



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of CHS West Palm Beach

on 02/12/2013

CINS/FINS Rating Profile

Standard 1: Management Accountability

1.01 Background Screening	Satisfactory
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Satisfactory
1.05 Interagency Agreements and Outreach	Satisfactory
1.06 Disaster Planning	Satisfactory
1.07 Analyzing and Reporting Information	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 Psychosocial Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management and Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petition Process	Satisfactory
2.07 Youth Records	Satisfactory

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

Standard 3: Shelter Care

3.01 Youth Room Assignment	Satisfactory
3.02 Program Orientation	Satisfactory
3.03 Shelter Environment	Satisfactory
3.04 Log Books	Satisfactory
3.05 Daily Programming	Satisfactory
3.06 Behavior Management Strategies	Satisfactory
3.07 Behavior Interventions	Satisfactory
3.08 Staffing and Youth Supervision	Satisfactory
3.09 Staff Secure Shelter	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	Satisfactory
4.03 Medications	Satisfactory
4.04 Medical/Mental Health Alert Process	Satisfactory
4.05 Episodic/Emergency Care	Satisfactory

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

Overall Rating Summary

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

Rating Definitions

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

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

Review Team

Members

- Marcia Tavares, Lead Reviewer and Consultant, Forefront LLC
- Brian K. Dye Residential Services Manager at B.E.A.C.H. House
- Rodney Dailey, Residential Supervisor, Orange County Youth Shelter



Bill Mann, Chief Operating Officer, Florida Keys Children's Shelter

Paula Friedrich, Delinquency Prevention Specialist, Department of Juvenile Justice

Persons Interviewed

- | | | |
|--|--------------------------|-------------------------|
| <input checked="" type="checkbox"/> Program Director | 0 Case Managers | 0 Maintenance Personnel |
| <input type="checkbox"/> DJJ Monitor | 2 Clinical Staff | 1 Program Supervisors |
| <input type="checkbox"/> DHA or designee | 0 Food Service Personnel | 2 Other |
| <input type="checkbox"/> DMHA or designee | 0 Health Care Staff | |

Documents Reviewed

- | | | |
|---|--|--|
| <input type="checkbox"/> Accreditation Reports | <input checked="" type="checkbox"/> Fire Prevention Plan | <input checked="" type="checkbox"/> Vehicle Inspection Reports |
| <input checked="" type="checkbox"/> Affidavit of Good Moral Character | <input checked="" type="checkbox"/> Grievance Process/Records | <input type="checkbox"/> Visitation Logs |
| <input checked="" type="checkbox"/> CCC Reports | <input type="checkbox"/> Key Control Log | <input checked="" type="checkbox"/> Youth Handbook |
| <input type="checkbox"/> Confinement Reports | <input checked="" type="checkbox"/> Logbooks | 3 Health Records |
| <input checked="" type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 3 MH/SA Records |
| <input checked="" type="checkbox"/> Contract Monitoring Reports | <input type="checkbox"/> PAR Reports | 13 Personnel Records |
| <input type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 6 Training Records/CORE |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 0 Youth Records (Closed) |
| <input type="checkbox"/> Escape Notification/Logs | <input type="checkbox"/> Sick Call Logs | 6 Youth Records (Open) |
| <input type="checkbox"/> Exposure Control Plan | <input checked="" type="checkbox"/> Supplemental Contracts | 0 Other |
| <input checked="" type="checkbox"/> Fire Drill Log | <input checked="" type="checkbox"/> Table of Organization | |
| <input checked="" type="checkbox"/> Fire Inspection Report | <input type="checkbox"/> Telephone Logs | |

Surveys

- | | | |
|---------|---------------------|---------|
| 3 Youth | 3 Direct Care Staff | 0 Other |
|---------|---------------------|---------|

Observations During Review

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

Comments

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

Rating Narrative

Policy and Procedures Manual

Written list of staff approved for medication distribution

Prescribed and over the counter medication inventories

Strengths and Innovative Approaches

Rating Narrative

Children's Home Society (CHS) is a statewide agency that employs more than 1,800 employees who are located in 15 divisions throughout the state. The agency is headquartered in Winter Park, Florida and, during the past year, has served nearly 200,000 kids and family members.

Children's Home Society of Florida, Safe Harbor Shelter, is located at 3335 Forest Hills Boulevard in West Palm Beach, Florida. This location is the site of the Children In Need of Services/Families In Need of Services (CINS/FINS) program which is sub-contracted with the Florida Network of Youth and Family Services (Florida Network) to provide temporary residential and non-residential services to youth and families in South Palm Beach County. Services are provided to male and female youth between the ages of ten and seventeen.

The program continues to demonstrate its commitment to providing a myriad of services to youth in the CINS/FINS program and offers life skills training, educational and career coaching, guidance and safe housing so teens can learn self-sufficiency as they transition into adulthood and pursue opportunities for life success. Each year, more than 7,000 teens and young adults benefit from these program offerings. At CHS Safe Harbor, select youth are involved in the "Teach-A-Teen" program that provides an opportunity for youth to interact with business owners in the community who serve as mentors and provide youth with necessary employment and job skills training. The youth work with a Job Coach during their time at Safe Harbor and upon discharge from the shelter, the youth and their family are offered non-residential services.

Additionally, the program provides structured enrichment activities for the youth such as: drug prevention; yoga; drama; broadcasting; pet therapy; and a tennis clinic. The shelter facility has created space to support these activities for the youth and has designated rooms for art therapy, group/family meetings, and an indoor game room where youth are encouraged to earn privileges to play video games.

The program also continues to leverage its relationship with the local schools and participates in meetings hosted by the school guidance counselors. The meetings are held separately for elementary, middle, and high school guidance counselors and increases knowledge of the CINS/FINS program as well as facilitate the referral process. In addition, CHS is a active advocate for funding to safe guard children's safety, well-being and future success. The agency also promotes public policy focused on proactive support for kids and families.

Standard 1: Management Accountability

Overview

Narrative

The program management team is comprised of an Executive Director, a Director of Program Operations, a Clinical Supervisor, a Residential Program Manager, and a Data Supervisor. In addition to the Residential Program Manager, the residential component of the program is staff by two (2) Shift Leaders, and eleven (11) Youth Care Workers (YCW). The program is operated around three ten-hour shifts that provide two hours overlap for shift exchange. The shift times are: 6 a.m. to 4 p.m., 2 p.m. to 12 a.m., and 10 p.m. to 8 a.m. The clinical component of the program includes two (2) MSWs, one RIMH, and one Bachelor's level Counselor II position. One of the Masters level Counselors is assigned to the Residential program. The program has also utilized the services of eight volunteers since the last onsite visit in April 2012. There were no vacant positions in the program at the time of the visit.

1.01 Background Screening

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy and procedures in place that address the background screening of all employees and volunteers. The policy requires all staff and volunteers to complete a Level 2 Screening that includes good moral character documentation, employment history checks, employment screening, criminal record checks, and juvenile record checks. Additionally, the provider conducts a background check with the Department of Motor Vehicles prior to hiring an employee.

A total of thirteen (13) applicable personnel files were reviewed for five staff and eight volunteers. The five staff were hired after the last onsite QI visit and all five received eligible screening results that were conducted by the Department of Juvenile Justice (DJJ) Background Screening Unit prior to hire.

During the review period, the program had five interns and three volunteers who were under the direct supervision of screened staff. All but one of the interns received a DJJ background screening and eligible screening results prior to their service start dates.

The provider did not have any staff eligible for the 5-year re-screening during the review period. Per the provider's policy, the HR Department reviews all eligible 5-year re-screenings in January each year and initiates the re-screening process in the applicable month.

The Annual Affidavit of Compliance with Good Moral Character Standards was completed and submitted to the DJJ Background Screening Unit on November 1, 2012.

The background screening request that was submitted by the agency to DJJ for one of the interns was rated closed/ineligible because DJJ did not receive the electronic prints from the vendor and they were not provided to the DJJ Background Screening Unit upon subsequent request by the Department. Consequently, an eligible screening result was not completed for the intern who was providing services to CINS/FINS youth. The provider stated that the intern was also an employee of the agency, working in a dependency program while interning in CINS/FINS, and, although not acceptable by DJJ, had received a background screening clearance from DCF prior to initiating intern services.

The provider was made aware of the missing DJJ Screening during the review and temporarily removed the Intern from duty pending final processing of the DJJ screening and receipt of the results. An incident report was also filed with CCC during the visit.

1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

Rating Narrative

The program has a current policy and procedure in place for the provision of an abuse free environment. The Florida Abuse Registry Hotline number, rights and responsibility, and other relevant numbers are posted at various locations throughout the facility. Youth are also informed of these procedures during program orientation and the number is included in the Resident Handbook. The program also has a grievance box and forms accessible to youth in the dormitory lounge near the staff desk. Upon hire, employees receive and sign receipt of the Agency's Code of Conduct which outlines the agency's expectation regarding the provision of a safe environment. Employees are required to report all known or suspected cases of abuse and/or neglect and youth have unimpeded access to self-report.

Per the Program Director, there has not been any imposed discipline towards staff for any incidents related to abuse. Similarly, no incidence of youth being deprived of basic needs or abused by program staffs was reported during youth surveys conducted during the review or observed

during the visit.

Abuse reporting was evident and the program maintains a log of calls that are made to the abuse hotline in the Incident Report binder. The abuse report is entered in the providers AirsWeb incident reporting database. Sixteen of these calls were recorded during the review period and copies of the incidents reported are on file. None of the abuse calls reviewed were institutional.

The three youth survey indicated knowledge of the abuse hotline and location of the posting of the number in the facility. None of the youth surveyed reported being stopped from reporting abuse. The three youth surveyed also indicated that they feel safe in the program and have never heard staff threaten them or other youth. The three staff surveyed said they have never witnessed another staff prohibit youth from calling the abuse hotline and have never heard the use of profanity in the presence of youth or have observed staff use threat or intimidation when interacting with youth. All staff agreed the working conditions have been fair and/or good at the program.

All of the staff training files that were reviewed documented staff training in Child Abuse Reporting.

No Exceptions noted at the time of the visit.

1.03 Incident Reporting

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written incident reporting policy. The agency's policy specifies that the agency notifies the Department's Central Communications Center (CCC) within two (2) hours of the incident, or within 2 hours of becoming aware of the incident.

The agency had a total of eleven (11) reportable CCC incidents over the last six (6) months. Copies of the DJJ CCC reports were provided by the DJJ Contract Manager for the Office of Prevention and Victim Services for the review. Additionally, a review of the agency's incidents reported to CCC was conducted and were compared to the reports from DJJ.

Of the 11 incidents reviewed, 3 were absconds, 5 were contraband, 2 were program disruption, 2 were theft of other property, and 1 was a medication incident. Nine (9) of the incidents were reported within the DJJ CCC 2-hour reporting time frame. The program documents reportable incidents in AirsWeb, an incident reporting database, and copies are maintained in a separate binder and also documented on a log.

Two of the eleven reportable incidents were not reported to DJJ CCC within the 2-hour required timeframe. The reviewer observed a higher frequency of contraband as compared to the other types of incidents that were reported. These items were discovered by staff during room search but youth have been successful in sneaking them into the facility.

1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

There is a policy and procedure in place that ensures that all direct care staff is appropriately trained within the first year of hire to adequately meet the needs of the sheltered youth. The shelter also has a policy and procedure that ensures all direct care staff is appropriately trained on an ongoing basis. Three (3) staff files that are in the 1st year of hire were reviewed. All 3 files meet the standard requirement of 80 hours of training. The training hours were listed on a training tracker form, which documents the training topic, hours of the training, and review monthly by a supervisor. On one staff's tracker chart it mentions that CINS/FINS Core is included in the orientation hour but after talking with Director of Program Operations it was determined that it is not included in the orientation hours. The staff did complete the training. In 1 staff's file it was confirmed the staff had taken the CINS/FINS Core training but it was not listed on their tracker chart.

Three (3) in-service staff files that are past the one year requirement were reviewed. Two (2) of the three files reviewed at the time of the review do not appear to be on track with completion of their training hours. One (1) file shows that the staff is on track to reach his target hours on time. The Director of Program Operations provided documentation that the 2 staff are scheduled for trainings but as of this time they have not taken the trainings.

The shelter's policy and procedure states that ongoing staff are required to complete 24 hours of training. However, since the shelter is licensed by DCF, in-service staff are required to take 40 hours of training annually. The DPO provided the reviewer with an updated policy and procedure reflecting the revision.

The two (2) staff that do not appear to be on track is at the following stage: 1 only has 11.50 hours at this time with only about 2 months left to go in his annual training period, and 1 staff only has 27.75 at this time with his annual period ending on 2/17/13.

1.05 Interagency Agreements and Outreach

Satisfactory Limited Failed

Rating Narrative

There is a policy and procedure in place that has established outreach activities, written agreements, and informal linkage with other community based service providers to target youth who are at risk. The interagency agreement binder was reviewed. All agreements reviewed were current and in compliance with the standard. Some services that are available through the agreements are referrals to community resources, 24 hour phone counseling, internships, education, HIV and Aids education/prevention, substance abuse treatment/assessments/counseling, family preservation services, family centered services, psychiatric and psychological evaluations, interpreting services, mentoring services, planned parenthood, mental health treatment, pet therapy, moving services for project18 clients and yoga services for shelter youth. The community outreach events binder was reviewed and the shelter attends events that provide a wide range of topics. The outreach activities/events are entered into Netmis by staff. The Netmis print out was reviewed and the events were: educational (truancy liaison meetings and school counseling and graduation support program, informative (Safe Place and respite bed work group), and legal (Circuit 15 Juvenile Justice Board meeting and Juvenile detention alternative program) to name a few. The shelter has a designated outreach person but all staff are allowed and encouraged to attend. The outreach info is shared with the staff and they have access to the binder.

1.06 Disaster Planning

Satisfactory Limited Failed

Rating Narrative

There is a policy and procedure in place for the safety of the program which includes disaster preparedness, fire prevention, fire safety, and water safety. The shelter's response plan is called DERP (Disaster Emergency Response Plan). The plan has a revision date of February 2013. It has contact information for all staff and has the chain of command in case of any disaster. The emergency drills were reviewed and are in compliance with the standard and the shelter's policy and procedures. Drills were completed by staff and signed by a supervisor. Fire drills were also reviewed and were in compliance with drills being done by each shift monthly. The fire drills document the number of people (youth and staff) who evacuated, date and time of the evacuation, and a brief summary of how the drill went. Evacuation/Egress plans were observed posted throughout the shelter during the tour. Youth files have an orientation form that documents staff's review of the procedures with the youth at intake. Both the youth and staff sign this at intake. Local fire officials approved the fire evacuation and prevention plan and the last one was done on 4/24/12 and is good for one year. Fire inspections are done yearly with the most recent one being conducted on 2/1/13; no violations were noted. All of the drills mentioned above are in binders and were reviewed. Maintenance staff also does quarterly inspections which were reviewed and problems were fixed in a timely manner. The log and logbook was reviewed with regards to the security system. The supervisor reviews the tapes biweekly and the review is listed in the log and the logbook. The MSDS book was located in the closet with the approved chemicals used in shelter. The book was in compliance with shelter policy. The vehicle inspection logs were reviewed and were in compliance with shelter policy. The vehicles are inspected by both staff and outside sources. The 2 vehicles inspected by the reviewer had fire extinguishers, fully stocked first aid kits and seat belt cutters that were in the driver's side door and not accessible to the youth. The shelter does not participate in water activities.

1.07 Analyzing and Reporting Information

Satisfactory Limited Failed

Rating Narrative

The program has a written policy and procedures for analyzing and reporting data for case record reviews, incidents, accidents, grievances, customer satisfaction, outcome data, and monthly review of Netmis data reports. In addition, there is a comprehensive CHS Quality Management Plan, FY 2011-2012, that is comprised of three sections. Section 1 describes the agency's philosophy, Quality Management structure, CQI strategies, and stakeholders. Section II includes a description of the agency's long-term strategic goals and objectives, management/operational performance, and program results/outcomes. Section III provides procedures for data collection, aggregation of review and analysis, communicating results, using data for implementing improvement, and assessment of the effectiveness of the QM process.

The program has a designated Quality Management Specialist (QMS) who is responsible for the implementation and oversight of its CQI program. In practice, the program's CQI program includes many activities that are conducted by all staff to ensure all aspects of analyzing and reporting data are consistently implemented and documented.

Quarterly case record reviews are conducted by the program clinical staff as directed by the program supervisor and are due by the 25th day of the 2nd month of each quarter. A separate case record review is also conducted by the youth care staff. Upon completion of each record review, the QMS aggregates the results and provides a copy of the aggregated report and Quality Management Division Evaluation to the

program supervisor to discuss themes, trends, and any areas of concern. Program supervisors ensure appropriated follow-up is taken by their staff and responded to in a timely manner. The QMS also follows-up at a later date to spot check specific files to verify completion of the corrective actions.

The program's Safety Committee, represented by the Shelter Manager and non-residential staff, is responsible for reviewing incidents and accidents, performing safety checks and fire drills, and making recommendations to management on a monthly basis. Each program and site has a representative who sits on the Safety Committee. The safety committee meets on the third Thursday of each month and if unable to attend, can appear by phone. The QM facilitates the call and meeting minutes from each meeting are produced and provided to committee members (including the QMS), Program Managers, and the Executive Director (ED). The Division Safety Committee Coordinator discusses safety concerns and suggestions with the ED monthly and follows up with the QMS as needed. The QMS will follow up with the ED and program supervisors as needed to ensure division safety. Consumer grievances are submitted by program supervisors and reported to the QMS on a monthly basis via the PPR.

Consumer surveys are administered twice a year during the second and fourth quarters. The QMS addresses consumer surveying via email and at a management team meeting and notifies the program supervisors of the outcome of the surveys. The surveys are aggregated by the QMS and provided to supervisors, DPO, and ED. A copy of the most recent Consumer Satisfaction Survey result was submitted.

The provider also has a CINS/FINS Analyzing and Reporting Workgroup comprised of the Director of Program Operations (DPO), Program Manager, Clinical Supervisor, QMS, and Data Specialist that meets monthly, on the third Friday, to review findings of the peer reviews, incidents/accidents, satisfaction survey results, outcome data, and Netmis data reports. A walkthrough of the facility is conducted to review key program requirements in the shelter prior to the meeting. Strengths, weaknesses, and goals are reviewed and documented in the minutes. Copies are provided to the Youth Care Workers and Counselors.

Outcome data is reviewed monthly, quarterly, and annually. Monthly and quarterly data is entered into the agency's Division Quality Performance Report (DQPR) into the following areas: program performance, program team minutes, safety, record review, consumer satisfaction, and outcomes. The outcomes data incorporates all of the contract, Netmis, and program outcomes required by the Florida Network and DJJ QI.

A copy of the Florida Network Agency Contract Benchmarks, July 1- December 31, 2012 was reviewed on site. The provider also submitted a copy of the Florida Network Client Service Satisfaction Survey for the same period.

No exceptions were noted at the time of the visit.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

The program provides centralized intake and screening twenty-four hours per day, seven days per week, every day of the year. Trained staff are available to determine the immediate needs of the family and youth. Each youth at the program receives an initial eligibility screening, CINS/FINS Intake Assessment, a psychosocial assessment, and a service plan. Additionally, case management, individual, family, and group counseling services, substance abuse prevention education, and referrals to local community agencies are provided as needed. The shelter program provides critical temporary shelter care services to run away and homeless youth, and takes care of their basic needs with the ultimate goal to reunite the youth with their families. The facility has eight beds available for both male and female youth in the CINS/FINS program and twenty-four hour awake supervision is provided for youth residing in the shelter.

As needed, CHS Safe Harbor coordinates the Case Staffing Committee, a statutorily-mandated committee that develops a treatment plan for habitual truancy, lockout, ungovernable, and runaway youth when all other services have been exhausted or upon request from the parents/guardians. The Case Staffing Committee can also recommend the filing of a CINS Petition with the court.

2.01 Screening and Intake

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy and procedure detailing the availability of centralized intake services twenty four hours a day, seven days a week which includes emergency intake and referrals. Youth and parents/guardians sign forms stating they have received available service options, rights and responsibilities of youth and parents/guardians, possible actions occurring through involvement with CINS/FINS services, and grievance procedures in writing during intake.

Three nonresidential files were reviewed. All three had screenings completed within seven days of referral. All three files had documentation that the youth and parents/guardians signed forms stating they received available service options, rights and responsibilities of youth and parents/guardians, a parent brochure containing possible actions occurring through involvement with CINS/FINS services, and grievance procedures in writing during intake. These forms were also available in Spanish versions for those clients that were not fluent in English.

Three residential files were reviewed. All three had screenings completed within seven days of referral. All three files had documentation that the youth and parents/guardians signed forms stating they received available service options, rights and responsibilities of youth and parents/guardians, a parent brochure containing possible actions occurring through involvement with CINS/FINS services, and grievance procedures in writing during intake.

The program has policy stating the CINS/FINS screening form will be completed within 7 working days of referral however the standard dictates that it must be completed within 7 calendar days.

The policy was updated during review.

2.02 Psychosocial Assessment

Satisfactory

Limited

Failed

Rating Narrative

The program has policy stating the Psychosocial Assessment is initiated within 72 hours of admission if the youth is in shelter care, updated if most recent psychosocial is over six months old, and completed within three face-to-face contacts following the initial intake if the youth is receiving non-residential services.

Three nonresidential files were reviewed. All three had the Psychosocial Assessments completed within three face to face contacts and all three were completed by at least a bachelor's level staff and contained a supervisor's signature for review. Two of the files had youth identified with an elevated risk of suicide and both had further assessment of risk suicide conducted by or under the direct supervision of a licensed mental health professional.

Three residential files were reviewed. All three had the Psychosocial Assessments initiated within 72 hours of submission and all three were completed by at least a bachelor's level staff and contained a supervisor's signature for review. All three of the files had youth identified with an elevated risk of suicide and all three had further assessment of risk suicide conducted by or under the direct supervision of a licensed mental health professional.

The Provider's policy does not state that the psychosocial assessment will be completed by bachelors/masters level and signed by supervisor; however it is done in practice.

2.03 Case/Service Plan

Satisfactory

Limited

Failed

Rating Narrative

The program has policy stating a service plan is developed with the youth and family within seven working days following completion of the Psychosocial Assessment and also details what is to be contained in a service plan as well as that the plan is reviewed every 30 days.

Three Nonresidential youth files were reviewed. All were developed with the youth and family within seven working days following completion of the assessment. All plans contained identified needs and goals; type, frequency, and location of services; persons responsible; target dates for completion and actual completion dates; date the plan was initiated, and signatures of youth, parent/guardian, counselor, and supervisor. When the parent was not available and, in the one case, the youth refused to sign, it was properly documented on the service plan.

Three residential youth files were reviewed. All three were developed with the youth and family within seven working days following completion of the assessment. All plans contained identified needs and goals; type, frequency, and location of services; persons responsible; target dates for completion and actual completion dates; date the plan was initiated, and signatures of youth, parent/guardian, counselor, and supervisor. Similarly, when the parent was not available in person the plan was reviewed with them via a phone call. All three youth interviewed were able to report goals that they were working towards during the youth interviews.

Program policy CHS/7202 states service plans will be reviewed every 30 days, policy CHS/7203 states the review of the plan will be made every 30 days for the first three months, and every six months thereafter. One youth file did not document reviews as specified in the policy, every 30 days after the 90 day review. Policy 7202 was updated to reflect the standard during the review.

2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

Rating Narrative

The program has policies relating to family involvement, referrals to outside agencies, recommending and pursuing judicial intervention in selected cases, and youth discharge.

Three nonresidential youth files were reviewed. All files had coordinated service plans implemented, very detailed progress notes reflected counselors monitored youth's and family's progress in services, provided support for families, and monitored out-of-home placement in the one youth file that was applicable. The program has many outside agencies with which to refer youth and families. The program makes multiple referrals and tracks them at least monthly on their service plan and referral checklist as well as in their progress notes and on service plans. The program provided case monitoring and review of court orders in the two files that were applicable. The program also provides follow-up services after discharge.

Three residential youth files were reviewed. Similarly, all files had coordinated service plans implemented, very detailed progress notes reflected counselors monitored youth's and family's progress in services, provided support for families, and monitored out-of-home placement. The program has many outside agencies with which to refer youth and families. Two of the three clients obtained jobs through a program called Project 18 H.I.R.E.D. The program also provides follow-up services after discharge. All three youth interviewed reported they knew who their counselor was during the youth interviews.

2.05 Counseling Services

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy to provide an array of services to preserve the unity and integrity of the family. The policy also includes supervisory review. In addition, the program has a staff directive that further defines required timelines for supervisory review.

Three nonresidential youth files were reviewed. All three files showed coordination between presenting problems, the psychosocial assessment, the service plan, the service plan reviews, case management, and follow-up. Chronological case notes on the youth's progress were maintained in all files. All files contained signatures of supervisory review by a LMHC.

Three residential youth files were reviewed. All three files showed coordination between presenting problems, the psychosocial assessment, the service plan, the service plan reviews, case management, and follow-up. Chronological case notes on the youth's progress were well documented and maintained in all files. All files contained signatures of supervisory review by a licensed clinician.

2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy detailing the CINS petition process including the case staffing committee. This policy requires that a case staffing committee is convened within seven 7 working days from receipt of the written request from the parent/guardian, and within 7 seven working days of the meeting, a written report is provided to the parent/guardian outlining the committee recommendations.

Two nonresidential youth files were reviewed. In both cases proper notification was given to the family as well as the case staffing team. Representatives included school personnel, CINS/FINS provider, law enforcement, and the parents/guardians. The family was provided a written report outlining the committee recommendations in both cases. The program does have an established case staffing committee as well as an internal procedure for scheduling case staffing meetings as needed.

The policy does not contain the statement that as a result of the case staffing committee meeting, the youth and family are provided a new or revised plan for services, and in one case although a service plan review was completed 11 days after the case staffing it was at a regular review time and did not incorporate new recommendations made by the case staffing committee.

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

The Program has a policy detailing the confidential nature of case files. It specifies how cases are opened, how they are closed, where they are kept and how they are stored, whose responsibility it is to keep the files maintained, how they are organized, that they will be marked confidential, and how long they are kept for.

Three nonresidential files were reviewed. All three files were marked "confidential" and files are kept in a secure room. All three file records were organized in a neat and orderly manner so that staff can quickly and easily access information.

Three residential files were reviewed. All three files were marked "confidential" and files are kept in a secure room. All three file records were organized in a neat and orderly manner so that staff can quickly and easily access information.

Standard 3: Shelter Care

Overview

Rating Narrative

CHS Safe Harbor Shelter program provides temporary residential shelter care for male and female youth identified to be at-risk. The program has adequate space for all indoor and outdoor activities and is equipped with one dormitory for youth of both genders. The dormitories, kitchen, restrooms and common areas were observed to be clean during the visit. Each bedroom is furnished with two beds with separate pillows and bed covering and a closet for youth belongings. Youth have access to a large yard with tennis and basketball courts for outdoor activities.

All youth who are admitted to the program receive a copy of the Consumer Handbook and an orientation to the facility. During the admission's process, each youth receives a new CINS/FINS intake screening to identify any medical, mental health, and/or substance abuse condition and this information is provided to the assigned clinical staff. The program provides individual, group and family counseling, as needed. Group sessions are scheduled five times per week. The program also has a Comprehensive Master Plan for Access to Mental Health and Substance Abuse Services in place. Interagency Agreements have been established for the provision of health education, leadership development, and substance abuse, mental health, and medical services. The program also has a Licensed Mental Health Counselor (LMHC) who serves as the Clinical Supervisor for four counselors and program interns. At least one of the counselors is assigned to the residential youth.

The shelter is not designated by the Florida Network to provide staff secure services. At the time of review, the current client census showed a total of seven active youth in the residential program. The Department of Children and Families has licensed Safe Harbor as a Child Caring Agency, with the current license for ten (10) beds, effective until January 23, 2014.

3.01 Youth Room Assignment

Satisfactory Limited Failed

Rating Narrative

The Safe Harbor Program has a policy and procedure in place for classification of youth for the purpose of room assignment. Interviews with Direct Care staff as well as a review of (3) client files revealed that the Program does a consistent job with assigning youth to their rooms based on several different factors. These include but not limited to: review of the youth's history or exposure to trauma; initial observations of youth; age of the youth; violent history or lack of; suicide history; sexual history; and victimization.

In addition, the program has a color coded system based on the aforementioned factors that is assigned to each youth based on their individual history. Documentation is also placed in the youth's file to coincide with the color coded system that is in place. This practice and procedure appears to keep the youth safe and ensure program accountability.

3.02 Program Orientation

Satisfactory Limited Failed

Rating Narrative

The Safe Harbor Program has a policy and procedure in place which identifies program expectations. A review of (3) client files, as well as interviews with clients and staff revealed that each youth are properly oriented into the program within (24) hours of entering the facility. A check list is completed with each youth going over items such as contraband, disciplinary actions, dress code, facility tour, grievance procedures, room assignments, and disaster procedures to name a few.

The youth is also given a client handbook and the orientation process is also reviewed with the parent once the guardian signs parental authorization forms for the client file. The Program appears to be doing a satisfactory job with this particular indicator and ensuring that the youth and parent are well aware of its expectations.

3.03 Shelter Environment

Satisfactory Limited Failed

Rating Narrative

The Safe Harbor Program has a policy and procedure in place, wherein they provide a safe, clean, neat and well maintained environment. Upon entering the grounds of the facility, it is very apparent that the grounds of the facility and building are well maintained and manicured. In addition, the facility is in outstanding maintenance and very clean. Furnishings are basically new in the common area, as well as the client rooms.

There is proper lighting throughout the facility and it is free of graffiti on walls doors and furniture. Furthermore, the facility appears to be safe

and secure for both clients and staff alike. Each youth has his/her own bed, appropriate linens, and pillows with sufficient back up in storage.

3.04 Log Books

Satisfactory

Limited

Failed

Rating Narrative

The Safe Harbor Program has a policy & procedure in place that demonstrates their common practices as it relates to Log Book Documentation. Log Book Documentation was reviewed dating back from August of 2012 to the present. A thorough review revealed clear and consistent documentation by Direct Care Staff, Supervisors and the Program Manager alike. Vital and important events were also highlighted within the Log Book.

The Log book contained pertinent information related to daily activities, events, incidents and client movement. Staff members for the most part were consistent with signing, dating and putting the time of each entry in the Log Book. However on occasion Staff had to be reminded by the Program Manager to ensure that they document that the Log Book was reviewed. The Program Manager or designee reviewed the Log Book weekly and the Program Manager initialed the top of each page daily.

Rating Narrative

The Safe Harbor Program has a policy and procedure in place in which it provides structured daily programming to engage youth in activities that foster health, social, emotional, intellectual and physical development. A review of the daily schedule, staff and client interviews, and log book documentation revealed that the Program does an outstanding job with this particular indicator.

The program has ample volunteers and individuals from the community who come out to the facility to provide services to the youth at the facility. Religious groups, music professionals, job coaches, fitness professionals, and tutors, just to name a few are active participants who have scheduled structured activities with the youth. The program has a daily schedule posted which also provides for group and individual counseling. Community partnerships are a major part of the program and they do an outstanding job with fostering and maintaining ongoing working relationships with them.

3.06 Behavior Management Strategies

Satisfactory

Limited

Failed

Rating Narrative

The Safe Harbor Program has a policy and procedure in place designed to not only gain compliance with program rules, but to change the behavior of the youth and increase accountability. The Program provided (2) detailed policies that demonstrate desired procedures when administering discipline to the youth. In addition, staff and client interviews, review of client (BM) System, Client point cards and grievance binder revealed that the program does a satisfactory job with its Behavior Management Strategies.

The program has a detailed (BM) System which equally distributes rewards and consequences, based on an individual youth's behavior. The staff is trained in the theory and practice of administering rewards and consequences. Staff's protocol for providing feedback regarding the (BM) System and its effectiveness or lack thereof is completed during monthly staff meetings or individual meetings with the Program Manager or Supervisors. Supervisors and staff also discuss rewards and consequences via monthly Staff Meetings.

3.07 Behavior Interventions

Satisfactory

Limited

Failed

Rating Narrative

The Safe Harbor Program has a policy and procedure in place which identifies Behavioral Interventions utilized by the Staff with the least amount of force necessary to address situations and ensure that basic youth rights are not violated. A review of (3) client files, grievance binder and interviews with clients, staff revealed that the Staff do a satisfactory job with behavioral interventions when dealing with the youth in their care.

Both youth and staff reported that verbal interventions and de-escalation techniques are the primary source of interventions used in the facility and physical interventions are used as a last resort. This is only when a youth poses an immediate threat to his or her self. All Staff are trained in the use of physical techniques approved by the Florida Network. Group punishment is never used and only the Staff administers discipline. Room restrictions are never used and the staff does not take away or deny youth meals or snacks, clothing, sleep, physical or mental health services, education or corresponding privileges due to negative behavior.

3.08 Staffing and Youth Supervision

Satisfactory

Limited

Failed

Rating Narrative

There is a policy and procedure in place that ensures the safety and security of both the youth and staff. The logbook and staff schedules were reviewed and it showed that the ratios of 1 to 6 during waking hours and 1 to 12 during sleeping hours are being met as required by the standard. In reviewing the schedules for the last 6 months, it shows that both male and female staff were on duty with the only exception of 6 days where there were 2 females on shift. Director of Program Operations stated that on those occasions, some staff were leaving the shelter and those spots needed to be filled by staff to meet the 2 staff on shift requirement. On two dates only 1 female was on the schedule. After reviewing the logbook and daily census it was determined that there was only 3 youth in shelter and all were female. Therefore, shelter was within ratio and had appropriate gender. The schedule is posted in the staff office and is accessible to all staff. Shelter has an emergency preparedness contact list with all staff and their contact numbers in case of needed coverage. The logbook was reviewed for room checks while youth were sleeping. Checks were done every 15 minutes in compliance with the standard and they were logged into the logbook. On the staff schedule it lists who is responsible for the room checks. The room checks are reviewed by a supervisor bi-weekly from the camera surveillance system and this review is recorded in a log and in the logbook.

The dates where there were 2 females on shift were 11/23/12, 11/24/12, 1/11/13, 1/12/13, 1/13/13 and 2/2/13.

The date where there was only 1 staff (female) on shift was 1/12/13 and 1/13/13.

3.09 Staff Secure Shelter

Satisfactory

Limited

Failed

Rating Narrative

There is a policy and procedure in place that provides a higher level of security for staff secure youth to help reduce running away incidents. At the time of this review the shelter is not designated as a Staff Secure Shelter by the Florida Network and has not had a staff secure youth within the last 6 months.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

CHS Safe Harbor has specific procedures related to the admission, interviewing and room assignment of youth to ensure the safety and appropriate supervision of youth admitted into the program. Upon admission, YCW staff will interview youth and complete the intake. An initial intake assessment occurs to determine the most appropriate room assignment given the youth's needs and issues, the current population at the facility, physical space available and staff's assessment of the youth's ability to function effectively within program rules and expectations. Staff conducting the initial interview and assessment considers the youth's physical characteristics, maturity level, history (including gang or criminal involvement), potential for aggression, and apparent emotional or mental health issues. Based on this information, the youth is assigned a room which can change after further assessment. Room assignment is documented on page 2 of the CINS/FINS Intake Assessment form.

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 Program Manager, Counselor and/or the DPO is notified immediately if risks and/alerts are present and recommendations regarding placement and supervision are provided to the direct care staff. This information is documented on the alert board that is mounted in the medication room, on a youth alert form, and in the youth files using a color coding system. Youth admitted to the shelter with prescribed or over the counter medication will surrender those medication to staff during admission. Medications are stored in a double locked medication cabinet and topical and/or injectable medications are stored separately from oral medication. Refrigeration is available for medication requiring cool storage. The program has a list of staff who are authorized to distribute medication. Medication records for each youth are maintained in a binder.

4.01 Healthcare Admission Screening

Satisfactory Limited Failed

Rating Narrative

The Provider maintains written policies and procedures that adhere to the requirements of the indicator including performing a preliminary physical health screening for each youth at the time of admission to the shelter. The preliminary screening includes current medications notation of existing (acute and chronic) medical conditions, allergies, recent injuries or illnesses, presence of pain or other physical distress, observation of the presence of any scars, tattoos or other markings.

The documentation reviewed indicates that the provider adheres to the agency policies and procedures and the standard. Of the three youth files reviewed, all three completed the preliminary health care screening to include evaluation or observation of all required elements. The files notated contact made with parents/guardians (or attempts at same) to coordinate scheduling of medical appointments or the need for provision of medications. Medical referrals (to prescribing physician) were documented in the files.

4.02 Suicide Prevention

Satisfactory Limited Failed

Rating Narrative

The provider maintains written policies and procedures that adhere to the standard in requiring a written plan for suicide prevention and response procedures. A copy of the provider's Comprehensive Master Plan for Access to Mental health and Substance Abuse Services was reviewed and found to delineate the roles of staff positions and their duties, documentation protocols, notification procedures, and referral system.

A review of three client files demonstrated the provider adheres to the standard and the policies and procedures in that all three youth were screened within 24 hours as required for suicide risk, without exception, as part of the initial intake process, with results reviewed and signed by a supervisor. One of three files reviewed indicated that the youth scored for sight and sound supervision based upon the screening results and the file documents that the youth was appropriately supervised at that level until the licensed mental health professional completed further assessment and released the youth from sight-and-sound. All three files reviewed indicated that youth were placed on the appropriate level of supervision based on the results of the suicide risk assessment. For the youth placed on sight and sound supervision, the supervision levels were not changed, as required by the policies and procedures until the licensed professional completed further assessment.

Of three direct care staff surveyed as to the responsibilities of direct care staff if a youth expresses suicidal thoughts, two (2) responded that the responsibility included notifying a mental health authority as well as searching the youth and the youth's room for hazards. Three (3) of three (3) staff identified constant sight and sound supervision and documentation of such supervision as responsibilities. Three (3) of three (3) staff identified that the Suicide Response kit is kept in the staff station desk or cabinet, with one (1) staff indicating the "supervisor's office" and "wall mounted".

4.03 Medications

Satisfactory
 Limited
 Failed

Rating Narrative

The program maintains written policies and procedures that align with the standard that address the safe and secure storage, access, inventory, disposal and administration/distribution of medications. The program's policies and procedures include all the mandatory components required by the standard. The written list of staff designated to have access to medications was reviewed. Shelter staff interviewed was aware of the potential side effects of the medications and that the information for each medication is included. Medications were found to be stored in separate locked cabinets which in inaccessible to youth. No controlled narcotics were currently prescribed for any of the youth in shelter at the time of this review, but the practice for storage of same was inspected and met the requirement the standard and the policies and procedures. Medication Distribution Records included the required identification components including youth name, photo, allergies, precautions and information about the possible side effects of each medication. The full name of each youth is printed on the medication distribution log and the youth sign their initials to acknowledge receipt of each dosage of medication.

The inventory logs for medications and sharps were reviewed and found to be compliant with the standard and policies and procedures with only designated staff having access to the secured medications. Sharps were observed to be secured with inventory counts conducted weekly without exception. The practice for refrigerated medications demonstrated that such medications are kept in a locked refrigerator in a locked room, which exceeds the requirements of the standard and the policies and procedures were updated to reflect during this review this practice.

All three staff surveyed indicated that they assist youth in the delivery of medication and all three staff are included on the written list of staff with access to medications. Of the three (3) staff surveyed responses to how they are informed of medication side effects included: two (2) indicating shift transition, Physician's Desk Reference and the alert form in the file, while one (1) indicated the alert form in the file, and all three indication the medical alert log. Two (2) of the three staff indicated that the process for communicating information was "very good", with one (1) staff indicating the process was "good".

EXCEPTIONS NOTED:

Although the standard does not delineate medication administration within specified time limits, the policies and procedures of the agency maintains the requirement that medications be distributed no more than one (1) hour before to one (1) hour after the time indicated for the administration of the medication. Exceptions to the agency's policies and procedures were found on three occasions (9/7/12, 11/24/12, 1/27/13) for the one client reviewed who was on prescription medication when documentation indicates that the single dose of daily medication was distributed more than one (1) hour after the indicated time. Two of the instances of late medication were documented to be a result of the youth returning to the facility more than one hour after the medication time, once from a movie outing and once from a weekend home pass.

4.04 Medical/Mental Health Alert Process

Satisfactory
 Limited
 Failed

Rating Narrative

The provider maintains written policies and procedures that adhere to the standard in requiring written procedures that ensure information on youth medical conditions, allergies, side effects of prescription medications, food and medication contraindications are effectively communicated to all staff through an alert system.

The alert system is clear and organized utilizing color dots to represent each type of alert (Dark Green = Food allergies; blue = medical; red = mental health/suicide; orange = substance abuse; yellow = behavioral issues; pink = runaway) which makes the identification of youth on each type of alert easily understood. The system from the posted alert board in the Medication Storage Room is echoed identically to each of the client files.

The program does have a process for necessary follow-up medical care for youth including medications, and practice observed indicated that the program makes repeated attempts to communicate.

Staff training files documented that staff is provided with training on the medical/mental health alert process as part of their orientation training within the first 90 days of employment as part of the "Signs and symptoms of mental health and substance abuse". Training for additional alerts (allergies, food, etc.) are covered in the training for "Intake". All staff training files reviewed documented that there were no exceptions for the required staff training.

Three (3) of three (3) staff indicated they are alerted to youth's medical/mental health alerts via the alert form and the youth file, while one (1) staff also indicated the log book and alert board as additional sources for the alerts. Two (2) of the three staff indicated that the process for communicating information was "very good", with one (1) staff indicating the process was "good".

4.05 Episodic/Emergency Care

Satisfactory
 Limited
 Failed

Rating Narrative

The provider maintains written policies and procedures that ensure that the provision of emergency mental health and substance abuse, crisis intervention and emergency services, including supervision requirements, authorization and contact procedures for transport, notification of administration, supervisors, outside authorities, parents/guardians.

Inspection of the unit demonstrated that the providers practice includes maintaining the knife-for-life (2) and first aid kits (2) in the control room for easy access by staff.

The policies and procedures adhere to the standard in requiring episodic emergency drills, on each shift, be conducted at least quarterly. A review of the emergency Response Simulation log reveals that the program's practice is to conduct such drills monthly on each shift, which exceeds the quarterly requirement of the standard and the policies and procedures.

There were three instances of emergency care for three separate youth during the review period noted in the Episodic/Emergency Care log, all for Baker Act incidents. The log also includes a printed copy of the CCC Incident Report for each of the three incidents. Routine medical care appointments were documented clearly in the Medical Care Log including the date and time of any follow up care needed.

Of the three (3) youth surveyed one responded that they had received medical care at the shelter. Two (2) youth surveyed responded that the "care provided" was "good" or "very good" [the question although immediately following the question of whether medical care was received at the shelter does not specify the rating of the care to be particular to medical care].