Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Sarasota YMCA

on 02/24/2015

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	Limited
1.05 Analyzing and Reporting Information	Satisfactory

Percent of indicators rated Satisfactory:80.00%
Percent of indicators rated Limited:20.00%
Percent of indicators rated Failed:0.00%

Standard 2: Intervention and Case Management	
2.01 Screening and Intake	Satisfactory
2.02 Needs Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management and Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petitiion Process	Satisfactory
2.07 Youth Records	Satisfactory

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

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

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:95.83%
Percent of indicators rated Limited:4.17%
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

Keith Carr, Lead Reviewer, Forefront LLC/FNYFS

Paul Sheffer, Regional Monitor, DJJ Office of Quality Improvement

Tracy Iverson, Systems Coordinator, Hillsborough County Government

Sandra Schwartz, Clinical Supervisor, Lutheran Services Florida - Southeast

Joel Rivera-Rosada, Counselor II, Youth and Family Alternatives, Inc.

Persons Interviewed

- [x] Program Director
- [x] DJJ Monitor
- [ ] DHA or designee
- [ ] DMHA or designee

3 Case Managers
2 Clinical Staff
0 Food Service Personnel
0 Health Care Staff

0 Maintenance Personnel
1 Program Supervisors
4 Other

Documents Reviewed

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

6 Health Records
4 MH/SA Records
12 Personnel Records
8 Training Records/CORE
11 Youth Records (Closed)
13 Youth Records (Open)
3 Other

Surveys

4 Youth | 5 Direct Care Staff | 0 Other

Observations During Review

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

Comments

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

The agency had no emergency events over the last 6 months or since the last onsite program review. Therefore, there were no samples of Episodic or Emergency care to review for Indicator 4.05 Episodic/Emergency Care.

Strengths and Innovative Approaches

Rating Narrative

Management Changes

In May of 2014, the agency made a change in leadership for Youth and Family Services which includes the Shelter and Non Res Services. The Executive Director, John Halcomb, resigned and Sonia Santiago, Clinical Director, was appointed as the Interim Director. The agency hired Shad Renick as their new Shelter Program Director in April 2014. Sonia Santiago was promoted to Vice President of Youth and Family Services in November2014. Mrs. Santiago continues to also provide services as the Licensed Mental Health Clinician.

Current Staffing

There are a total of four (4) administrative staff members that include a Program Director, Counselor, Case Manager, and Quality Improvement Specialist. There are fifteen (15) Behavior Coaches, five (5) full-time and ten (10) PRN staff members. At the time of this on site program review, the agency reported that there are several PRN positions available, as well as one (1) full time male staff position available. The program has been challenged this year to replace staff members that resigned. It was found that staff left due to family issues that they were experiencing.

Facilities

The Shelter Education Room was recently remodeled. The room was repainted, floors refinished and all the cabinets removed. The cabinets were removed and replaced with book shelves and new round tables make more effective use of the room. The bathrooms also had some remodeling done. New air conditioning units were provided in both the residents' living room and the education room. The Shelter also underwent tenting for Bed Bugs. A window air conditioner was installed in the outdoor shed where clothing that is donated is stored. This was done to prevent mildew affecting the stored items.

Funding:

The agency reapplied for the Basic Center Grant funding, but they did not receive an award. No CINS programming or services were negatively impacted by this reduction in revenue. The agency reduced expenses by restructuring the shelter administration staffing.

Non Resident Community Meetings:

The agency's non-residential program staff members have been attending community meetings. The agency has also attended local Juvenile Justice Committee for District 12 and Safe Free Schools Committee – Sarasota County Schools.

The agency participated in three (3) separate Crisis Intervention Trainings (CIT).

At these presentations information is provided to Law Enforcement Officers regarding services the type of services provided to youth and their families, especially the Shelter, Non Residential Counseling and School House Link (based on the McKinney Vento legislation). This week long course featured presentations from various community agencies specializing in Mental Health and crisis situations. The information provided is designed to assist law enforcement officers to be better prepared in handling these crisis's as they encounter them.

The agency is involved in serving the Homeless population through their School House link program.

The agency is a part of the local Community Behavioral Health Stakeholders Consortium. The Consortium holds monthly meetings where Community Providers gather to educate and inform each other about services available in the community. Updates are provided on community services and new opportunities are shared to all participants.

The agency is a part of the Community Legislative Group. The Community partners meet to identify legislative concerns, discuss and then present the community legislative concerns to State Representatives.

The agency is a part of the Drug Free Youth committee. This group is organizing in the Sarasota area. It is presently functioning in North Port and Venice areas in Southwest Florida.

The agency participates in Substance Abuse subcommittee as part of the Stakeholders Consortium. Presently the group has assisted in local ordinances being passed to deal with Pain clinics and Designer Drugs. These ordinances have been passed to reduce the negative impact drugs have on the community as Sarasota County has one of the highest accidental death rates due to drug use.

The agency arranges Safe Place Presentations to area schools who allow presentations. The agency presents to 6th graders at the local Middle Schools informing them of services as well as the significance of the Safe Place emblem. The agency contacts and maintains Safe Place sites at Libraries, Fire Departments, retail stores, and the SCAT bus system.

These efforts include training of new staff members, participating in Community Fairs with information on Sarasota Y services (Shelter, Non Res, School House Link, Achievers). The agency is also a part of the "Back to School" festival with 20 community partners participating, as well as commercial entities such as Publix, Home Depot, Smoothie, Sweet Tomatoes and others.

Other:

-Anger Management and Parenting groups are offered to the community on an eight week continuum. All that is needed to register is a phone call. Information is sent to local schools and posted on the Y web site.

-Adventure Based Counseling (ABC) is provided to at risk students at the Shelter and the Triad Program.

-All staff members have received training on working with the six to nine year olds and their families.

-All Counseling staff members are actively using Motivational Interviewing as that particular framework assists in identifying the level of motivation youth have to implement change.

-This past summer, staff provided groups for parents at Alta Vista Elementary School – Eaglet Academy focusing on Behavior Modification and Parenting. This school has a high percentage of kids on the school lunch program indicating levels of poverty.

Desoto County:2014-2015

- Mental Health Services in DeSoto County will now be provided by Charlotte Behavioral Health Services

Community Outreach

- **Desoto High School**-Meeting with new administrative staff/teachers and weekly attendance meetings
- **Desoto Middle School-** Meetings with administrative staff/teachers and weekly attendance meetings
- **Desoto Connections**- Meetings with administrative staff/teachers to discuss referral process and bi-weekly meetings with Education Specialist
- **Desoto Board of Education**-Meetings to discuss services, contract and referral process (periodical meetings were conducted with Superintendent and School Social Workers)
- **Family Service Center**-Monthly meetings with Social Service department to discuss referrals (brochures distributed)
- **Desoto Sheriff Department**-Meeting (three times/prn basis) with officers and School Resource Deputies to discuss services and referrals (brochures distributed)
- **Desoto Police Department**-Meeting with officers to discuss services and handout pamphlets
- **Domestic Violence Advocate**-Meeting to discuss referral process and monthly concerns within the community concerning teens.
- **Desoto Alternative Program**- Meeting with new staff to discuss services and new program process for referrals
- **DJJ**- Meeting to discuss referral process
- **Teen Court**- Monthly meetings held to introduce services, referral process and handout brochures and business cards for potential clients
- **DCF**- Monthly meetings to discuss referrals with new staff and receive new referrals
- **Churches**- Summer meetings to introduce services
- **Community Care**- Meeting to discuss potential referrals

Standard 1: Management Accountability

Overview

Narrative

The Sarasota Family YMCA is governed by a Board of community volunteers that are dedicated to the advancement of the YMCA's mission to build “strong kids, strong families, strong communities”. The Sarasota YMCA Board of Directors represents a vast cross section professions and industries. A Metropolitan Board of Directors oversees the operations and strategic planning of the entire corporation. This board is comprised of chairpersons from the branch boards of management and community leaders.

Sonia Santiago, is Vice President and oversees the residential and non-residential CINS/FINS programs and related services provided through its branches of services in Sarasota, Florida service region. Additionally, at the time of this on site Quality Improvement review the agency’s organizational chart lists Shad Renick, Program Director. Mrs. Santiago, LMHC is also responsible for the Non-Residential Program Director/Clinical Services Director. The agency also includes Karen Mersinger, Quality Improvement Specialist, Charles Harris as Case Manager and Sarah Blonsky, Residential Counselor.

The agency has formal rules that govern the behavior of all staff members including an employee handbook and code of conduct. In addition, the agency has a centralized human resources department that oversees all major background screening duties. The Sarasota YMCA received a minimum of 80 hours of training for all new staff members and a total of 40 annual hours of training for on-going staff members.

1.01 Background Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has Background policy that includes all of the major requirements for this indicator. The current policy is call Background Screening and was last updated on August 2014. The agency has centralized Human Resoruces Division that is responsible for screening all prospective employees seeking employment with the agency. The agency also conducts all five year rescreens.

A total of eleven (11) employee files were reviewed to determine their adherence to the requirements of this indicator. Of these files reviewed, ten (10) were initial background screenings and one was a five-year rescreen. All employee files screened meet the screening requirements of being screened and approved prior to their hire and start date.

The agency has a live screening machine to affords them the capability to conduct finger printing scanning and verification on site in real-time. The agency has documentation of all parts of the process.

There are no exceptions documented for this indicator Background Screening.

1.02 Provision of an Abuse Free Environment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The Sarasota YMCA Youth Shelter has a policy in place that adheres to the requirements of the Abuse Free Environment indicator. Staff members are expected to sign and comply with the Y Code of Conduct that forbids staf from using physical or emotional abuse, profanity, threats or intimidation. The shelter staff members model positive and appropriate behavior.

The youth are given a Youth Shelter Resident Handbook that addresses abuse/neglect reporting during intake. The abuse reporting hotline number is posted by all phones and is accessible to the youth.

This reviewer assessed the client grievance logbook and all available grievances have signatures from the youth and staff.

A total of five residents were surveyed during the on site program reiview. All youth know about the abuse hotline number to report abuse. No youth had made any attempt to call the abuse hotline. All youth said that they feel safe at the shelter. Four youth stated that they know about the grievance process. No youth have ever been sent to their room for punishment.

There are no exceptions documented for this indicator.

1.03 Incident Reporting

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The Sarasota YMCA Youth Shelter has a policy in place to address the requirements of the Incident Reporting indicator. Staff are expected to sign and comply with the Sarasota Y Incident Reporting requirements. There is an incident reporting binder that contains incidents for the shelter. There were a total of thirteen (13) incidents. Three out of the 13 incidents was reported to the DJJ CCC. It was reported within 2 hour timeframe. All parties were contacted and supporting documentation was placed in each client file. There was a reported incidnet related to an absconding on 10/4/14, bed bug clothing pm 10/28/2014, and a medication error on 12/8/2014. A staff member was given a written reprimand and placed in his file for the medication errors. Further, the reviewer assessed the client grievance logbook and found that all grievances had signatures.

There were no exceptions noted by the this reviewer for this indicatior.

1.04 Training Requirements

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

The program has a policy and procedure in place that addresses the Training Requirements indicator in Standard One. The shelter uses the employees date of hire to track annual training hour requirements. Training files are maintained with a cover sheet that has the total hours and what is remaining in order to meet their hours.

The reviewer assigned to this standard reviewed eight (8) employee training files. Four (4) out of the (8) eight training files reviewed were First Year Training files. Only one staff member had exceeded the required eighty (80) hours. The three (3) remaining staff members had 67 hours, 62.5 hours and 57.5 hours. All of these staff members were missing the CINS/FINS Core training. Three (3) staff members were missing the Fire Safety Equipment training. Three (3) were missing the Suicide Prevention training.

The remaining four (4) staff member training files reviewed were for Annual On-Going training. Two (2) out of the four (4) had exceeded the forty (40) hours of required annual training. The other 2 staff members only had 15.5 and 26.5 hours of training for that year.

All staff have current First Aid/CPR training.

1.05 Analyzing and Reporting Information

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy to collect and review several sources of information to identify patterns and trends. All data is analyzed and for strength and weaknesses. Case files are reviewed weekly by the Quality Improvement Specialist. Findings are discussed with the shelter supervisor and any corrective actions are handled immediately. During the monthly staff meetings, the Quality Improvement Specialist will cover incident reports, Florida Network contract benchmark and satisfaction surveys to inform staff members of their benchmarks and what needs to be done in maintaining or increasing their numbers.

This reviewer did a search of the shelter staff meetings logbook which provided the documentation for informing staff of the trends and outcome measures.

An interview with the Quality Improvement Specialist was conducted with the agency's Shelter Director to discuss the trends and any findings after analyzing the data. This information is shared with Direct Care and Counseling staff members and with individuals one-on-one if needed.

The agency has no active policy to address the requirments of this indicator.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

Sarasota YMCA is contracted to provide both CINS/FINS residential and non-residential services for youth and their families in Sarasota and DeSoto Counties. The program provides centralized intake and screening twenty-four hours per day, seven days per week to status offenders that include runaways, truants, ungovernable and lockout youth. Trained staff members are available to determine the needs of the family and youth upon call or referral for services. Residential services, including individual youth, family and group services. Case management and substance abuse prevention education are also offered on an as needed basis. Aftercare planning includes referring youth to community resources, on-going counseling and educational assistance on an cas-by-case basis. The Sarasota YMCA Family Counseling component is also responsible for coordinating 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. This component of the agency also recommends the filing CINS Petitions with the court as needed.

The agency's organizational chart lists Mrs. Sonia Santiago, LMHC as the Vice President and Clinical Director. Mrs. Santiago oversees all CINS/FINS residential and non-residential staff and members. Additionally, the organizational chart lists Shad Renick as Shelter Director.

Ten (10) radomly selected cases were reviewed to assess the agency's adherence to this indicator. Five (5) of these cases were residential: 3 open and 2 closed, and 5 were non-residential: 3 open and 2 closed. The cases varied in admission and discharge dates and were assigned to a range of counselors. An additional 2 cases were reviewed for Standard 2.04 since none of the original 10 cases had been through the completenadjudication process.

2.01 Screening and Intake

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency policies and procedures are clear and succinct regarding the Screening and Intake indicator. A total of five (5) residential cases were reviewed: 3 open and 2 closed cases. All 5 client cases met the requirement of eligibility screening within 7 calendar days of referral.

All 5 cases contained documentation that youth and parents/guardian received a list of available service options, rights and responsibilites of youth and parents/guardians, the Parent/Guardian brochure, the grievance procedure, and the possibe actions occuring through involvement with CINS/FINS services, including case staffing, CINS petition, and CINS adjudication.

No exceptions were noted during this site visit.

2.02 Needs Assessment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency policies and procedures are clear and succinct regarding this Needs Assessment indicator. A total of ten (10) client files were reviewed. In the files, the Needs Assessment occured within 72 hours of admission. However, in one file, the Needs Assessment occured within 4 days of admission, rather than three (3). A total of 10 files were reviewed consisting of five (5) residential cases: 3 open and 2 closed, and five (5) non-residetial cases: 3 open and 2 closed.

In the 5 residential files, there was evidence that the Needs Assessment was completed within 72 hours by a bachelor's or master's level staff member and the Needs Assessment and was reviewed by a supervisor. In 3 of the 5 files reviewed, as a result of the Needs Assessment, the youth was identified with an elevated risk of suicide. In each case, an Assessment of Suicide risk was performed under the direct supervision if a licensed mental health professional.

In the 5 non-residential client files, there was evidence in all 5 files that the Needs Assessment was completed within 2 to 3 face-to-face meetings by a bachelor's or master's level staff member and the assessment and was reviewed by a supervisor.

All 10 Needs Assessments were signed and dated by the counselor and clinical supervisor.

The only exception found in Needs Assessment is includeds 1 file the Needs Assessment did not occur within 72 hours of admission.

2.03 Case/Service Plan

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency policies and procedures are clear and succinct regarding this Case/Service Plan indicator. A total of ten (10) files were reviewed consisting of five (5) residential cases: 3 open and 2 closed, and five (5) non-residetial cases: 3 open and 2 closed. Case/Service Plans are varied within indfividualize plans across the 10 files reviewed.

Three (3) of the 5 residential files reviewed did not have completion dates or reason why they were not completed recorded. One (1) of the 5 residential files reviewed had received services for over 5 months and had been presented for case review with no follow-up service plan.

2.04 Case Management and Service Delivery

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy and procedure that addresses all the key elements of the Case Management adn Service Delivery indicator. The policy and procedure manual was reviewed in August 2014 and was signed by the agency CEO and the Clinical Director.

A total of five (5) residential (3 active and 2 closed) and five (5) non-residential (3 active and 2 closed) were reviewed. An interview was also conducted with the Clinical Director to obtain information on the process of case management and delivery of services related to referrals.

All files document service plan implementation and youth's/family's progress in completing services. All cases had a counselor/case manager assigned. All files document support for families, and 5 of 5 residential files provided evidence of monitoring out-of-home placement. One out of 5 non-residential files required case staffing, and referrals were provided. Five out of 5 non-residential cases did not require court hearings/related appointments and case monitoring/review of court orders. All closed residential files documented up-to-date follow-up, and 2 of 2 closed non-residential files were not applicable for follow-up.

There were some exceptions documented for this indicator. Four out of 5 residential files reviewed identified needs for referrals and documented referrals to services provided over the telephone. However, there were no written referrals available in the files. Three out of 5 non-residential files reviewed identified needs for referrals and 2 out of 5 documented referrals to services. The non-residential file that did not document referral to services identified the last use of tobacco was 2 weeks ago and "some experimentation" in the Needs Assessment. An interview was conducted with the Clinical Director who explained that tobacco was not considered a significant risk. The Clinical Director also explained that the alternative school the youth attends provides substance abuse counseling.

2.05 Counseling Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy and procedure that addresses all key elements of this Counseling Services indicator. The policy and procedure manual was reviewed in August 2014 and was signed by the agency CEO and the Clinical Director.

A total of five (5) residential (3 active and 2 closed) and 5 non-residential (3 active and 2 closed) files were reviewed. All clien tfiles addressed presenting problems in Needs Assessments, case/service plans, case notes, and clinical reviews of case records/staff performance. All files included up-to-date chronological case notes on progress. All residential files documented weekly clinical reviews. All non-residential files documented monthly clinical reviews.

One exemption was noted. Group was not conducted 5 times per week 5 weeks in the last 6 months.

2.06 Adjudication/Petitiion Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency policies and procedures are clear and succinct regarding this Adjudication/Petition Process standard. Since none of the 10 cases reviewed were taken from case staffing through the adjudication/petition process, an additional two (2) files were requested that had been through the adjudicated process.

Of the 10 cases originally reviewed, 1 case was taken to the case starfffing comittee; however, this case did not go through the adjudication process. The exception noted with this case was that, after the case staffing committe meeting, a new or revised treatment plan was not enacted.

Of the additional 2 cases reviewed, both cases were taken to the case staffing comittee and met all of the requirments of the standard and through the adjudication/petition process.

2.07 Youth Records

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of the Youth Records indicator. The policy manual was last reviewed in August 2014 and was signed (2 signatures were noted, but titles were not identified).

A total of nine (9) non-residential files were reviewed. All files were marked confidential, kept in a secure area, and locked in a file cabinet. The areas with the file cabinets could also be locked. All youth records were neat and orderly.

A secure method of transporting non-residential files from satellite location(s) to main office was unclear. An interview was conducted with the Clinical Director who indicated transporting files is not the program's general practice.

Standard 3: Shelter Care

Overview

Rating Narrative

Sarasota YMCA is licensed by the Department of Children and Families (DCF) for twenty (20) beds and it primarily serves youth from Sarasota and DeSoto Counties. The shelter also provides services to youth referred to them from the Department of Children and Families. The Sarasota YMCA shelter facility that is located in central Sarasota near the intersection of Bahia Vista Street and Tuttle Avenue. The shelter is adjacent to the YMCA's gymnasium which provides access to recreational opportunities for youth during their shelter stay. The shelter building includes a common or day room, girls and boys dorm style bedrooms. The shelter also includes a industrial kitichen, dining room, laundry room, Shelter Director and Staff offices, large patio, open courtyard area and a multipurpose/activity/computer room.

The Sarasota YMCA residential team is comprised of over twenty (20) Residential staff members (full-time, part-time and on-call). This number of residential staff members includes one (1) Program Director and 2 counselors and a Quality Improvement Specialist. The Direct Care workers are responsible for completing all applicable admission paperwork, orientating youth to the shelter, and providing necessary supervision. The youth care workers are responsible for processing new admissions, and providing orientation of youth to the shelter; the supervision of youth; and for maintaining inventories on all sharps and medications. Youth care workers also assist in the delivery of self-administered prescribed and over-the-counter medications.

3.01 Shelter Envonment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The reviewed documentation and observation indicate the shelter provides a safe, clean, and well maintained environment. All health and fire safety inspections were found to be current. The program had a bedbug infestation in September of 2014. They instituted a plan to purchase single bed covers and they developed a protocol to address the infestation problem. The problem grew to a point requiring fumigation, and the shelter was treated on October 28, 2014. After a dontaion from a community provider, the program instituted a new procedure in which they are provided with a sweat suit to change into while their clothes are laundered upon intake. Each youth is also provided with clean sheets, a blanket, and pillow as well at the time of admission.

The grounds were observed to be landscaped and well maintained. Each of the bathroom areas were found to be clean and functional, and furnishings were found to be in good repair. There were minor issues seen during the tour, including a missing switchcover and a missing cover on an overhead light fixture within the girls dorm. The program director reported these issues have been shared with maintenance staff and are being addressed. The program provies each youth with a space to lock up any valuables they may have. The program also has a daily schedule in place which provides structured activities, which includes at least one hour of physical activity. The daily schedule is provided to youth upon orientation and is posted for both staff and youth. Daily programming also provides opportunities for youth to complete homework, and also gives them access to age appropriate books for reading. Youth are also provided with an opportunity to participate in faith-based activities during their stay, and are allowed to attend with their parent/guardian, or program staff if they are available. Reviewed documentation reflected the program maintains a an inventoty for all chemicals which is checked weekly, and is updated as items are used. The chemicals are stored securely and they have a Material Safety Data Sheet (MSDS) for each item.

During tour, small issues with physical plant were noted. Missing lightswitch cover and light fixture exposed in girls dorm. The program director reported he is aware of the deficiencies and has made the maintenance staff aware of their need to be addressed.

3.02 Program Orientation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of the Program Orientation indicator. Five (5) youth case management records were reviewed for program orientation procedures. Each of the reviewed records reflected evidence that each youth received a comprehensive orientation, and each was provided a resident handbook, on the day of admission. During this process the youth are given information about disciplinary action, the grievance procedure, emergency/disaster procedures, and contraband rules. During this orientation process each youth is assigned to a room. They are also given a layout of the facility, daily activities are reviewed, and the abuse hotline information is provided. Four (4) of the 5 reviewed records reflected the parent/guardian signed the intake paperwork on the day of admission. The other reviewed file was for a runaway youth, and the parent did not report to the facility and sign the paperwork for two weeks after admission.

Minor exceptions were noted on youth surveys. Five youth responded to the survey, and 4 reported they had been told what to do in case of a fire. Four of these youth also reported that the grievance process had been explained to them as well.

3.03 Youth Room Assignment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the requirements of the Youth Room Assignemnent indicator. Five (5) youth case management records were reviewed for the requirements of this indicator. Each of the reviewed records contained documentation indicating the program completed an initial classification of each youth which included a review of their history and exposure to trauma, the age, their gender, their history of violence, any disabilities, their physical size, gang affiliation, suicide risk, and any sexually aggressive or reactive behavior. This information is used to assist in assigning youth to a room and a designated bed.

The program does not specifically ask any gender identification questions during the classification and screening process; however, this area is usually addressed during the needs assessment process. This information is captured during the needs assessment process and changes can be made if needed. Initial observation and interaction and included in their classification process, along with any collateral information provided. All alerts were found to be documented in the internal alert system

3.04 Log Books

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has Log Book policy that includes all of the major requirements for this indicator. Logbook documentation was reviewed for the past six (6) months. A review of entries found that all safety and security issues were documented. Each entry was brief, legible, and written in ink. Each entry was documented with the date and time, and was initialed by the staff member making the entry. Minimal recording errors were found to be written over. Staff were found to sign the logbook at the beginning of each shift, while also documenting a review of the two (2) previous shifts. The program supervisor reviewed the logbook each time they worked. This review reflected their review of all entries since they last worked, and provided instructions when needed. All important events, including counts, visitation, home visits, were found to be documented in the logbooks.

No exceptions found.

3.05 Behavior Management Strategies

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a Behavior Managment System policy that includes all of the major requirements for this indicator. The program has a five (5) tiered behavior management system (BMS). This system is shared with youth during the orientation process and is expanded upon in the resident handbook. When youth arrive at the shelter they start on level 0, but can immediately begin earning points. The BMS provides incentives such as privileges such as extra phone calls, later bedtimes, and the ability to participate in special activities as the youth progress to higher levels.

A review of staff member training records indicated that all staff have received training in the BMS. The process in place provides for positive reinforcement, as well as consequences when the rules have been violated. Consequences include the potential of a level drop, or the youth not being allowed to participate in outings being offered. The program also works to ensure that consequences are delivered on an individual basis. None of the five (5) surveyed youth reported having been sent to their room as a punishment.

No exceptions are noted.

3.06 Staffing and Youth Supervision

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policy in place to address general staffing ratio requirements. Reviewed documnentation reflects the shelter maintains the required ratios of 1 staff to 6 youth during awake hours, and 1 staff to 12 youth during sleeping hours. Reviewed documentation reflected they have a minimum of two (2) staff present on each overnight shift. The program makes efforts to maintain at least one (1) staff on duty of each gender; however, they recently had a full time male staff member resign. The program provided documentation reflecting efforts to hire part-time male staff since June of 2014, and efforts to hire a replacement full-time male staff member since the staff member left at the beginning of January 2015.

The program has a surveillance system, with well-placed cameras, which captures video coverage within the program. The system only maintains this footage for 14 days. Reviewed documentation and video coverage reflects staff performs observations of the youth every 10 minutes while they are in their sleeping rooms.

There are exceptions noted for this indicator. The program does not have enough male staff to operate with one member of each gender per shift. This was occurring minimally prior to the loss of a full-time male staff member on 01/05/2015. This problem was exacerbated and the occurrences of two females staff per shift has doubled. They were able to provide documentation reflecting hiring efforts that have been made.

3.07 Special Populations

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a Special Populations policy that addresses the major requirements for this indicator. The shelter had one youth applicable for domestic vioence respite in the last six month period. A review of this closed file found an approved domestic violence referral from the Florida Network. The length of stay for this youth did not exceed fourteen days. The case plan for this youth reflected a focus on reducing their anger through family counseling. The placement for the youth was changed before the shelter had an opportunity to assist the youth and family with this plan. The youth participated in all other general services offered during their stay. The shelter had three (3) applicable youth placed in the last six (6) months for probation respite. Each reviewed file contained a probation respite referral which had been approved by the Florida Network prior to the placement. None of these youth stayed in the shelter longer than thirty days; therefore, no extension requests were required. The shelter does not provide staff secure services. Program staff reported they have not been asked to take youth in this staus, and they also shared they do not have enough staff available to serve youth in this capacity currently.

No exceptions were noted for this indicator.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The Sarasota YMCA residential program provides screening, counseling and mental health assessment services. The agency has a Program Director and Assistant Program Director that oversee the daily operations. The program has direct care staff member members are that are trained to screen, assess and notify all employees of conditions and risks of all youth admitted to both residential and non-residential CINS/FINS programs. The agency provides risk screening and identification methods to detect youth referred to their programs with mental health and health related risks. Specifically, the agency utilizes screening and a CINS Intake form to determine eligibility and various screening methods to determine the presence of risks in the youth past mental health status, as well as their current status. The agency also screens for the presence for acute health issues and the agency's ability to address these existing health issues. The agency also uses a general alert board and 2 colored system of notification to inform all staff members on each shift of the health and mental health status of all youth in residential youth shelter.

The Sarasota Y CINS/FINS program assists in the delivery of medications to all youth admitted to the youth shelter. The agency operates a detailed medication distribution system. The agency provides medication distribution training to all direct care staff members, first aid response, CPR, first aid, fire safety, emergency drills and exercises and training on suicide prevention, observation and intervention techniques.

The agency employs both male and female staff members across all three (3) work shifts. There are a total of fifteen (15) Behavior Coaches, five (5) full-time and ten (10) PRN staff members. Agency training files indicate that direct care staff members received annual crisis intervention, first aid, CPR, suicide prevention and medication distribution training. The agency also has several measures in place to address emergency, accidents, injuries and safety and security events. The agency has disaster plans, knife-for-life, wire cutters, and first aid kits that are located in the youth work station. A medical and mental health alert system with general alerts is in place. The system is practical and staff interviewed onsite are very familiar with the alert system. Staff members are also trained to provide first aid as needed when emergencies occur.

4.01 Healthcare Admission Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure manual that addresses all key elements of the CQI indicator. The policy manual was reviewed in August 2014 and was signed by the agency's President and the program's Shelter Director. There is a process for obtaining medical care if needed indicated in the program policy and procedure manual.

A total of five (5) residential files were reviewed (3 active and 2 closed files). There is evidence in all five (5) files that the program performs preliminary health screening for each youth. The preliminary health screening includes, but is not limited to current medications; existing (acute and chronic) medical conditions; allergies; recent injuries or illnesses; observation for evidence of illness, injury, pain or physical distress, difficulty moving, etc.; and observation for presence of scars, tattos, or other skin markings. There is also evidence in all 5 files that there is a screening for diabetes, pregnancy, seizure disorder, cardiac disorder, asthma, tuberculosis, hemophilia, and head injuries. None of the files reviewed required a referral for medical care.

No exceptions were noted for this indicator.

4.02 Suicide Prevention

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency's policies and procedures for suicide prevention in the residential setting are not stated in Standard 4.02, however, they are covered in 2.02. The agency's policies and procedures for suicide prevention in the residential setting are succinct and clear on Standard 4.02 and are followed exactly. Of the 5 residential files reviewed, 3 youth had reported suicide ideation and were assessed through a suicide risk assessment. All 3 youth were placed on sight-and-cound supervision and the supervision level was not changed until the youth was determined, by a licensed professional, to be no longer at risk.

Of the 5 non-residential files, 2 youth were administered the suicide risk assessment due to mention of suicide. One youth assessment screening was completed during a session with the counselor.

There are no exceptions documented for this indicator.

4.03 Medications

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a comprehensive policy on Medication practice and distribution. The agency's current policy is called the Medications policy and was recently reviewed and approved by the Sarasota Y President and Shelter Director in August 2014. In general, the agency's policy contains language that addresses the safe and secure storage, access, inventory, disposal and distribution of medications. Review of the agency policy reveals that the policy contains language to address and require Verification of all medication accompany all residents admitted the Sarasota Y Youth Shelter facility.

The staff members authorized to assist in the delivery in medication have all been trained by a registered nurse. The agency recenlty received on site medication distribution training from Christine Gurk, Registered Nurse Consultant with the DJJ Office of Health Services on January 20, 2015. The reviewer observed mediaction pass and found no issues related to the practice being executed regarding the assistance of the delivery of medication.

On site observations found that all medications in the shelter are stored in a locking wood cabinet inside the Youth Care Work (YCW) Station. This room is secure and requires key access. There is a single access point at the front door of the YCW office and the pad lock on the wood cabinet. There is an additional lock on a box that houses all controlled medications. All medication in the room is stored in shelves designated as oral, topical and over the counter medications. All resident medications are stored in plastic Ziplock bags with the resident's name written on the outside of the bag. At the time of this on site program review, there was only 1 CINS/FINS resident on prescription medication.

The agency maintains a Medication Distribution Binder that houses all of the medication distribution logs (MDL) of each resident with medication. At the time of this on site program review, the MDL binder includes the medication log, picture of the youth, over the counter record, side effects notice, dosage, reason for medication, date received, method of administration, controlled substance inventory, non-controlled weekly inventory, staff names, Verification of Medication and individual staff and resident initials on the MDL when medication is disbursed and received. A review of six (6) client medication logs were conducted onsite (1 open and 5 closed). At the time of this on site review, there is one (1) active CINS/FINS client on medication. Of the files reviewed, all6 files contained evidence of screening for medication needs and all forms are present.

The shelter has a system in place for the refrigeration of medication. There is small non-locking refrigerator dedicated specifically for medication. At the time of this on site review, there were no medications requiring medication on site.

All controlled medications are locked in a cabinet behind two (2) locks. All Controlled medications are stored and placed in a locked metal box inside the aforementioned cabinet. At the time of this review, there was only 1 CINS/FINS youth on controlled medication. The agency does provide over-the counter medication. The agency only distributes three (3) OTCs that include Pepto Bismol, Acetaminophen and cough drops. The agency maintains a weekly sharps form for each over the counter (OTC) medication.

Sharps are also kept in 2 cabinets. The tweezers, finger nail clippers and first aid scissor are maintained in 1 cabinet. The second cabinet houses safety scissors. This cabinet resident boxes that have razors, nail clippers, nail files, scissors in individual resident boxes. A sharps log is maintained in the shelter. Inventories on sharps are conducted three (3) times per day on each shift. The agency provided the previous six (6) month of sharps inventories dating back to August 2014 to present. Over the counter counts for all of the aforementioned OTCs on a weekly basis are consistent for all weeks during the past six (6) months.

The agency had a total of one (1) documented DJJ CCC incident that involved a medical error. These incidents were self-reported as required. The reviewer requested all evidence of documented follow up performed by the agency's management in response to these documented incidents. The agency provided satisfactory evidence of follow up on this case to demonstrate supervisory review, assessment and managerial action steps taken to address each medication incident error.

There are exceptions documented for this indicator.

The agency had a total of one (1) documented DJJ CCC incident related to medication errors.

One (1) active resident medication distribution log contained missing documented initials of the staff assisting in the distribution of medications.

Additional closed files included several documented errors on the medication log where either medication counts or initials were not documented on a consistent manner across medication distribution sessions taken by residents.

A review of documentation Sharps counts for all of the aforementioned sharps on a daily basis are not consistent. Routine daily sharps counts

are consistent for some days and there are less frequent documentation of completed counts observed in other daily sharps counts.

The shelter has a system in place for the refrigeration of medication that includes a small non-locking refrigerator dedicated specifically for medication. At the time of this onsite program review there was no lock on the medication refrigerator.

4.04 Medical/Mental Health Alert Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has an operation/policy and procedure for the Indicator 4.04. The agency's policy is called The Sarasota Y Youth and Family Services Medical Mental Health Alert Process. The agency's last revision date is documented as August 2014. The current policy is designed to ensure that all staff members are aware and notified regarding a youth medical, mental health condition, allergies, common side effects of prescribed medications, food, medication contradiction and other pertinent treatment information.

The agency requires that all youth are screened upon being admitted by the shelter for physical, mental health, and substance abuse needs by non-medical staff. It is the agency's practice to place a red dot on the client's hard or shelter file and also on the client census board. The agency also uses a "Yellow" Medical and Mental Health Alert form to capture and document general alert information. This form is placed in the Intake section of the client's hard file. All shelter residents that are assessed and place on sight and sound supervision status are required to have a "Green" dot placed on the census board until they are cleared from this elevated supervision status by the agency's Clinical Director. All youth that are admitted with prescription drug requirements have this status placed on the resident's screening form in the file and a red dot place on the outside of the client's hard file. Residents with food allergies are placed on a food allergy notice that is posted in the kitchen. In general a red dot is placed next to the youth's name on the census board and on the outside of the hard file.

Staff members are required to check if there any new alerts posted at the beginning of each shift. Changes and updates are required to be posted in the communication log and on the youth's daily log note. All staff members are required to be trained on the Alert system to ensure that they are aware of the system and able to recognize and respond to medical and mental health issues that require emergency care or treatment.

At the time of this on site program review, a total of six (6) CINS/FINS residents are in the youth shelter. A review of medical and mental health alert files was conducted on six (6) client files. Of these files, all 6 contained all required forms that were completed as required. Of these residents, all six (6) were screened for alerts as required. All files contained the Yellow Medical and Mental Health Alert form that was completed as required.

An exception is noted for this indicator. Upon review of the general alert board, the reviewer found a red star on the census board in the youth care work station indicating that the youth was medication. Youth that are on medication are required to have red dot displayed by their name on the general alert board indicating that the client is on medication.

4.05 Episodic/Emergency Care

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has an operation/policy and procdure for the Indicator 4.05 Episodic Emergency Care. The agency's policy is called The Sarasota Y Youth and Family Services Episodic/Emergency Care. The agency's last revision date is documented as August 2014 by the President of the Sarasota Y. The current policy is designed to ensure that the Sarasota Y youth shelter ensures client/resident safety by providing rapid and appropriate emergency medical and dental care.

The policy requires that all instances of first aid and or emergency medical care is documented in the Episodic First Aid Emergecy care log, Episodic First Aid Critique Log, client record and in the communication log. All parents are required to be notified immediately of any medical/dental emergencies.

At the time of this on site program review, there were no official cases of off-site medical care documented in the last six months between August 2014 and January 2015. A review period futher back of July 2014 back to February 2014 was also conducted. No off-site medical incidents were found for this period.

The agency has record of providing CPR and First Aid Training. The agency has a knife for life, and other related safety equipment such as first aid kits, bio hazard watse disposal and safety equipment in the transporation vehicles.

No exceptions are noted for indicator 4.05 Episodic/Emergency Care.