Review Highlights

Highlights of Legislative Auditor report on the Review of Governmental and Private Facilities for Children, issued on December 8, 2010. Report # LA10-26.

Background

Nevada Revised Statutes 218G.570 through 218G.585 require the Legislative Auditor to conduct reviews, audits, and unannounced site visits of governmental and private facilities for children.

We identified a total of 57 governmental and private facilities that meet the requirements of NRS 218G: 21 governmental and 36 private facilities. In addition, 121 Nevada children were placed in 25 facilities in 12 different states as of June 30, 2010.

NRS 218G requires facilities to forward to the Legislative Auditor copies of any complaint filed by a child under their custody or by any other person on behalf of such a child concerning the health, safety, welfare, and civil and other rights of the child. During the period from July 1, 2009, through June 30, 2010, we received 868 complaints from Nevada facilities.

Purpose of Reviews

Reviews were conducted pursuant to the provisions of NRS 218G.570 through NRS 218G.585. The report includes the results of our reviews of 6 children's facilities, unannounced site visits to 6 children's facilities, and surveys of 57 children's facilities. As reviews and not audits, they were not conducted in accordance with generally accepted government auditing standards, as outlined in *Government Auditing Standards* issued by the Comptroller General of the United States, or in accordance with the *Statements on Standards for Accounting and Review Services* issued by the American Institute of Certified Public Accountants.

The purpose of our reviews was to determine if the facilities adequately protect the health, safety, and welfare of the children in the facilities and whether the facilities respect the civil and other rights of the children in their care. These reviews included an examination of policies, procedures, processes, and complaints filed since July 1, 2008. In addition, we discussed related issues and observed related processes during our visits. Our work was conducted from February 2010 to November 2010.

Recommendations

Specific recommendations based on our observations were made to each of the six facilities reviewed. In addition, we are making one recommendation to all Nevada facilities. This recommendation is to strengthen medication management training by having key medication management staff participate in training conducted by an agency independent of the facility. This training should include the administration of medication, documentation of administration and medical orders, and minimizing and handling medication errors.

Review of Governmental and Private Facilities for Children

December 2010

Results of Reviews

Based on the procedures performed and except as otherwise noted, the policies, procedures, and processes in place at the facilities we reviewed provide reasonable assurance that they adeqeuately protected the health, safety, and welfare of the youths at the facilities, and they respect the civil and other rights of youths in their care. In addition, during the six unannounced visits conducted, we did not note anything that caused us to question the health, safety, welfare or protection of rights of the children in the facilities.

All six of the facilities reviewed could improve their medication management. For example, we noted at least one type of medication management error at each of the facilities reviewed. Errors included not following physician's orders, missing or incomplete medication documentation, and youths not receiving medications timely. Although employees receive training on the administration of medication, the delivery of instruction needs strengthening.

In general, staff receive training on the administration of medication to youths and how to identify the signs and symptoms of illnesses. However, facilities should consider training surrounding both medication management and handling medication errors. For example, facilities should document medication missed and the reason why, and medication errors, like incorrect dosage.

NRS 449.037(6)(e) requires employees of residential facilities for groups who assist residents with their medications to successfully complete training and pass an examination approved by the Health Division of the Department of Health and Human Services. Residential facilities for groups include facilities that furnish food, shelter, assistance, and limited supervision to a person with mental retardation or with a disability or a person who is aged or infirm. Most of the children's facilities that are included in our reviews pursuant to NRS 218G are not required to receive training as outlined in NRS 449.037. However, this type of training may help reduce the number of medication errors and improve the facilities' responses to errors that do occur.

The Bureau of Health Care Quality and Compliance maintains a list of approved medication training programs on its website. As of September 2010, there were 10 programs on this list. We contacted eight of these training providers. Six provide medication management training to persons outside of their organizations and they provided us with information on the topics covered in the training. While some of the topics are not applicable to children's facilities, since they deal with elderly populations, most of the topics addressed common problems at children's facilities. For example, some of the topics included dispensing, storage and handling of medications, over the counter medications, documenting medication errors, and disposing of discontinued and expired medications. This training is available at a cost ranging from $70 to $100 for a full day class.

Facility Observations

All six facilities reviewed needed to develop or update policies and procedures. The types of policies and procedures that were missing, unclear, or outdated ranged from mandatory reporting of child abuse and neglect to off-campus activities.

Medication administration processes and procedures need improvement at all six facilities. Youth medical files did not always contain complete or clear documentation of dispensed, prescribed medication at five of six facilities. Some youths' files were missing evidence of physicians' orders at four facilities. Some medication administration records were missing at two facilities. In addition, youths at two facilities did not always receive medication timely. Staff did not check for "cheeking" at four facilities. Cheeking is a method used to conceal medication administered. Finally, four facilities need to develop or update their over-the-counter standing order forms.

Complaint and grievance processes also need improvement. For example, youth files did not contain evidence of a youth's acknowledgment of his right to file a complaint at three of six facilities. In addition, a description of the complaint process was not posted or visible to youths at three facilities.

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