Florida Network of Youth and Family Services Quality Improvement Program Report

Review of YFA-George W Harris

on 09/26/2012

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 Interagency Agreements and Outreach	Satisfactory
1.06 Disaster Planning	Satisfactory
1.07 Analyzing and Reporting Information	Satisfactory

Percent of indicators rated Satisfactory:85.71%
Percent of indicators rated Limited:14.29%
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/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 Youth Room Assignment	Satisfactory
3.02 Program Orientation	Satisfactory
3.03 Shelter Environment	Satisfactory
3.04 Log Books	Satisfactory
3.05 Daily Programming	Satisfactory
3.06 Behavior Management Strategies	Satisfactory
3.07 Behavior Interventions	Satisfactory
3.08 Staffing and Youth Supervision	Satisfactory
3.09 Staff Secure Shelter	Satisfactory

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

Standard 4: Mental Health/Health Services	
4.01 Healthcare Admission Screening	Satisfactory
4.02 Suicide Prevention	Satisfactory
4.03 Medications	Limited
4.04 Medical/Mental Health Alert Process	Satisfactory
4.05 Episodic/Emergency Care	Satisfactory

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

Overall Rating Summary

Percent of indicators rated Satisfactory:92.86%
Percent of indicators rated Limited:7.14%
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

Mark Shearon-FL Network Peer

Karen Mersinger-FL Network Peer

Jackie Esposito-FL Network Peer

Tina Levene-DJJ Peer

Persons Interviewed

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

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

0 Maintenance Personnel
5 Program Supervisors
2 Other

Documents Reviewed

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

0 Health Records
0 MH/SA Records
6 Personnel Records
40 Training Records/CORE
Youth Records (Closed)
Youth Records (Open)
Other

Surveys

0 Youth | 0 Direct Care Staff | 0 Other

Observations During Review

- [ ] Admissions
- [ ] Confinement
- [ ] Facility and Grounds
- [ ] First Aid Kit(s)
- [ ] Group
- [x] Meals
- [ ] Medical Clinic
- [x] Medication Administration
- [ ] Posting of Abuse Hotline
- [x] Program Activities
- [x] Recreation
- [x] Searches
- [ ] Security Video Tapes
- [ ] Sick Call
- [ ] Social Skill Modeling by Staff
- [ ] 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

Strengths and Innovative Approaches

Rating Narrative

George Harris Youth & Family Alternatives in Bartow, FL was more than cooperative with the review team. The Program Director, staff and youth were available to offer assistance in any supporting documents, interviews, surveys and paperwork needed in order to complete the QI review. This reviewer found their files to be organized, clearly concise in documentation and thorough. Every file reviewed had documentation in the same location with a tab finder indicating location within the file. This reviewer found it is easy to navigate through files, documentation, admission and discharge (if applicable) summaries, as well as case plans. George Harris Youth & Family Alternatives displayed both professional staff and respected youth at this time of review. Most of the case plans, assessments and documentation required for each youth was completed within a few days of admission. This reviewer found it a pleasure to assist with this review of George Harris Youth & Family Alternatives.

The Street Outreach program utilizes social media including YouTube to increase community awaress of services provided by the shelter, non-residential program and Safe Place.

The Florida Department of Juvenile Justice (DJJ) is the State of Florida's agency that is responsible for Prevention and Intervention Services that provide programming and services to reduce juvenile crime and increase public safety. According to Florida Chapter 984 the state must provide a continuum of services to prevent Status Offenders from entering the Juvenile Justice system. These services are typically referred to as for Children in Need of Services and Families in Need of Services (CINS/FINS). The Lead Agency for Children in Need of Services and Families in Need of Services (CINS/FINS) Services for the State of Florida is the Florida Network of Youth and Family Services (FNYFS). Youth and Family Alternatives contracts with the Department of Juvenile Justice, through the Florida Network of Youth and Family Services, Inc., (FNYFS) to provide residential and nonresidential services for youth and their families in Polk, Highlands, and Hardee Counties.

The agency promotes its broad range of service offerings to youth and families in need in this region. The agency has multiple interagency agreements with local community stakeholders and partners. The agency places a high degree of importance on creating opportunities and that promote getting the word out through its street outreach and community partnership efforts. A large part of these efforts go to promoting its residential and non-residential CINS/FINS services. The agency has community partners in key areas that local schools, law enforcement, local mental health and receiving facilities, local area businesses, faith–based organizations and various other community-based organizations. Along with LSF NW these community partners provide an array of services that help to work with youth and their family to resolve family issues and increase family stabilization and unification.

Both residential and non-residential staff members or Youth and Family Alternatives, Inc. were very cooperative with the Quality Improvement (QI) review team in all phases of the review process. Prior to the QI Team's on-site visit, the agency's personnel were notified of the monitoring visit and informed how to obtain all of the current monitoring tools that were to be utilized. All of the staff members were prepared for the onsite review and cooperative with the monitoring team which created a productive and hospitable monitoring environment.

The agency has an active Street Outreach component that markets all of the agency's service offerings. The agency also has an active eighteen (18) member Board of Directors that provides leadership, support and promotes the agency's services throughout the service region. The Outreach staff members conduct presentations to various entities, organizations, human service agencies. Agency information is also presented to interested persons and/or groups, community provider meetings and at community events. The agency also distributes information cards and brochures. Youth and Family Alternatives promotes the National Safe Place Program and secures numerous safe place sites throughout their service area. The program has grant funds the Department of Health and Human Services to conduct street outreach activities to support these efforts. Through this grant, materials such as hygiene products, blankets, tee-shirts, snacks and bottled water, as well as information about the services provided at the shelter, are provided to at-risk youth. In addition, the agency has recently received funding support from Publix Supermarkets, CSX and Bach Tower. The agency also has posted an informative video featuring its services on the internet website Youtube. Further, the agency has invested in producing professional full color marketing materials that include tri-fold brochure, booklets and seasonal newsletters.

The agency also has two (2) licensed staff members at the youth shelter that assist with review all youth placed on elevated or sight and sound supervision status.

Standard 1: Management Accountability

Overview

Narrative

The shelter employs a Director, a Residential Supervisor, a Team Leader, a therapist, two (2) counselors, three (3) Shift leaders, ten (10) Youth Development Specialists, two (2) Outreach Caseworkers and an Office Specialist. At the time of the onsite Quality Improvement review, the agency reported having 1 vacant full-time YDS position and 1 part-time YDS position.

Youth and Family Alternatives, Inc. is accredited by the Council on Accreditation (COA). Their current (COA) Accreditation is active through October 2012. The program's Continuity of Operations Plan (COOP) was approved by the Florida Network in May, 2012.

1.01 Background Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

1.01 Background Screening of Employees/Volunteers

Six (6) of six (6) personnel files reviewed had completed background screenings of employees prior to hire. Four (4) of six (6) employees were re-screened for the required five (5) or more years of employment. Six (6) employees were found eligible for this QI; no employees were applicable for exemptions obtained prior to working with youth (if rated ineligible).

The Annual Affidavit of Compliance with Good Moral Character Standards (Form IG/BSU-006) were completed by the program and sent to the DJJ Background Screening Unit by January 31st of each year. YFA George Harris is in compliance with this standard as indicated by the Program Director submitted verification to Keith Carr.

1.02 Provision of an Abuse Free Environment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy on Abuse Reporting and general Reporting requirements. Additionally, the agency has policies on De-escalating Conflict RM 750. The agency provided documentation of all internal incidents, DJJ CCC Incidents, Grievances, and Agency disciplinary infractions or work performance issues. The agency reports that it has seven (7) documented DJJ CCC reports, two (2) documented resident Grievances, and four (4) documented internal agency action reports. A review of the aforementioned reports was conducted. Two (2) grievances documented as occurring on the same day involving the same youth and staff member. The grievances indicate behavior by a staff member that the resident states as making him feel that he's been threatened. In both of these cases, management reviewed the cases and verbally discussed the incident with the staff member involved as being inappropriate. No written documentation was provided related to management's efforts to address these examples of inappropriate behavior by the staff member towards the youth that filed the grievances. Both grievances also lack follow-up and evidence that the grievances had been reviewed and signed by the agency Program Director.

The agency provided documentation on four (4) agency action reports that cited behavior contrary to employee behavior requirements. Of these documented internal write ups, two (2) involved staff persons that were found to have committed fraudulent medication documentation entries. Both of these employees had incidents that were called into the DJJ CCC and both were subsequently terminated by the agency. Another staff member was suspended and later terminated for writing and inappropriate letter to a resident. In addition, the agency currently has an open case that involves the same employee that is alleged by a resident to have threatened them during his stay at the shelter. The agency has placed this staff person on paid administrative leave and the staff person is under investigation by both DCF Child Protection Investigation and the DJJ Office of the Inspector General.

Management demonstrates that written measures are in place to address incidents of physical and/or psychological abuse, verbal intimidation, use of profanity and/or excessive abuse. In addition, staff members are required to use crisis intervention techniques in an attempt to resolve issues of indifference with both youth and co-workers.

1.03 Incident Reporting

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

1.03-Incident Reporting:

Agency has a current policy in effect: RM830, RM840, and RM850.

Policy #RM830 specifies documenting incidents pertaining to youth/staffs health/safety, property damage and/or places YFA George Harris at risk or may cause media publicity (that would cause a negative image of shelter).

Policy #RM840 specifies distribution of reports to appropriate departments along with proper procedures to be followed.

Policy #RM850 specifies the reviewing of incidents to analyze and critique the protocol followed by staff that satisfies this Incident Reporting Policy.

The agency policy meets the reporting requirements. All onsite documentation of internal reports were available for review during this QI.

CCC incidents between March 1, 2012 and September 25, 2012, were obtained for this QI. A total of seven (7) incidents were reported by the CCC. The write ups are legible and clearly describe the 7 incidents. Two (2) of the seven (7) incidents reported on CCC consisted of inappropriate actions by staff with youth. One (1) incident reported on March 25, 2012 consisted of a substantiated finding as an Improper Conduct/Staff-Youth Relationship. The suspected staff member was suspended with pay pending the outcome of the investigation. An update was given at the time of QI, that staff member involved with that incident was terminated. The other incident reported which occurred on September 19, 2012, was classified as Improper Conduct/Sexual Nature between a staff and youth. The suspected staff has been placed on suspension with pay until the conclusion of the internal investigation.

Two (2) interviews were conducted with one (1) staff member and one (1) youth to indicate that staff and youth are familiar with reporting procedures and requirements. Mike N. is a fourteen (14) year old youth that has been living in the shelter for 2 weeks now. Youth has previously resided in this shelter five (5) times in the past since the age twelve (12). The longest period of time this youth has resided at the shelter has been forty (40) days. Mike N. indicated that if an incident occurred, he has been instructed to write a grievance and/or call the abuse hotline depending on the incident. Youth said he would tell his counselor and/or the Program Director, Mr. Glenn as soon as possible. The youth indicated that he would report incidents such as fights between youth and staff, and any violent acts. Youth reported that he has not reported or experienced any emotional or sexual abuse in this shelter.

The other interview was conducted with a staff member, Augustine R. (AYD Specialist); she has worked for YFA George Harris for 14 years. Staff indicated that she is aware of the policy of reporting incidents as soon as possible. Staff reported that she is to call the abuse hotline, fill out incident report paperwork, and give the paperwork to the Program Director, Mr. Glenn as soon as possible. Grievance forms are given to youth by this staff upon request and submitted to the supervisor. Incidents that should be reported are sexual, fights (any kind of violence), medical, any abuse, anything drug related and/or staff/youth altercations.

Two (2) grievances were reported at the time of QI. The same staff member was identified in both grievances with the same youth on July 7, 2012. The staff member also had a CCC incident report in September 2012 for Improper Conduct/staff-youth.

1.04 Training Requirements

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

The program has a written policy and procedure to address staff training requirements for CINS/FINS residential and non-residential programs. In addition, the program establishes an Individual Training Plan for each employee. The plan contains all mandatory training topics required by the indicator as well as additional training opportunities. The program maintains an individual training file for each employee, which includes an annual employee training hours tracking form and supporting documentation that includes certificates and sign-in sheets. Training is scheduled throughout the year and is provided by the Florida Network, local resources and YFA supervisory staff.

A total of 6 training files were reviewed to assess compliance with this indicator. 4 were assessed for compliance with first year requirements and 4 were assessed for compliance with annual requirements. Of the 4 files assessed for compliance with first year training requirements, 4 met the 80 hour requirement. However, 3 of 4 were missing at least 1 required component: 1 CINS/FINS Core training, 2 Mental Health and Substance Abuse, and 1 Cultural Competency. Of the 4 files reviewed for compliance with annual training requirements, 3 met the 40 hour training requirement established by YFA. Of these 4 files reviewed, 3 were missing at least 1 required component: 2 Suicide Prevention, 2 Mental Health and Substance Abuse, 2 Universal Precautions, and 2 Cultural Competency. All 4 staff received refresher training regarding fire safety equipment and training to maintain CPR and First Aid certifications.

While the program's Training Plan contains all mandatory training topics, the template used in the 6 files reviewed was last updated in October 2008. The program's policy and procedure contains a template that was updated in September 2011. It is recommended that the program ensure the new Training Plan template is used as required.

Of the 4 files assessed for compliance with first year training requirements, 3 of 4 were missing at least 1 required component: 1 CINS/FINS Core training, 2 Mental Health and Substance Abuse, and 1 Cultural Competency. Of the 4 files reviewed for compliance with annual training requirements, 3 met the 40 hour training requirement established by YFA. Of these 4 files reviewed, 3 were missing at least 1 required component: 2 Suicide Prevention, 2 Mental Health and Substance Abuse, 2 Universal Precautions, and 2 Cultural Competency.

1.05 Interagency Agreements and Outreach

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a written policy regarding public awareness and outreach activities targeting youth and families in need of services. Youth and Family Alternatives, Inc.'s CINS/FINS Program submitted Interagency Agreements to the three local school boards in the counties served for the 2012-2013 fiscal year: the Polk County School Board, Highlands County School Board and Hardee County School Board. The agreements establish the services to be provided as well as the referral process. While the program contains an Interagency Agreement binder, it appears some agreements are over 3 years old. It is recommended the program update these agreements.

The program maintains strong community partnerships with mental health and substance abuse providers in the three counties served, including Peace River, Tri-County and Lakeland Hospital. These providers offer services to clients in accordance with their service plan. In addition, Planned Parenthood, Peace River and Tri-County provide sex education, healthy relationships training and substance abuse education (respectively) to shelter youth regularly. Program staff are active members of local community boards, task forces, and clubs. Local elected officials are also active supporters of the program.

The program has 2 Street Outreach case workers responsible increasing community awareness, offering informational and educational services, and distributing health/hygiene and food/drink items to youth and families in need. The program works to increase community awareness, and offers informational and educational services to youth and families, related to: drug and alcohol use/abuse; adolescence/adolescent behavior; parenting/family; educational issues; food and hygiene; rape crisis/sexual abuse; and general information about the CINS/FINS program and Safe Place. The 2 Street Outreach counselors participate in activities including group presentations, community events, group discussions, media events and individual meetings. Counselors also hold open houses for the shelter and innovatively create and post videos on YouTube intended to increase awareness of the shelter and non-residential services offered by YFA.

The Street Outreach component facilitates the Safe Place program which assists youth in crisis and keeps them off the streets. Currently, the program maintains 195 Safe Place sites. This includes 66 stationary sites that include parks/recreation centers, non-profit organizations, fire departments, stores, and health clinics as well as 129 mobile sites (public transportation).

The program maintains a log and documentation of all early intervention, prevention and outreach activities. Information is maintained in a binder and includes but is not limited to the number of people who attend tours and/or speaking engagements; participation in community forums and events; and distribution of informational and educational materials. This information is entered into NETMIS on a monthly basis.

While the program contains an Interagency Agreement binder, it appears some agreements are over 3 years old. It is recommended the program update these agreements.

1.06 Disaster Planning

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program maintains a comprehensive Disaster Plan for the 2012-2013 fiscal year. The plan includes all elements required by the indicator: local evacuation facilities; procedures to follow in a severe weather warning; conditions under which evacuation would occur; transportation arrangements in case of evacuation; procedures to address bringing food, medications, log books, cell phones, and other necessities during an evacuation; and the process to notify Florida Network. The program also contains procedures for natural disasters (severe heat, severe weather/lightning, flooding, tornadoes, tropical storms, hurricanes, and tropical depressions), man made emergencies (civil unrest, bioterrorist/terrorist acts, nuclear accident, hostage situation, shooting/armed person on site, youth disturbance/riot, chemical spill/hazardous material accident, bomb threat/suspicious devise/object) as well as fires, medical emergencies and power outages. The program also participates in the Universal Agreement Emergency Disaster Shelter with the Florida Network agencies.

6 staff training files reviewed. All 6 received training regarding disaster preparedness. Program staff report receiving training multiple times per year regarding the Disaster Plan. In addition, copies of the Disaster Plan are located throughout the facility and are readily accessible to staff and clients.

1.07 Analyzing and Reporting Information

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Youth and Family Alternatives, Inc.'s CQI Plan for 2012-2013 establishes CQI teams, CQI goals, and documents policies for gathering data, analyzing data, identifying trends and making recommendations for program improvement. The program is nationally accredited by the Council on Accreditation and has a comprehensive CQI process that meets accreditation standards. The program collects and reviews several sources of information to identify patterns and trends. This includes: yearly record reviews; client satisfaction surveys; consumer grievances; incidents

and accidents; NETMIS data; and Florida Network reports.

The organization maintains multiple committees responsible for gathering and analyzing data and information. Youth and Family Alternatives, Inc. maintains a Peer Review Committee that is responsible for reviewing case records in YFA operated programs. The policy indicates that record reviews are completed yearly and a written report with the findings is provided to the Program Director. The Peer Review Committee is responsible for identifying positive and negative trends in case file documentation and provides feedback to program management regarding trend data and makes recommendations for enhancing quality documentation. The Peer Review Committee is also responsible for submitting quarterly reports to the CQI Council regarding quarterly reviews, positive and negative trends and recommendations for improvement.

The organization also holds Stakeholder Involvement Team meeting which review consumer satisfaction survey results for each program to identify issues and request follow-up from programs when needed. In addition, the program holds Outcome Measurement Team meetings bi-monthly to assess whether agency performance outcome measures are being met, makes recommendations/request follow-up action from programs regarding trends and monitors the effectiveness of follow-up action. The organization also holds Risk Prevention Team meetings quarterly to review incident reports and consumer grievances. Aggregate incident, accident and grievance report data is also distributed to senior management quarterly as part of the CQI Process. This data is also presented to the CQI Council.

Program policies indicate that the organization's Data Management Department is responsible for providing NETMIS and Florida Network data to the program. Program data reports from NETMIS and Florida Network are sent to senior management monthly and discussed at monthly Management Team Meetings. Reports are reviewed to assess accuracy, compliance with contractual requirements and program performance. In addition to reviewing NETMIS and Florida Network reports, the Monthly Management Team Meetings review monthly incident reports, Title IV-E, data questions, and HIPPA. In addition, Corrective Action Plans resulting from record review results are reviewed, as well as recommendation from the CQI Committee. Program policies also indicate that data is communicated to stakeholders during board meetings, Youth Leadership Council meetings, management meetings and other workgroups and task forces. Meeting agendas and meeting minutes were reviewed to confirm compliance with the agency's CQI policies.

In speaking with program staff and reviewing agency policies, there is not a clearly documented process for relaying issues/concerns to staff, implementing recommendations for improvement, and following-up with the program to assess whether recommendations are implemented and issues/concerns are resolved/improved. The process in place consists of the Program Director addressing issues/concerns identified by the Risk Management, Management Team, Record Review Team and CQI Team either one on one with staff or at monthly staff meetings. Staff meeting minutes were not available for this reviewer to assess whether issues identified during the previous record review in March 2012 were addressed with program staff. Management reports that while issues identified during the record review were addressed one-on-one with staff, there has been no follow-up to assess whether recommendations made by the Peer Review Team were implemented and whether interventions led to program improvement. Staff meeting agendas were available for review and there is evidence to suggest that incident/accident reports are addressed at staff meetings when there is cause for concern. Management reports that client satisfaction survey results, NETMIS reports and Florida Network outcome data are not usually addressed with staff.

YFA is in the process of re-vamping its CQI process. The program recognizes the need to further involve staff in the CQI process by enhancing communication regarding data, outcomes, record review results, client satisfaction survey results, incident/accident trends, etc. The program also recognizes the need to devise a follow-up mechanism to assess whether program recommendations are carried out by staff and whether interventions lead to program improvement. Senior management reports that other YFA programs began implementing a CQI Follow-Up Worksheet in July 2012, and this program will be trained in the process soon.

One exception to this standard is that record reviews are not completed on a quarterly basis. However, the residential and non-residential Program Directors report that case files are reviewed regularly for compliance and staff are notified when there is a concern.

One exception to this standard is that record reviews are not completed on a quarterly basis. However, the residential and non-residential Program Directors report that case files are reviewed regularly for compliance and staff are notified when there is a concern.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

The nonresidential component consists of a Non-Residential Program Manager, two (2) full-time Counselors in the Bartow area and a Counselor in the Highlands service region. The agency is contracted to provide residential and nonresidential CINS/FINS services to youth and families residing in Polk, Highlands and Hardee Counties. The non-residential component of the program consists of a Program Manager, a therapist that is a Licensed Mental Health counselor, a Master's level counselor and a Bachelor's level counselor.

The program provides non-residential services that are provided at the agency's office, local schools, and at the offices of other community based organizations. At the time of the Quality Improvement review, the program has provided non-residential services to more nearly forty (40) families over the last 6 months.

The The agency has been servicing increased numbers of youth and families in the Lakeland service region. The non-residential program is involved in working with the residential program staff using the Pillars of Development and Outcomes of Character. The non-residential staff members are still involved in a community-based organization Stand-Up Polk. Further, the non-residential staff are still using the Why Try program that is used to address family issues with both youth and parents.

2.01 Screening and Intake

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

2.01 Screening and Intake

Eight (8) of eight (8) youth files (four (4) active/four (4) closed) were compliant when reviewed for eligibility screening within seven (7) calendar days of referral by a trained staff member using the NetMIS screening form. Eight (8) of eight (8) youth files (four (4) active/four (4) closed) were compliant with providing youth and parents/guardians receiving available service options, Rights and Responsibilities of youth and parents/guardians, and receiving the parent/guardian brochure. Eight (8) of eight (8) youth files (four (4) active/four (4) closed) were compliant with providing the youth and parents/guardians with possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication). Eight (8) of eight (8) youth files (four (4) active/four (4) closed) were compliant with receiving information about Grievance Procedures.

2.02 Psychosocial Assessment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

2.02 Psychological Assessment

Eight (8) of eight (8) youth files (four (4) active/four (4) closed) were compliant with conducting a Psychosocial Assessment within 72 hours of admission (for youth in shelter care). Three (3) of the eight (8) youth files received the Psychosocial Assessment the same day as admission. Eight (8) of eight (8) youth files (four (4) active/four (4) closed) were compliant with completing a Psychosocial Assessment within 2 to 3 face-to-face contacts after the initial intake or updated, if most recent assessment is over six (6) months old. Four (4) of the eight (8) files had updated Psychosocial Assessments completed due to six (6) months old assessments from prior admissions. Eight (8) of eight (8) youth files (four (4) active/four (4) closed) were compliant with a Bachelor's or Master's level staff member completing the Psychosocial Assessment. Eight (8) of eight (8) youth files (four (4) active/four (4) closed) were compliant in having a Supervisor review signature on the Psychosocial Assessment upon completion. One (1) Supervisor signature date was four (4) months and four (4) days after Psychosocial Assessment was completed. Eight (8) of eight (8) youth files (four (4) active/four (4) closed) were compliant with evaluating the risk of suicide with one (1) youth having an elevated risk of suicide as a result of the Psychosocial Assessment. That one (1) youth was under direct supervision of a licensed mental health professional.

2.03 Case/Service Plan

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

2.03 Case/Service Plan

Eight (8) of eight (8) case/service plans reviewed were developed within 7 working days of Psychosocial Assessments. Two (2) case/services plan were developed the same day as admission. Eight (8) of eight (8) case/service plans reviewed were individualized and prioritized need (s) and goal (s) identified by the Psychosocial Assessment.

Eight (8) of eight (8) case/service plans reviewed included the following service type, frequency, location, person responsible and target dates for completion.

Three (3) of eight (8) case/service plans reviewed included the actual completion dates. Four (4) of eight (8) case/service plans reviewed did not include an actual completion date due to the clients still working toward their goals. All four (4) case/service plans were admitted in September 2012.

Eight (8) of eight (8) case/service plans reviewed included youth signatures, counselor signatures and supervisor signatures.

Seven (7) of eight (8) case/service plans reviewed included the date the plan was initiated.

Four (4) of eight (8) case/service plans reviewed for progress/revised by counselor and parent (if available) every thirty (30) days for the first three months and every six (6) months. Four (4) of eight (8) case/service plans were not reviewed for progress/revised by counselor and parent (if available) every thirty (30) days for the first three months and every six (6) months due to the admission date being in September 2012 (it has not been thirty (30) days yet).

One (1) of eight (8) case/service plans reviewed did not include an actual completion date for a client that was discharged for June 7, 2012.

One (1) of eight (8) case/service plans reviewed did not include a date the plan was initiated. The reviewer had to search for the date near the bottom of the page by the counselor signature.

Four (4) of eight (8) case/service plans reviewed did not include a parent/guardian signature on the case/service plans in the file. Two (2) parent/guardians met with the counselor as indicated in the case notes; however, a signature was never captured on the case/service plans. Two (2) parent/guardians spoke to the counselor on the phone; however, it was not indicated on the case/service plan that a parent/guardian was notified of such a plan.

2.04 Case Management and Service Delivery

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

2.04 Case Management and Service Delivery

Eight (8) of eight (8) cases reviewed were assigned a counselor/case manager. Eight (8) of eight (8) cases reviewed included that the counselor/case manager completed the following: establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs. Eight (8) of eight (8) cases reviewed included that the counselor/case manager completed the following: coordinated service plans implementation, monitored youth's/family's progress in services and provides support for families.

Eight (8) of eight (8) cases reviewed included that the counselor/case manager did not monitor out-of-home placement due to these all being residential files reviewed.

Eight (8) of eight (8) cases reviewed included that the counselor/case manager completed the following: establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs.

Eight (8) of eight (8) cases reviewed included that the counselor/case manager completed the following: referrals to the case staffing committee, as needed, to address problems and needs of the youth/family, refers the youth/family for additional services when appropriate and provided case monitoring and reviews court orders. Three (3) of eight (8) cases reviewed included that the counselor/case manager did not accompany the youth and parent/guardian to court hearings and related appointments due to that client not being involved in court services. Five (5) of eight (8) cases reviewed included that the counselor/case manager accompanied youth and parent/guardian to court hearings and related appointments as evidenced by court paperwork being present in the file.

Eight (8) of eight (8) cases reviewed did not provide case termination with follow-up (within 180 days) due to the discharge dates for four (4)files being less than 180 days. Four (4) files are still actively open.

2.05 Counseling Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The Agency's policies for Counseling Services include the requirements for Case/Service Planning that reflects the issues on the intake and Psychosocial Assessments consistent with Standard 2.05. Sixteen files were reviewed:Four (4) Open and (4)Closed Residential Files and Four (4) Open and (4) Closed Residential Files. All of the files reviewed had service/treatment plans which reflected the issues documented on the intake and psychosocial assessments. All treatment/service plans listed treatment methods, responsible party/staff, frequency & time of treatment as well as target dates. In the four(4) Residential Open Files that were reviewed, there was no parent signature on the Service/Treatment Plan but the Counseling notes reflected that contact and discussion of service/treatment plan had been made by a phone call. All Sixteen Files reviewed showed 30 and/or 60 day reviews with signatures as required. Files that required coordination of after-care counseling and/or other services documented the linkage in the after-care plan and discharge summary.

Of the eight (8) non-residential files reviewed, two (2) were missing completion dates for past target dates (6/7/2012 & 8/24/2012).

In the eight (8) residential files reviewed, one was missing 30,60, 90 day completion dates but those dates were on the counseling notes. In all four (4) currently open files had group logs as evidence that groups have been conducted five (5) days a week during their time at this facility. Of the four (4) closed files reviewed, each file had at least one week during their stay at this facility that groups were not conducted five days a week. Two of those weeks did contain a holiday and one was when the facility was closed one day for Hurricane Threat.

2.06 Adjudication/Petitiion Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The Agency has a clearly defined Policy that encompasses all the requirements of Section 2.06. However, no files were available for review for this area. The only petition case was a transfer from Orange County. The case was already adjudicated in the courts when it was transferred to this Agency. The youth’s case was requested to be closed due to her being placed in a statewide Intensive Psychiatric Program and no longer appropriate for the YFA program.

2.07 Youth Records

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

A review of the agencies policies for Youth Records was conducted and found to be inclusive of all requirements of Standard 2.07. All records reviewed were marked “Confidential”.

Non-Residential Records have a page listing Chart Protocol on the top of each side of the page with areas noted and dividers marking subject areas. Residential files also have dividers indicating subject areas. There is a protocol sheet for files that was pointed out to reviewer but it is located under a section. Recommendation would be to put it in a more conspicuous place to be able to locate areas more readily.

All files contained forms located in the appropriate indicated places. Forms were legible and neat.

All open and closed files are kept in a locked room in file cabinets.

Standard 3: Shelter Care

Overview

Rating Narrative

The Youth and Family Alternatives – George W. Harris Runaway and Youth Crisis shelter is located at 1060 US Highway 17 South in Bartow, Florida. This residential shelter operates 24 hours a day, 365 days a year and is licensed to serve up to twenty-four (24) 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 CINS/FINS residential program includes a Program Director, a Team Leader, a Master's level therapist, two (2) Bachelor's level counselors, a Youth Development Specialist (YDS) Team Leader, nine (9) Youth Development Specialists, an office specialist, a receptionist and youth care specialists. The shelter has an effective grievance process, with the forms available to the youth. Youth responded to an online survey and reported that they feeel safe and that they had not witnessed of experienced vey; one rated the grievance process very good, one rated it fair, and one youth never filed a grievance.

The agency provided an Employee Position List of Vacancies that included one (1) YDS Shift Lead, six (6) Part-time YDS staff, 1 Part-time On-Call YDS staff and 1 Part-time YDS Cook position. At the time of this onsite Quality Improvement (QI) review, the GWH shelter had four (4) residents in the youth in the shelter.

The agency has recently completed renovations to the youth shelter that include repainting the exterior and interior walls throughout the youth shelter. In addition, the agency also has two (2) licensed staff members at the youth shelter that assist with review all youth placed on elevated or sight and sound supervision status.

3.01 Youth Room Assignment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There is an agency policy in effect that includes all the components of Standard 3.01 Youth Room Assignment. Eight files were reviewed - four (4) open and four (4) closed. Of those eight files all had documents that recorded information about youth history, status, exposure to trauma, age, gender, history of violence, physical strength, gang involvement or other indicators that could interfere with the safety of a youth in the facility.

Initials interactions and observances are reviewed in the Psychosocial Evaluation and in the sessions with Counselor.

In one (1) chart the Bed Assignment was not listed on the Intake Sheet but was on the Admissions Sleeping Assignment Form. In this record there was no indication of Yes or No on the areas under the bed assignment for gang affiliation, etc but they were answered on the Admissions Sleeping Assignment Form.

The Admissions Sleeping Form is a very informative document which allows for quick review of issues that are helpful in placing youth in a proper and safe bed assignment.

3.02 Program Orientation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

This agency has a comprehensive Policy on Program Orientation that contains all the requirements of Standard 3.02. A total of eight(8)residential files were reviewed - four (4)open and (4)closed. All files contained documentation that Orientation had been provided within the mandated 24 hour period. A checklist of orientation information as well as a House Rule information form, and Handbook Receipt Acknowledgement was signed by resident and staff. Only one closed file contained a possible suicide ideation. In that file, there was documentation of immediate placement on sight and sound and documented observation for the length of time until the in depth suicide assessment was completed. The documentation of the suicide assessment and appropriate signatures removing the youth from sight and sound was readily available in the file.

3.03 Shelter Environment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

At time of the interview the review team was notified by the Program Director that the Agency had received a donation and was able to repaint the inside and outside of the facility and renovate the bathrooms. Which is clear by the good condition that the shelter is in. All Health and safety inspections are satisfactory and completed in the appropriate time frame. The grounds and landscaping are exceptional. The furniture in the facility is well kept and free of any insects. Lighting is very adequate and natural light. The bed linen are clean and well kept and every Client has a safe and secure place to lock personal belongings if requested. The Health Dept did list 5 comments of concerns however the Program Director did write a corrective Action Plan and put it into place right away with speaking to the staff.

Although the facility is very well kept the rooms do have some graffiti in them. The staff tries to keep up with this and when available the maintenance man is asked to work on it too. The last 6 months of fire drills were reviewed and in July there were only 2 fire drills completed that month. All the First aid kits appear complete however only one kit has an eye wash bottle in it and best practice would be that all kits have eye wash placed in them. At end of first day exit interview Program Director provide the review team with bottles of eye wash that he removed thinking they were out dated but after further review they are within compliance and were placed back in the first aid kits.

3.04 Log Books

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The current logbook was reviewed from 4/16/12 to the present day. Any entries that might impact the security and safety of the Clients or program are highlighted. Logbook entries are legibly written. Any mistakes that are made are struck through with a single line and are voided. The Program Director reviews logbooks on a weekly bases as well as the oncoming supervisor and YDS do review the logbook and sign at the beginning of each shift.

For Best Practices each staff making entries in the logbook should print, sign and initial the front of the logbook so that their signatures and initials can be interpreted be outside reviewers. Also, a color code ledger so reviewers will be understand the different entries made. Continuing, best practice would be that the date and shift should be placed on the top of each page to make it easier to find dates of the entries.

Rating Narrative

The Shelter Handbook and the daily scheduled was reviewed as well as an interview with Residential Supervisor. Daily schedule is clearly setup and post in Dayroom and on each wing of the dorm. Clients appear to have activities from wake up to bedtime. Groups are scheduled daily and are given by Counselors or people from the community and are documented in a group logbook. Clients are given time every evening to read and have spiritual time.

With this being a new daily schedule for the Agency the YDS staff need to familiarize themselves more with the schedule to ensure they are executing the schedule properly. Four months worth of Group logs were reviewed and 7 out of the 16 weeks only had four groups were held those weeks.

3.06 Behavior Management Strategies

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

At time of the review the review team was informed by the Program Director that the Agency had started a new Behavior Management System in March of this year. It is a program that is a combination of a points system and a level system. There was 17 staff training files reviewed and out of that only 2 staff had not received the training. Agency policy and procedures are clearly written and list all behavior expectations for both Staff and Clients. The house rules and consequences are clearly posted in Dayroom and on each wing in the dorm. Weekly the counselor, residential supervisor, and client meet to discuss the progress of clients behavior and goals for the client. As the client advances in his/her levels they take charge of evaluating themselves. Client and staff surveys were reviewed and 5 out of 5 staff report that clients are not sent to their rooms as a punishment but 4 kids were surveyed and 3 of the 4 stated they have never been sent to their room for punishment but 1 client did state they were sent to their room but the room door was left open.

With this being a new program for this agency they are still working out the kinks that are associated with that. After interviewing the Residential Supervisor there is a clear rewards system in place however, there is nothing posted anywhere in the policy and procedures nor the public areas that would let anyone know what the rewards are except for asking someone.

3.07 Behavior Interventions

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program maintains a written policy regarding Behavioral Interventions. The policy indicates that physical intervention is used only as a last resort after preventative one-to-one intervention and de-escalation fails to protect the youth from imminent harm to self and others. The policy prohibits use of the following interventions: seclusion, mechanical/chemical restraint, group punishment, privilege suspension, corporal punishment, use of adverse stimuli, withholding nutrition or hydration, demeaning language, unnecessary punitive restriction, forced physical exercise, punitive work assignments, punishment by peers, and withholding clothing, regular sleep, health services, participation in educational activities, contact with parents, legal assistance, or religious needs. The policy also prohibits using room restriction to prevent the youth from participating in routine activities.

Youth and parents/guardians are informed of behavioral intervention practices at intake and are required to sign an acknowledgement form that specifies circumstances under which restrictive interventions may be used by trained staff. If an intervention is used, the program's procedure requires staff to complete a de-briefing 24 hours after an incident involving the use of physical restraint. The debriefing includes the youth, parent/guardian, staff involved, the youth's counselor, the program director and vice president. In addition, an administrative review of the physical restraint occurs within one working day following the event by the Critical Incident Review Team and shelter management. The purpose is to critique the event to determine if the physical restraint was consistent with YFA policies and procedures and if not, if there is a need for additional training or modification of procedures. Program staff report not having to engage in physical intervention in years. Therefore, this reviewer was unable to assess whether this procedure has been followed in practice.

The program's policy indicates that all direct care staff receive training regarding the use of behavioral intervention techniques. The policy indicates that only staff trained in the use of physical restraints by a certified trainer endorsed by the Florida Network and Florida Department of Juvenile Justice may engage in physical interventions. 8 training files were reviewed to assess compliance with this standard. Of the 8 files reviewed, 6 received Crisis Intervention/Physical Intervention training by a certified trainer approved by the Florida Network. This training is offered yearly, and the 2 employees who have not received the training were hired within the last 6 months.

6 youth files were reviewed to assess use of the Behavior Management Acknowledgement Form. Of the 6 files reviewed, 6 contained the form which was signed and dated by the youth, his or her parent/guardian and staff.

9 surveys were reviewed to assess this standard: 3 youth and 5 staff. All 5 staff report never observing a co-worker use profanity toward a youth; using threats, intimidation, or humiliation; or placing a child in their room for isolation or punishment. All 3 youth surveyed state that staff are respectful to youth and report never hearing adults threaten youth or use curse words when speaking to youth. All 3 youth also report never being sent to their room for punishment. Grievances were also assessed and there is no indication that practices are inconsistent with the requirements of this indicator.

3.08 Staffing and Youth Supervision

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The last 6 months of staff schedules were reviewed and all shifts were covered with in ratio and all shifts were covered with at least 1 male and 1 female staff. Also the logbook and client logbook was reviewed and it appears that bed checks were conducted every 15 min through out the overnight.

Upon reviewing the staff schedule it appears there is a lot of overtime by several staff but after speaking to the Program Director and reviewing the Employee positions/ vacancies it is clear that there is many positions open and the Agency is clearly working towards filling those position. Also, Best Practices would be that the overnight bed checks be done on a rotating bases instead of exactly every 15 mins. Continuing it is recommended that maybe an outside company come in and check the camera system to ensure proper recordings are taking place.

3.09 Staff Secure Shelter

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The Agency has a very detailed policy regarding Staff Secure that contains all the components of Standard 3.09. Only one(1)resident had been staff secure in the past six months In accordance with the standard he was court ordered to the Program. Review of this chart showed it met the requirements of an in-depth orientation, admission, assessment and service planning. Log book documents his intake and the assignment of a specific Youth Development Staff on each shift. The counseling sessions were a minimum of five days a week, as required. The after care plan provides for him to continue the counseling he has been referred to. A six month follow-up was not available as he has not been discharged six months.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

Youth and Family Services 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 is screened by staff members for the severity of the 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 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 on the CINS Intake form. Further, the agency's Program Director is a Licensed Mental Health Counselor and oversees the suicide risk screening and assessment process. Specifically, the agency also has two (2) licensed staff members at the youth shelter that assist with the review all youth placed on sight and sound supervision status. These staff persons are primarily responsible for conducting assessments to determine if these youth need to stay on this status or have this level of supervision reduced. 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.

4.01 Healthcare Admission Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

At time of the review there was 6 charts reviewed. Four open and two closed charts. All of the Healthcare screening were initiated at intake and were very well documented. Of the six charts review 2 of the Clients were on medication and that was clearly noted on the form. Three of the 6 had allergies and that was clearly noted on the form and on the front of their charts. Three of the clients had observed scars,tattoos or other skin markings and that was clearly documented on the healthcare form. The Agency has clear policy and procedures on referrals and follow-up medical care. It also explains the involvement that the Agency will have and the parents involvement. The program log does show doctors appts.

4.02 Suicide Prevention

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The shelter had a detailed suicide risk plan that addresses the agency's suicide prevention and response procedures. In addition, the agency has two (2) staff members that are licensed clinicians. The agency's Program Director is a licensed Clinical Social Worker (LCSW) and another staff member is a Licensed Mental Health Counselor (LMHC). The suicide risk policy indicates that all residents admitted to the shelter will be screened for suicidal risk by the six (6) suicide risk questions on the CINS/FINS Intake form. In the event that the resident responds with a "Yes" to any of the 6 questions, a designated Youth Development Specialist (YDS) will immediately places the youth on sight and sound supervision. According to agency policy sight and sound supervision requires that the agency maintain direct supervision of the youth's location and their actions are recorded every five (5) minutes on his/her individual Sight and Sound Supervision form. A monitoring note is required to be documented in the Communication Logbook on every shift informing YDS staff members of the youth's status.

Youth that screen positive on the suicide risk section on the CINS Intake form are then referred for review by a qualified mental health professional to determine the specific level of suicide risk or, if a qualified mental health professional is not available the youth are then placed on Constant Sight and Sound supervision until a full suicide assessment can be completed by a qualified mental health professional. The shelter has two (2) levels of supervision: one to one supervision and constant sight and sound supervision. The current suicide risk policy encompasses all elements of the indicator and complies with the procedures outlined in the Florida Network's Policy and Procedure Manual for CINS/FINS.

A total of five (5) five files were reviewed (5 closed files) contained documentation that indicated a suicide risk screening was completed during the initial intake and risk screening process. All 5 files contained documentation that indicated the suicide screening results were reviewed and signed by the supervisor and the Program Director who is also the licensed clinical social worker. All applicable youth were placed on sight and sound supervision until assessed by a licensed professional or non-licensed staff under the direct supervision of the licensed professional. In all 5 cases the level of supervision was not changed or reduced until approved by one of the agency's licensed staff members. Supportive documentation was reviewed to include precautionary observation logs and 5 minute checks.

The agency's policy requires that a Monitoring Note is completed for every shift to inform all staff of the youth status and recorded in the Communication Logbook. Monitoring notes for 1 youth were not found in the logbook across 2 shifts (1 overnight and 1 day shift). The youth was taken off sight and sound within 23 hours of being placed on this supervision status. Monitoring notes for second youth were not found in the logbook across 2 shifts (youth was admitted to shelter around 1:30, but late entry was not made until end of 2nd shift at 10:00pm. No monitoring notes on youth sight and sound on following morning shift and 2nd shift until youth was discharged). This 2nd youth is documented as being discharged in less than 24 hours. Monitoring notes were not found in the logbook for the 3rd youth across shift 1 morning shift and 2nd

shift for this youth. This 3rd youth is documented in logbook as being discharged in less than 24 hours. This 3rd youth came into shelter with a Baker Act in his history. Youth was placed on sight and sound and taken off per all agency requirements. All requirements and counts are performed and documented as required. Monitoring notes were not found in the logbook for the 4th youth across shift 1 morning shift and 2nd shift for this youth. This 4th youth is documented in logbook as being discharged in less than 24 hours. This 4th youth came into shelter with a Baker Act in his history. Youth was placed on sight and sound and taken off per all agency requirements. All other assessment and supervision requirements and counts are performed and documented as required.

Monitoring notes were not found in the logbook for the 5th youth across shift 1 morning shift and 2nd shift for this youth. This 5th youth is documented in logbook as being discharged in less than 24 hours. This 5th youth came into shelter with a Baker Act in his history. This youth was placed on sight and sound and taken off per all agency requirements. It is recommended that that agency ensure that notes are reflected in the logbook per their agency's policy.

4.03 Medications

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

The shelter has a detailed four (4) page written policy that explains and addresses the documentation, safe distribution, secure storage, limited access, inventory and disposal of medication in accordance with the DJJ Health Services Manual. The program had a typed list of staff members that are designated to have access to distribute prescribed and controlled medications. All medications in the shelter are stored in a designated separate secure room. This room features a separate storage cabinets each with double locking cabinets 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.

At the time of this onsite program review, there was only one (1) CINS/FINS youth on prescribed medications in the youth shelter. This file and four (4) closed files were to determine the agency's adherence to this indicator. At the time of the onsite QI program review, all five (5) files had evidence that each youth's medication record contained youth's name; date of birth; allergies; medication side effects and/or precautions; picture of youth; youth intitals medication record; full printed name, signature, and title of each staff member that intials a dosage; and documentation of youth receiving medication. One file did not have evidence that staff initialed the youth's medication record.

Two (2) of the staff members involved in the April 2012 medication error incidents were terminated for failure to follow the necessary steps to correctly assist in the delivery of medications to resident on prescribed medications.

A review of the Central Communication Center (CCC) reports indicated a total of three (3) medication errors within the last six (6) months. On April 19, 2012 a staff member falsified medication documentation. On April 19, 2012, a DJJ CCC report states that the staff failed to give youth medication due to not getting the medication subscription filled. A third medication incident occurred on May 3, 2012 during a room search staff discovered a zip lock bag in a small quantity under the youth’s bed. The agency terminated both staff members involved in the April 2012 DJJ CCC incidents. The agency does not have a policy on responding to medication errors. The agency did not provide any evidence of follow up regarding medication errors and terminations in Management Team and or Risk Prevention Team meetings.

Due to recent concerns regarding risks related to the distribution of medications, as of July 1, 2012 FNYFS policy has deemed it necessary for all local CINS/FINS service providers to revise and implement Medication verification procedures. Review of the agency's policy revealed that the agency does not currently address Verification of Medication. The agency must revise its current policy and practice to incorporate the agency's ability to verify all medications entering the residential youth shelter in ordedr to meet this requirement.

4.04 Medical/Mental Health Alert Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The Agency has a documented policy detailing the use of Medical and Mental Health Alerts that is in accordance with Standard 4.04. A review was conducted of eight (8) residential files; four (4) open and four (4) closed.

Two (2) of the files, both open cases, had no Medical or Mental Health Alerts. In the additional six (6), all had either medical or mental health alerts including food, medication, and seasonal allergies, and anxiety, depression.

All files have labels on the outside indicating allergies and Alerts. In addition, Alert System Forms are on the inside right cover of the file. The reviewer was able to go to the kitchen and the medication room to observe and confirm that these alerts were in place for the Youth currently at the Program. In addition a copy of the Alert System Form is put in a separate binder at the Staff Station.

Trainings are conducted on this Alert System by the YDS Team Lead, Bobby Alexander, during staff orientation. In addition all but four (4) of seventeen (17) staff training files also had current training on "Substance Abuse and Mental Health" from the Florida Network.

4.05 Episodic/Emergency Care

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policy regarding episodic/emergency care. The policy includes all mandatory components: a procedure for obtaining off-site emergency services; parental notification requirements; and the development and implementation of a daily log. The Episodic Care Log contains the date of the episode, the illness/injury, treatment rendered, and referral (if applicable) to a registered nurse, physician, or hospital. Episodes included on the log are hospitalizations, first aid administration and police notification/Baker Acts.

9 episodic events have occurred since January 2012. All 9 were documented in the Episodic Care Log and incident reports were logged. In 8 of 9 incidents there is documented evidence that the child’s parent/guardian was notified.

6 training files were reviewed. indicate that all 6 staff received CPR and First Aid training and training regarding use of the Knife-for-Life. The shelter also has 4 Knife-for-Lifes, 4 first aid kits and 4 sets of wire cutters dispersed throughout the building.

9 episodic events have occurred since January 2012. All 9 were documented in the Episodic Care Log and incident reports were logged. In 8 of 9 incidents there is documented evidence that the child’s parent/guardian was notified.