doses to the patient, for example, one or more dosage units in addition to those that were ordered.
6= Wrong Dosage-Form Error	Administration to the patient of a drug product in a different dosage form than ordered by the prescriber.
7= Wrong Drug-Preparation Error	Drug product incorrectly formulated or manipulated before administration.
8= Wrong Administration Technique Error	Inappropriate procedure or improper technique in the administration of a drug.
9= Deteriorated Drug Error	Administration of a drug that has expired or for which the physical or chemical dosage-form integrity has been compromised.
10= Monitoring Error	Failure to review a prescribed regimen for appropriateness and detection of problems, or failure to use appropriate clinical or laboratory data for adequate assessment of patient response to prescribed therapy.
11= Compliance Error	Inappropriate patient behavior regarding adherence to a prescribed medication regimen.
12= Other Medication Error	Any medication error that does not fall into one of the above predefined categories.
Medication Error Outcome[2]	
1= Circumstances or events that have the capacity to cause error	
2= An error occurred but the error did not reach the patient (An "error of omission" does reach the patient).	
3= An error occurred that reached the patient but did not cause patient harm.	
4= An error occurred that reached the patient and required monitoring to confirm that it resulted in no harm to the patient and/or required intervention to preclude harm.	
5= An error occurred that may have contributed to or resulted in temporary harm to the patient and required intervention.	
6= An error occurred that may have contributed to or resulted in temporary harm to the patient and required initial or prolonged hospitalization.	
7= An error occurred that may have contributed to or resulted in permanent patient harm.	
8= An error occurred that required intervention necessary to sustain life.	
9= An error occurred that may have contributed to or resulted in the patient's death.	

[1] American Society of Hospital Pharmacists. (1993). ASHP Guidelines on preventing medication errors in hospitals. *American Journal of Hospital Pharmacy, 50:305-14.*

[2] National Coordinating Council for Medication Error Reporting and Prevention. (1998). *NCC MERP taxonomy of medication errors.*