MISSISSIPPI DEPARTMENT OF HUMAN SERVICES
DIVISION OF YOUTH SERVICES
JUVENILE INSTITUTIONS

Subject:	Policy Number:
Quality Assurance Program	**1**
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Attachments A. Audit Report Template B. Corrective Action Plan Template	**Related Standards & References** **ACA 3-JTS-1A-23**
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I. POLICY:

The Mississippi Department of Human Services, Division of Youth Services (DYS), shall establish and implement a comprehensive quality assurance (QA) process to assure that the Division is following established policy and procedure, achieving its goals and objectives, and ensuring accountability. At a minimum, the process shall evaluate implementation of policies, procedures, practices and training related to protection from harm, suicide prevention, mental health and rehabilitation, medical and dental services and special education. As well, the QA process shall rely on an established set of standards governing all areas of facility operations which are supported by a multifaceted methodology to assess the extent to which standards are being met. Administrative and facility staff shall be informed of the level of performance in each area via a written report and shall respond to deficiencies in a written Corrective Action Plan.

II. DEFINITIONS

As used in this policy and procedure, the following definitions apply:

A. Administrative Review Team – Group of staff persons designated by the Facility Administrator to review serious incidents and other instances that require immediate attention and or may be reviewed for training implications or corrective action.

B. Audit – Formal evaluations conducted to determine the organization's progress towards, or compliance with, agency policy, procedures and mandatory practices.

C. Audit Report - A detailed report containing the methodology, findings and recommendations of auditors, which is published following each audit to document the status of the agency's compliance with DYS standards. The audit report follows an established template.

D. Audit Standards – Standards based on DYS policy and procedures, established and applicable correctional or juvenile justice standards, and applicable Consent Decree and or Memorandum of Agreement provisions, which shall form the basis for the quality assurance process.

E. Audit Team – At least three (3) staff members who are knowledgeable in the area being reviewed and trained in the development and use of the methodology, who are designated by the QA Director to conduct an audit.

F. Compliance Levels – Status designation given to each area audited based on performance.

a. Non-Compliance - Little or no evidence of expected level of performance; implementation is minimal; documentation could not be produced to substantiate practice.

b. Beginning Compliance: Expected level of performance is observed but not facility-wide or on a consistent basis; implementation is approaching routine levels but frequent gaps remain; documentation was difficult to produce in some areas.

c. Partial Compliance - Expected level of performance is consistently met across the facility; gaps are temporary and/or isolated and minor; documentation is organized and readily available.

d. Substantial Compliance - Strong evidence that all areas of practice consistently exceed the standard across the facility.

G. Corrective Action Plan – A formal plan developed by a committee of facility staff, chaired by the Facility Superintendent, that responds to the deficiencies identified in the Audit Report. The Corrective Action Plan discusses the causes or source of the deficiencies, describes the interventions designed to correct them, and identifies the timeline and party responsible for completion.

H. Performance Review – monthly presentations to the Agency Executive Director, of statistical data used to quantify training school performance

I. Quality Assurance – A system of self-auditing and improvement to assess the implementation of DYS policies, procedures, and standards; evaluate the effectiveness of organizational and institutional practices; identify any deficits that may exist; and to effectuate new measures to cure deficits identified.

J. Quality Assurance Director – The person assigned by DYS to manage the quality assurance process for the Division. This person will oversee quality assurance activities which include: creating audit tools and forms, conducting training, establishing audit schedules as required by policy, directing quality assurance reviews, synthesizing input from the quality assurance team, and publishing regular reports that summarize quality assurance activities, accomplishments, and findings.

III. PROCEDURE

A. Role and Responsibilities of Quality Assurance Director – The role and responsibilities of the QA Director shall include, but not be limited to the following:

1. Develop audit standards and tools; and

2. Coordinate entry and exit conferences, and

3. Actively participate in the audit process, by directing team members and ensuring that requested documents are provided;

4. Compile the Audit Report using the sections that are written by the QA team members in each area.

B. Audits – At a minimum the following audit types shall be conducted regularly:

1. Scheduled – The Audit Team shall conduct a comprehensive audit of all facility operations, which shall last no longer than a week, as scheduled by the QA Director. Such audits shall take place on a semi-annual cycle, according to the following:

   a. Period 1 - September (covering the period March - August),

   b. Period 2 - March (covering the period September - February)

2. Periodic – The QA Director or designee shall conduct targeted audits of areas of operation that require immediate attention, as identified by the Division Director and those receiving non-compliance ratings in previous audits on an unscheduled and on-going basis.

C. Audit Methodology – All audits shall, at a minimum, use the following methods to ascertain the extent to which the established standards are being met and determine compliance levels relative to an identified DYS standard.

1. Documentation Review – Where applicable, auditors shall examine a sample of the documents specified as part of DYS policy and procedure relevant to each Audit Standard, to assure that compliance with policy and procedure is fully and properly recorded and apparent.

2. Observation – Where applicable, auditors shall examine or observe actual institutional practice and/or physically verify that practice is consistent with policy, procedure and documentation reviewed.

3. Interviews – Where applicable, auditors shall interview staff and/or youth to assess whether institutional practice is consistent with the relevant standard.

D. Audit Reports – The Director of Quality Assurance shall compile and submit reports of all quality assurance review activities to the Director of DYS, which shall follow the approved format (see Attachment A). The report shall be submitted according to the following schedule:

1. Draft – a Draft shall be submitted within 10 working days of the completion of an audit, excluding holidays.

2. Draft Review – an additional 5 working days shall be provided for the Facility to review and make correction to the draft.

3. Final – A final report shall be submitted within 5 working days of the last day of draft review.

E. Format - All audit reports shall be made available to all staff and shall be developed according to the following format:

a. Standard – There should be a notation of the complete standard being reviewed.

b. Discussion – There should be a statement which clarifies what is required and intended by the standard. The specific actions taken by the auditor to determine compliance with the standard. This, at a minimum, shall include the following: a review of documentation, an observation period, and interviews and other activities felt necessary to comprehensively assess the organizational practices relative to the standard being audited. The relevant facts derived from the documentation, observations, and interviews, which shall be used to decide what compliance level, will be identified based upon the parameters outlined in the definition section of this policy. As well, the assigned level of compliance shall be noted.

c. Areas in Need of Corrective Action – The Auditor shall identify those items and or areas that require correction in order to become substantially compliant.

d. Areas in need of Remediation – Items that can be corrected immediately and/or are of a less than critical nature that require improvement.

F. Corrective Action Plans – The Facility Administrator, with the assistance of the Administrative Review Team, shall review the audit report and assign any areas with a compliance rating other than substantial compliance to staff for corrective action and indicate when corrective action is to be completed. Based on the recommendations of the Administrative Review Team, the Facility Administrator shall compile a corrective action plan, which shall follow the approved format (see Attachment B). Periodic updates on the status of all corrective action items shall be presented by the Facility Administrator during monthly Performance Reviews. The Corrective Action Plan shall

be forwarded to the Division Director within 10 working days from the submission of the final audit report, and shall be developed according to the following format:

a. Problem Analysis – This will include the determined cause of less than substantial compliance and the specific actions to be taken to bring the area into substantial compliance.

b. The responsible staff member – This is the person expected to take action and implement the defined solutions.

c. The target date for achieving substantial compliance.

d. If appropriate, the percent or threshold of compliance deemed satisfactory.

G. Training Requirement – Any staff person designated as a member of an audit team shall participate in a detailed training session prior to conducting an actual audit. Such training shall at a minimum shall include:

1. An overview of the Quality Assurance Policy

2. An overview of established DYS standards;

3. An overview of the Audit Report Template; and

4. An overview of the Corrective Action Plan Template.

5. Protocols for conducting an audit.