



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of YFA-George W Harris

on 09/17/2014

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 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 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 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 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

- Ashley Davies, Lead Reviewer and Consultant, Forefront LLC
- Martha Fitzpatrick, Clinical Program Supervisor, Children's Home Society
- Jennifer Calame, Clinical Services Director, Orange County



Tracey Iverson, Business Analyst, Hillsborough County

Persons Interviewed

- | | | |
|--|--------------------------|-------------------------|
| <input checked="" type="checkbox"/> Program Director | 3 Case Managers | 0 Maintenance Personnel |
| <input type="checkbox"/> DJJ Monitor | 3 Clinical Staff | 4 Program Supervisors |
| <input type="checkbox"/> DHA or designee | 0 Food Service Personnel | 0 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 | 5 Health Records |
| <input checked="" type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 5 MH/SA Records |
| <input type="checkbox"/> Contract Monitoring Reports | <input type="checkbox"/> PAR Reports | 8 Personnel Records |
| <input type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 10 Training Records/CORE |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 5 Youth Records (Closed) |
| <input type="checkbox"/> Escape Notification/Logs | <input type="checkbox"/> Sick Call Logs | 5 Youth Records (Open) |
| <input checked="" type="checkbox"/> Exposure Control Plan | <input 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

- 5 Youth 6 Direct Care Staff 0 Other

Observations During Review

- | | | |
|---|--|--|
| <input type="checkbox"/> Admissions | <input checked="" type="checkbox"/> Posting of Abuse Hotline | <input checked="" type="checkbox"/> Staff Supervision of Youth |
| <input type="checkbox"/> Confinement | <input checked="" type="checkbox"/> Program Activities | <input checked="" type="checkbox"/> Tool Inventory and Storage |
| <input checked="" type="checkbox"/> Facility and Grounds | <input type="checkbox"/> Recreation | <input checked="" type="checkbox"/> Toxic Item Inventory and Storage |
| <input checked="" 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 checked="" type="checkbox"/> Meals | <input type="checkbox"/> Sick Call | <input type="checkbox"/> Use of Mechanical Restraints |
| <input checked="" type="checkbox"/> Medical Clinic | <input checked="" type="checkbox"/> Social Skill Modeling by Staff | <input type="checkbox"/> Youth Movement and Counts |
| <input checked="" type="checkbox"/> Medication Administration | <input checked="" type="checkbox"/> Staff Interactions with Youth | |

Comments

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

Strengths and Innovative Approaches

Rating Narrative

The agency received a \$20,000 grant from the Law Foundation and George Jenkins foundation in order to purchase a new vehicle for the shelter. The shelter is currently in the process of trying to find a new vehicle.

Youth and Family Alternatives had a change in leadership and now has a new C.E.O., Mark Wickham.

This past December the agency received the Non-profit Agency of the Year award from the Bartow Chamber.

The shelter raised \$4,300 from their annual 5K run fundraiser.

The shelter Director is vice chair of the circuit DJJ board and involved in the human trafficking task force.

Due to the shelter being located next door to the county JAC, the number of youth they provide Domestic Violence Respite to is high.

The shelter video system was not working during the on-site review. The system had been hit by electricity and was in Orlando to be fixed. This was the third time the system had been hit.

The non-residential program has expanded and was able to hire two full time staff for Highlands County and one full time staff for Hardee County. They hired a new counselor in Polk County and had an additional position to be filled on the 29th of September in Polk County. The schools in each county have given the counselors space to use free of charge.

George Harris is a twenty-four bed shelter and served over 600 youth this past year.

The local Leadership Council, Youth for Christ, and Crickette Club visit the shelter once a month to bring food and cook for the youth. They also plan parties for the youth around the holidays.

The agency has recently installed a new server that securely stores all data and email in the Cloud. During the on-site review the agency was installing a new state-of-the-art phone system.

Standard 1: Management Accountability

Overview

Narrative

Youth and Family Alternatives' organizational structure at the Executive Level includes George Magrill, President and Chief Executive Officer, Ken Conley, Senior Vice President for Administration and Andy Coble, Vice President of Prevention Services. At the time of this onsite program review, the YFA Residential program employs a Residential Director, two Office Specialists, four Youth Development Specialist (YDS) Shift Leaders, one YDS Team Leader, three Residential Counselors, one Life Skills Specialist, and eight Youth Development Specialists. The Non-Residential Program employs a Program Director, a Program Supervisor, and five counselors. At the time of the onsite Quality Improvement program review, the agency position vacancies include five vacant YDS Part-time time positions. There was one non-residential vacancy reported by the agency which included a counselor. The agency operates a Risk Prevention and Management Team Meeting that reviews various issues that reviews incidents on the quarter. This team is comprised of various staff YFA staff members. Youth and Family Alternatives, Inc. is accredited by the Council on Accreditation (COA).

1.01 Background Screening

Satisfactory Limited Failed

Rating Narrative

There were six new staff hired since the last on-site review. All six staff were appropriately screened prior to their hire date. All six staff received an eligible rating. There were three staff applicable for a five year re-screening. All three staff received a re-screening within the appropriate time frame. The Annual Affidavit of Compliance with Level 2 Screening Standards was submitted on January 28, 2014.

1.02 Provision of an Abuse Free Environment

Satisfactory Limited Failed

Rating Narrative

The shelter has a policy in place for Provision of an Abuse Free Environment. All staff are required to adhere to a code of conduct which prohibits them from using profanity, threat, or intimidation when interacting with the youth. There have been no issues management has had to address with staff, relating to the code of conduct, since the last on-site review.

Out of six staff surveyed, five reported working conditions at the shelter were very good and one reported good. All six staff knew the process for allowing a youth to call the abuse hotline. None of the staff have ever heard a co-worker telling a youth they could not call the abuse hotline. None of the staff have ever heard another co-worker using profanity, threats, or intimidation when speaking with the youth.

Out of the five youth surveyed, four youth reported they are aware of the abuse hotline and their ability to call the abuse hotline if wanted. One youth reported they were not aware of the abuse hotline. Four youth reported they have not called the abuse hotline and one youth reported they had. All five youth reported they have never been stopped from calling the abuse hotline. Four youth reported they have never heard a staff member use profanity and one youth reported they heard a counseling staff use profanity. All five youth reported they have never heard a staff member threaten another youth and that they feel safe in the shelter.

1.03 Incident Reporting

Satisfactory Limited Failed

Rating Narrative

The agency has a policy in place for incident reporting. There has been one incident reported to the CCC in the last six months. It was a youth who ran away from the shelter. The incident was reported within the required two hour time frame and all required parties were notified.

1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

There were three staff training files reviewed for first year training requirements. All three staff documented more than the required number of training hours with 108.5, 118.5, and 116 hours. Two of the staff documented all required training topics were covered with the exception of First Aid and CPR. The third staff documented all topics with the exception of CINS/FINS Core Training.

There were six staff training files reviewed for annual training requirements. Five of the six staff documented more than the required number of annual training hours. One staff completed thirty-three out of the forty required hours. All staff documented fire safety training and had a current First Aid and CPR certification.

1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

The agency has a comprehensive continuous quality improvement process that is established in policy for identifying patterns and trends across the agency. A number of committees have been established and meet regularly to review different aspects of the quality environment.

Quarterly review of incidents, accidents and grievances - incident reports are reviewed as they come in and data is compiled on a month to month basis. QI staff and management staff review the data monthly and the QI Council reviews it quarterly.

Annual review of customer satisfaction data - customer satisfaction data is reviewed at least once a year as part of the strategic planning process.

Annual review of outcome data - outcome data is reviewed monthly and is compiled for review by the management team and the QI Council. This data is also compiled for the board at least once a year.

Monthly review of NetMIS data reports - Program management reviews monthly NetMIS data and clearly knows where the agency is in terms of objective achievement at all times.

The agency has instituted a feedback process for the peer review and CQI plans that involves a staff that coordinates the QI process, monitors compliance, and follows up to see if improvements have had the desired result. This information is shared freely with program supervisors.

Subcommittees of the QI Council keep detailed minutes of their meetings, plans and results are tracked. There is documented evidence of training related to issues identified through the QI process and review of incidences afterward to monitor its success.

The committee's have identified three areas of concern within the shelter and developed CQI Worksheets to address the issues. The worksheets identify the issue and desired outcome. One issue identified was group notes not being entered in the youth's file at least five days each week. A team of reviewers came to the program and reviewed all youth files for group notes. The issues were identified and corrective actions were put into place. A follow up review is scheduled to ensure recommendations were implemented. Supporting documentation from the file reviews was attached to the CQI Worksheet. The second issue identified was the service plans in the non-residential files not being

reviewed/signed every 30/60/90 days. Again all files were reviewed and issues were identified. Supporting documentation was attached to the CQI Worksheet and a follow-up review was scheduled. The third issue identified was related to medication errors. This issue was identified at the other two programs operated by the agency; however, they felt it was a good idea to review the process at this shelter to avoid this issues happening in the future. The agency had the nurse from DJJ deliver a refresher training on the self-administration of medications in shelter settings. The shelter directors from all three shelters discussed practices at each shelter along with specific incident data to determine best practices. Each shelter is going to review and train medication control and management policy with all staff. CQI validation will occur at each shelter at 45 day intervals.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

The agency is contracted to provide residential and nonresidential CINS/FINS services to youth and families residing in mainly in Hardee, Highlands, and Polk counties. The program consists of a Non-Residential Program Director, a Non-Residential Program Supervisor, and five Counselors. The non-residential program has expanded and was able to hire two full time staff for Highlands County and one full time staff for Hardee County. They hired a new counselor in Polk County and had an additional position to be filled on the 29th of September in Polk County. The schools in each county have given the counselors space to use free of charge. The counselors are responsible for the case from screening to discharge.

2.01 Screening and Intake

Satisfactory Limited Failed

Rating Narrative

Five Non-residential files were reviewed. Three files had screenings that were not completed within 7 days of the referral. In each of these cases, there were progress notes that showed multiple attempts to reach the parent by phone and then when needed a letter was sent. Each of the five files showed evidence that the parent and youth were given information about the program, case staffing, and grievance procedures as well as what services that are offered. The program gives the families Notice of information practices as well as a brochure regarding their rights and responsibilities (included is the services provided information and grievance process). Five Residential files were reviewed. Four of the records had a screening completed the same date as referral. The fifth file had a screening completed within six days of referral. All files document that the youth was provided with information regarding services offered, their rights and responsibilities, and the grievance process. Each also documenting providing the parents with this information as well as a brochure except one youth who was brought to the shelter after his mother did not pick him up from detention. Shelter staff attempted to reach mother by phone on the day of intake.

2.02 Psychosocial Assessment

Satisfactory Limited Failed

Rating Narrative

Of the five Non-residential files reviewed, the Psychosocial Assessments were all completed at intake during first face to face with youth and family. Each psychosocial assessment was signed by both counselor and supervisor upon completion. Program Supervisor stated that her staff counselors range in credentials from Bachelor level, Master level and Licensed. One of the five youth was identified during intake as having an elevated risk of suicide during the assessment process. This youth completed a suicide assessment with shelter staff within 24 hours which was signed off by a licensed staff. Youth was found to be at low risk of self harm. Three of the Residential files had a psychosocial assessment initiated within 72 hours of youth intake. Two of the files had a psychosocial completed within the past two to three months with also a current psychosocial addendum completed within 72 hours of the youth's most recent intake. Each psychosocial was signed off by counselor and supervisor. None of these three youth had an elevated level of suicide risk.

2.03 Case/Service Plan

Satisfactory

Limited

Failed

Rating Narrative

Five Non-residential files had service plans completed on the same date as the psychosocial assessments. Each appeared to be individualized to meet with identified needs of the youth. Each contained the necessary elements of service type, frequency, location, person(s) responsible, and target dates. One of the five cases had been closed but did not have completion dates on the service plan. Each had all required signatures and the initiated date of the plan. Each contained the necessary 30/60 day reviews. Three of the five Residential cases had a service plan completed within seven working days of the psychosocial assessment. All service plans appeared individualized to youth needs identified during intake process. One youth was discharged within six days and did not require a service plan. One youth had a late service plan. Program counselor and director explained that this youth had a lot going on with her, being that she had involvement with FINS in another county as well as she had inappropriate behavior while at the shelter and had to be transferred from a male counselor to a female counselor. It was documented in the file that the youth came out of her room wearing a t-shirt and underwear. Notes in the file documented that this was addressed right away with the youth. The service plan was completed within five days of case transfer to female counselor. None of the five cases were open long enough to have a thirty day service plan review.

2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

Rating Narrative

Each of the 5 files had a counselor/ case manager assigned who addressed youth service needs and coordinated and monitored the service plan implementation and youth/ family progress. This was evidenced by case notes and supervisor review/case notes present in the files. None of the five youth required shelter, case staffing or Court action. One of the five files was closed and a termination summary was present in the file with update of youth service progress noted.

Residential: Each of the 5 files had a counselor/ case manager assigned who addressed youth service needs and coordinated and monitored the service plan implementation and youth/ family progress.

2.05 Counseling Services

Satisfactory

Limited

Failed

Rating Narrative

Each of the five cases were offered counseling through YFA in accordance with their case/ service plan. The youth's presenting issues as identified in the Psychosocial Assessment and Case/Service plan were addressed. One youth was identified with needing grief counseling but the youth refused to participate. Neat and easy to read progress notes were present in the files. The program's internal on-going clinical reviews of the case record is evidenced by the 'chart supervision' forms present in each file.

Each of the five residential youth files reviewed had documentation in the file of the youth participating in group counseling during their shelter stay as well as having an individual counselor assigned to them. There is clear documentation in the progress notes by counselor of sessions with each youth addressing their service plan needs. Group sign in sheets are kept in separate binders. One youth did not have a service plan due to her short stay (6 days) but she still had a counselor assigned and received group counseling as well. Referrals provided by staff for follow up services were documented where needed.

2.06 Adjudication/Petition Process

Satisfactory Limited Failed

Rating Narrative

CINS case staffing binders were reviewed for Polk, Highlands, and Hardee. The Program Director and Supervisor were also available to discuss the process and answer questions. The binders each showed an established case staffing committee. The binder included notification to the case staffing committee members and letters to the family about the case staffing committee. The letter to the parent included notice that the family may bring a representative of their choice.

There were three (3) cases were reviewed: two (2) from Polk and one (1) from Highlands. Two cases involved families that were not participating in treatment. One staffing resulted from a decision between the counselor and parent. A new or revised service plan was present for all three cases. One was signed by the family providing evidence that they were informed of the committee recommendations. In the cases where the family was not participating, the explanation was the service plan was not mailed to the families because the addresses were undeliverable. Documentation was provided that showed the notice of the case staffing to the family was returned undeliverable in both cases.

2.07 Youth Records

Satisfactory Limited Failed

Rating Narrative

Youth files are marked confidential. The closed and open files for this location were observed to be stored in a locked room in locked cabinets. Non-residential director stated that files are kept in the same manner at their Lakeland office as well.

Standard 3: Shelter Care

Overview

Rating Narrative

The George Harris Youth Shelter is located in Bartow, Florida. It is one of three (3) shelters that Youth and Family Alternatives operates in the state. The other two (2) residential youth shelters are located in New Port Richey and Brooksville. The Bartow shelter is a well-designed facility that is clean, nicely furnished, attractively landscaped and well maintained. There were no signs of graffiti, property damage or any hazardous or dangerous conditions during this site review. A comprehensive tour of the facility was conducted to determine the environmental conditions of the facility and the living conditions for the youth. This residential shelter operates twenty-four hours a day, 365 days a year and is licensed to serve up to twenty-four residents for runaway and emergency shelter services. The youth shelter is contracted to serve both CINS/FINS youth and children placed by the Department of Children and Families (DCF). The youth shelter utilizes effective documentation practices in the agency's program logbook. The agency has also provided new Youth Development training to staff members. At the time of this onsite Quality Improvement (QI) review, the shelter had six CINS/FINS youth. Youth in the shelter at the time of this onsite review responded to an online survey. These residents reported that they feel safe and that they had not witnessed or experienced any adults threatening any residents.

3.01 Shelter Environment

Satisfactory
 Limited
 Failed

Rating Narrative

YFA- George Harris Youth Shelter maintains a safe, clean, and well maintained shelter.

The youth dorm and bathrooms were very clean. Daily schedule was posted in several locations for the youth. Those areas included the great room, dining room, boys and girls dorm board. The youth have access to the 4-week meal cycle which is posted on their dorm board and in the great room.

The Shelter is current on all health and safety inspections. The DCF license expires on December 18, 2014.

The agency has very good relationship with several clubs that volunteer and provide food once a month for the youth at the shelter. They are the Leadership Council, Youth for Christ, and Crikket Club.

3.02 Program Orientation

Satisfactory
 Limited
 Failed

Rating Narrative

The agency has a policy and procedure in place that addresses the program orientation process. During intake, the staff will complete an intake packet with the youth and parent (if available) in an intake room. The youth is given a tour of the facility to familiarize them with the program, rules, expectations of the program and egress system. The staff will introduce the youth to other youth and staff. This helps the youth to feel welcome and safe.

Reviewed eight of eight files and all files had documentation that the youth received an orientation to the program. The youth and staff initialed and dated when this was completed.

3.03 Youth Room Assignment

Satisfactory
 Limited
 Failed

Rating Narrative

The agency has a policy and procedure in place for youth room assignment. Reviewed eight (8) files and all files had an admission sleeping assignment form located in their file. Also, an alert system is in place if a youth is admitted with special needs or risks. Each youth file had an alert for medical or allergies placed on the outside of the their file.

3.04 Log Books

Satisfactory Limited Failed

Rating Narrative

YFA - George Harris Youth Shelter maintains three logbooks. There is a shift, girls, and boys dorm logbook. The shift logbook documents the routine activities, events and incidents. When the staff comes on shift, they review the shift logbook for the last two shifts in order to be aware of any important information and sign that they have reviewed the logbook. The dorm logbooks contain the youth counts and where the youth is located. The logbooks were reviewed weekly by the Director.

Rating Narrative

YFA - George Harris Youth Shelter has a written Youth Development System (YDS) which consist of three levels with varying time frames and objectives. The three levels are orientation, education, and graduation.

When a youth comes into the program, they are placed on orientation level for three (3) days. After the third day, they will move up to education level for five (5) days and then to graduation. If they violate on any level by getting three (3) minors or one (1) major, then they will be placed on reflection for three (3) days. This will give the youth time to reflect back on their actions and think about how they can do better. The youth can request to move to the next level during house meeting and the youth care staff will determine if they are eligible.

The agency did not have any grievances during this review period.

3.06 Staffing and Youth Supervision

Satisfactory Limited Failed

Rating Narrative

The agency has a policy and procedure in place that addresses the staffing and youth supervision. YFA - George Harris maintains a staffing ratio as required by Florida Administrative Code. There is always at least one staff on duty of the same gender as the youth. Staff utilize the shift lead logbook to sign in when they are on duty.

3.07 Special Populations

Satisfactory Limited Failed

Rating Narrative

The agency has a policy and procedure in place that addresses the standard. Three (3) of the eight (8) files reviewed were DV youth. All three (3) files had evidence of being screened and referred by the JAC. Each youth admitted to the DV program length of stay were less than six (6) days. A case plan is not developed until the youth has been in the shelter for seven (7) days. Since each DV youth reviewed were in the shelter less than six (6) days, the counselors met with the youth and discuss the youth's situation for being placed in the shelter. The counselor also make contact with the legal guardian to discuss the situation. Documentation is noted on the progress note. The youth participates in the life skills group while they are in the shelter. When the youth were discharged, the youth were referred to various community organizations for services.



Standard 4: Mental Health/Health Services

Overview

Rating Narrative

Youth and Family Alternatives (YFA) has screening systems and processes to detect general health and mental health risks presented by prospective residents. This process requires that each resident that meets CINS/FINS eligibility requirements be screened by staff members for the severity of potential health and mental health issues. Designated trained YFA residential and non-residential staff members utilize agency screening forms that include the general screening form, CINS Intake form, Psycho-Social Assessment and the Evaluation of Imminent Danger for Suicide (EIDS). The CINS intake form includes a health screening section that is required to be completed by staff members. The agency also utilized a Suicide Risk Assessment instrument that is conducted on youth that indicate a positive "hit" on the CINS Intake form. The agency's staff members consult directly with the Program Director who is a Licensed Clinical Social Worker (LCSW). All YDS staff members at the youth shelter are trained on the suicide risk screening process and utilize the CINS Intake form to screen for potential risks prior to placing all youth on sight and sound supervision status. The agency utilizes an effective color-coded general alert system that informs direct care staff of the youth's health, behavior or mental health status. The agency also documents any youth that has received onsite or offsite first aid or medical care. Staff members are trained on safety and first aid training topics as confirmed by documentation in training files.

4.01 Healthcare Admission Screening

Satisfactory
 Limited
 Failed

Rating Narrative

There is a written policy in place for Health Care Admission Screening and Ongoing Monitoring.

Five (5) residential files have been reviewed. A preliminary health screening was located in all five files. In addition to the CINS/FINS Intake Form, a YFA Health Screening form was also located in all five files. Three (3) files contained documentation of referrals mailed to parents. The other two (2) youth were already connected with community resources.

One youth was temporarily released to parent(s) to participate in community counseling appointments, which demonstrated supporting continuity of care.

4.02 Suicide Prevention

Satisfactory
 Limited
 Failed

Rating Narrative

Five residential files have been reviewed. Each file had the CINS/FINS Intake Form with the suicide risk questions answered. All five youth were placed on sight and sound. Three youth were placed on sight and sound as a result of their answers. Two youth were placed on sight and sound as a precaution related to their history; they did not have yes responses to the risk questions. This is considered above the standard and demonstrated best practices toward well being of the youth. The sight and sound logs were observed in all five files. The sight and sound documentation is every five minutes, in excess of the standard of at least every thirty minutes. The EIDS was used to further assess the risk level of all five youth. The supervision level was changed within the standard practice for all five youth.

4.03 Medications

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place for medication storage, access, and inventory. The shelter had a list of staff members that are designated to have access to medications. All medications in the shelter are stored in a designated separate secure room. This room features a separate storage cabinet with double locking doors that are inaccessible to youth. Oral medications are stored separately from topical medications. There were no injectable medications on site, or identified as needed for any youth during the time of the review. The shelter has a system in place for refrigeration of medication if needed, however there was no medication that required refrigeration during the time of review.

There were four closed files reviewed for medication administration. All four files documented the prescriptions were verified with the parent and the pharmacy. All four files contained the youth's Prescription Medication Log Sheets. These log sheets documented the youth names, date of birth, any allergies, side effects of the medication, dosage, instructions, and medical conditions. Each log sheet documented when the medication was given, staff signature, youth signature, and perpetual inventory with running balance. All four files documented the youth's medications were given as required.

All medications are inventoried three times each day, on each shift, and also by maintaining a perpetual inventory. All four files reviewed contained a Daily Shift Medication Count form that was completed for each medication the youth was on. There was documentation in all four files that medications were counted three times every day. When the youth are released from the shelter the staff complete the Medication Release Form, which documents all medications the youth was taking and how much is left of each medication. This form is signed by the staff and guardian upon returning the medication to the youth's guardian.

A review of staff training files revealed staff have been trained in the medication administration process.

4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

Rating Narrative

There is a written procedure for Medical and Mental Health Alert System. The alert system is also noted in the Health Care Admission Screening and Ongoing Monitoring policy. The alert system consists of the letters A through H with each letter representing a different alert. A form is placed in the front of each youth's file that documents each alert the youth is on and the reasons for the alert. The alerts are then documented on the outside front cover of the youth's file so it is easy of staff to glance at the file and know what alerts each youth has.

One file had inconsistencies in the alerts. The alert system form identified A B C D H at the top, while A B C D F G were specified. The folder label identified A C D H. The counselor identified that B was denied at intake and revealed during the needs assessment, therefore it was added to the alert system form. It was missed on the label. The use of H instead of G on the top of the form and the label appeared to be an error. This did appear appear to impact service delivery to the youth. There was a referral related to B at discharge.

4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

Rating Narrative

There is a written procedure in place for Episodic/Emergency Care System.

Knife-for-life was located in the kitchen, med room, and file room. First aid kits/supplies were located throughout the building.

The incident report notebook was reviewed for the past six months. There was one incident of off site emergency medical care. The youth was taken to regional medical center, treated, and released. An incident/complaint form, that serves as the daily log for the program, was reviewed.

The parent/guardian was notified.

Five(5) residential files were reviewed. There was no apparant identified need for off-site episodic/emergency care in those cases. It is noted that one youth was taken to the ER by parent(s). There was a temporary release form in the file. Copies of the ER discharge paperwork were observed in the file.

The program conducts quarterly mock emergency drills. They simulated a suicide attempt in March. They simulated a client overheating on a basketball court in May. They simulated a snake bite in September.