



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of YFA-George W Harris

on 02/09/2017

CINS/FINS Rating Profile

Standard 1: Management Accountability

1.01 Background Screening of Employees/Volunteers	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
1.06 Client Transportation	Satisfactory
1.07 Outreach Services	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
3.08 Video Surveillance System	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 Needs Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management and Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/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%

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

Rating Definitions

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

Satisfactory Compliance	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.
Not Applicable	Does not apply.

Review Team

Members

Marcia Tavares, Lead Reviewer, Consultant-Forefront LLC

Vernon Pryer, QI Monitor, Department of Juvenile Justice

Danielle Taylor-Fagan, Director of Quality and Integrity, Family Resources Inc.

Sandra Schwartz, Non-Residential Program Manager, Lutheran Services Florida Southeast

Felicia Wells, Program Director, Youth Advocate Programs, Inc.

Persons Interviewed

- | | | |
|---|--|---|
| <input type="checkbox"/> Chief Executive Officer | <input checked="" type="checkbox"/> Executive Director | <input type="checkbox"/> Chief Operating Officer |
| <input type="checkbox"/> Chief Financial Officer | <input checked="" type="checkbox"/> Program Director | <input checked="" type="checkbox"/> Program Manager |
| <input type="checkbox"/> Program Coordinator | <input checked="" type="checkbox"/> Direct- Care Full time | <input checked="" type="checkbox"/> Direct-Care Part Time |
| <input type="checkbox"/> Direct-Care On- Call | <input type="checkbox"/> Volunteer | <input type="checkbox"/> Intern |
| <input checked="" type="checkbox"/> Clinical Director | <input type="checkbox"/> Counselor Licensed | <input checked="" type="checkbox"/> Counselor Non- Licensed |
| <input type="checkbox"/> Case Manager | <input type="checkbox"/> Advocate | <input checked="" type="checkbox"/> Human Resources |
| <input type="checkbox"/> Nurse | | |
| 1 Case Managers | 0 Maintenance Personnel | 0 Clinical Staff |
| 1 Program Supervisors | 0 Food Service Personnel | 1 Other |
| 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 checked="" type="checkbox"/> Logbooks | <input checked="" type="checkbox"/> Fire Drill Log | 6 # Health Records |
| <input checked="" type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 6 # MH/SA Records |
| <input type="checkbox"/> Contract Monitoring Reports | <input checked="" type="checkbox"/> Table of Organization | 7 # Personnel Records |
| <input type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 6 # Training Records |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 3 # Youth Records (Closed) |
| <input checked="" type="checkbox"/> Fire Inspection Report | <input type="checkbox"/> Telephone Logs | 9 # Youth Records (Open) |
| <input checked="" type="checkbox"/> Exposure Control Plan | <input checked="" type="checkbox"/> Supplemental Contracts | 0 # Other |

Surveys

3 Youth 4 Direct Care Staff

Observations During Review

- | | | |
|--|--|--|
| <input type="checkbox"/> Intake | <input checked="" type="checkbox"/> Posting of Abuse Hotline | <input checked="" type="checkbox"/> Staff Supervision of Youth |
| <input checked="" type="checkbox"/> Program Activities | <input 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"/> Discharge | <input type="checkbox"/> Group |
| <input checked="" type="checkbox"/> Security Video Tapes | <input type="checkbox"/> Treatment Team Meetings | <input checked="" type="checkbox"/> Meals |
| <input checked="" type="checkbox"/> Social Skill Modeling by Staff | <input checked="" 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

Since its inception in 1970, Youth and Family Alternatives, Inc. (YFA) has helped more than 225,000 children and families in the Tampa Bay & Central Florida area. Initially, YFA served as a “drop-in” center and safe haven for youth to gather and participate in everything in games, discussion groups, or individual counseling with a trained volunteer. Currently, the agency has program operations in ten counties throughout the State of Florida and provides the following services:

- Runaway, homeless, and youth crisis shelters
- Family help
- Substance abuse prevention and intervention programs
- Child welfare case management
- Adoption services
- Family preservation and reunification

YFA earned accreditation through the Council on Accreditation (COA) and has continuously maintained COA accreditation effective through 10/31/2020.

YFA George W. Harris (GWH) Shelter is located at 1060 US Hwy 17 South, Bartow, Florida. The shelter is licensed for 24 beds by the Department of Children and Families effective through December 2017. The shelter facility is located on a large campus that includes its administrative/staff offices and the residential facility. The GWH program is the agency’s Children In Need of Services/Families In Need of Services (CINS/FINS) program in Bartow, Florida which is sub-contracted with the Florida Network of Youth and Family Services (Florida Network) to provide temporary residential and non-residential services to youth and families in Hardee County. Services are provided to male and female youth under the age of seventeen.

Standard 1: Management Accountability

Overview

Narrative

YFA-GWH is under the leadership of Andrew Coble, Vice President of Prevention Services. The management team consists of a Residential Director, a Non-Residential Program Director, two Non-Residential Program Supervisors, a Youth Development Specialist Team (YDS) Leader, and two Office Specialists. In addition to the Youth Development Specialist Team Leader, the residential component of the program is staffed by 2 counselors, 6 Shift Leaders, 5 full-time (FT) YDS, 7 part-time (PT) YDS, and a contracted Registered Nurse. The program had three vacant positions at the time of the QI review for 1 FT and 2 PT YDS. The Non-Residential CINS/FINS Family Help component serves 3 counties and is staffed by a program director, a program supervisor, 6 counselors, and an Office Specialists. There were no vacancies in the Non-Residential program during the visit.

The agency's Residential Director is a licensed clinical social worker (LCSW) who oversees the Residential program and is responsible for clinical oversight. The Residential Director has been Vice Chair of the local DJJ Board for over five years.

All non-residential staff training files are maintained electronically through Relias, the agency's on-line training system. All residential staff training files are maintained on Relias, as well as, hard copies are maintained in individual training files.

1.01 Background Screening

Satisfactory

Limited

Failed

Rating Narrative

The provider's Background Screening Policy and Procedure, SH 100, effective September 13, 2013 was reviewed. (There is no indication of a review or revision of the policy since the effective date.) The provider has a separate policy, DJJ 1.01-1 to address the 5-year re-screening of employees and volunteers and policy DJJ 1.01-2 regarding the annual submission of the Affidavit of Compliance with Good Moral Character Standards to the Background screening unit by January 31st each year.

YFA SH 100 policy requires all staff and volunteers to complete a DJJ background screening that includes good moral character documentation prior to hire or volunteer start dates. In addition to the DJJ background screening, the provider conducts a background check with the Department of Motor Vehicles, local City/County law enforcement screening, and drug screening for all new hires.

A total of seven background screening files were reviewed for 6 new hires and 1 volunteer. All of the new employees were background screened prior to hire date and e-verified. Similarly, the one volunteer was successfully background screened prior to start date. The provider did not have any eligible 5 -year rescreening during the review period.

The provider completed the annual Affidavit of Good Moral Character and submitted it to the Department of Juvenile Justice Background Screening Unit via FedEx mail on January 24, 2017, prior to the January 31st deadline.

No exceptions noted as of the date of this QI visit.

1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

Rating Narrative

The program has multiple policies and procedure in place for the provision of an abuse free environment (DJJ 1.02, SH 420) and Grievance policy (CS 495, revised December 1, 2015 and SH 420, effective September 13, 2013).

Upon hire, employees receive and sign receipt of the employee handbook which includes the agency's Code of Conduct that outlines the agency's policy regarding behavioral expectations and provision of a safe environment. Employees are required to report all known or suspected cases of abuse and/or neglect and youth have unimpeded access to self-report. Abuse reports are documented in CCC reports and a log of the number of abuse calls made monthly is tracked along with incident reports.

The Florida Abuse Registry Hotline number, rights and responsibility, and other relevant program information are visibly posted in the great room and on each wing of the dormitory. Youth are also informed of these procedures during program orientation and the abuse hotline number is included in the Shelter Handbook. The grievance procedure is also reviewed with the youth during intake and the program has a grievance box with forms accessible to youth in each dormitory area. Per the provider's grievance policy and the shelter handbook, youth are allowed to submit their completed grievance to any staff.

A total of seven abuse allegation incidents were reported and reviewed during the onsite visit for the current fiscal year to date. None of the abuse allegations were institutional. There were no reported incidents of youth being deprived of basic needs and no physical abuse by program staff was reported during youth surveys conducted during the review or observed during the visit.

One of the three youth survey indicated knowledge of the abuse hotline and location of the posting of the number in the facility. None of the youth surveyed reported being stopped from reporting abuse. The three youth surveyed also indicated that they feel safe in the program and have never heard staff use profanity, threaten them or other youth.

The four staff surveyed said they have never witnessed another staff prohibit youth from calling the abuse hotline and have never heard the use of profanity in the presence of youth or have observed staff use threat or intimidation when interacting with youth. All staff agreed the working conditions have been fair (1) and/or good (3) at the program. All of the staff's training files reviewed documented staff training in Child Abuse Reporting.

Per the Residential Director the program has not received any youth grievances since the last onsite review in September 2015. Two of the three youth surveyed indicated knowledge of the grievance process.

Exceptions:

Per the provider's grievance policy and the shelter handbook, youth are allowed to submit their completed grievance to any staff; however, per indicator 1.02 direct care workers shall not handle complaints/grievance documents unless assistance is requested by youth.

The program does not have a grievance box for depositing of grievances as program policy specifies it has.

Two of the three youth survey stated they did not know about the abuse hotline or location of the posting of the number in the facility. One of the three youth did not know about the grievance process.

1.03 Incident Reporting

Satisfactory

Limited

Failed

Rating Narrative

The provider has a policy that was updated on October 20, 2015. The policy references reporting requirements and entities as well as notification processes and procedures. Staff teams are identified that are responsible for reviewing incidents on a quarterly basis to determine trends, and further action to be taken if necessary.

Staff are required to call CCC within two hours of an incident and/or learning of an incident. The initial incident and any follow-up of incidents is entered electronically, printed and placed in an incident report binder. Staff and a supervisor sign and date the incident. Dates and times of incidents are entered into the House Log Book.

A total of five CCC reportable incidents occurred within the six-month review period. Four of the incidents were called in to CCC within the two hour time-frame. Three of the incidents included a supervisor's signature. Two of the incidents were documented in the House Log Book.

Exceptions:

Incidents on 08/27/16 and 09/25/2016 were not signed by a supervisor. Both incidents had the same signature for staff and supervisor. Incident on 11/17/16 was not signed by a supervisor. The follow-up report on 11/18/16 was signed by a supervisor.

Incident on 10/12/2016 was called in 48 minutes past the two hour time-frame.

Incidents on 08/27/2016, 10/12/2016, 12/25/2016 were not documented in the House Log Book.

1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

The provider has a draft policy (SH 150) that has not yet been signed that includes training procedures and topics for the first 120 days of employment, first year of employment, and in-service training requirements.

Staff training files are maintained that include required training by hire date, a running list of training topics completed which includes the number of hours for each training topic, and the total hours of training completed to date. The information is entered into an Excel spreadsheet and printed for each training file. Certificates of completion are maintained in the file. Training topics and hours are also maintained in Relias. For non-residential staff, training topics and hours are maintained in Relias and certificates of completion are uploaded into the Relias system.

The Reviewer reviewed seven individual staff training files for six residential and one non-residential staff. The training files for first year staff were for one counselor and two direct care staff in the residential program and one first year counselor from the non-residential program. Training files for first year exceeded the number of required 80 training hours and have completed most required training topics. Three of the first year staff are still within the first 120 days of hire and has time remaining to complete the necessary training topics required in the first 120 days of training. Documentation for trainings completed were found in all of the training files reviewed.

Three training files for direct care in-service staff from the residential program were reviewed. To date, two of the three staff exceeded the training hours required and have completed all of the required training topics. The third staff is on target and has ample time to complete the remaining 16 hours of training.

Exception:

One of the first year staff (DOH 8/1/16) did not complete "Understanding Youth/Adolescent Development" training required during the first 120 days of hire.

1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

The program has multiple policies and procedures that outline its Continuous Quality Improvement (CQI) process (QI 275, dated August 18, 2011), CQI Teams (QI 280, September 1, 2016), and Data Collection and Evaluation (QI 350, December 1, 2015). In addition, the agency has a comprehensive CQI Plan for FY 2016-2017 that describes the agency's CQI structure, committees, stake holders, CQI cycles, data collection and analysis, reporting, and corrective actions.

The program has a designated VP for Quality Improvement who is responsible for the implementation and oversight of its CQI program throughout the State. In practice, the program's CQI program includes many activities that are conducted using staff at various levels to ensure all aspects of analyzing and reporting data are consistently implemented and documented.

YFA appoints staff at various levels to participate in the CQI process on seven CQI teams in addition to the CQI Council. The teams are as follows: Outcomes Measurement, Risk Prevention, Training, Employee Rewards and Recognition, Stakeholder Involvement, and Information Technology. Each team has an appointed team leader who is responsible for coordinating team meetings and attending the CQI Council meetings. The CQI council and CQI teams meets quarterly. The Director of QI and Risk Prevention maintains a calendar and a log of all team meetings. Agendas for all team meetings are maintained respectively along with meeting minutes. The CQI teams are responsible for providing updates and recommendation to the CQI Council on a quarterly basis regarding areas outlined in the purpose and goals for each team. Quarterly reports are to be written for each team. Annual reports are also required from each CQI Team and are due by July 31 for the FY activities.

The Director of QI and Risk Prevention coordinates case record reviews for all of the agency's programs statewide. Due to the size of the agency, number of programs (12) and number of youth served, the CINS/FINS program has a formal case record review and follow-up within 90 days only once per year. Upon completion of case record reviews, the results are aggregated and a report is submitted to the VP of QI to be presented at the CQI Council meeting. A review of the only peer record review conducted in during the FY on September 2016 showed a total of 20 files were reviewed for the CINS/FINS program. A summary of the findings was documented on an excel spreadsheet and accompanied by a cover page that documented deficiencies based on the criteria of falling below 85%.

Incidents, accidents, and grievances are reviewed quarterly by the Risk Prevention Committee. The committee is responsible for reviewing incidents, accidents, and grievances for each program and report to the CQI council. The Risk Prevention Committee is facilitated by the Vice President of Prevention and meets quarterly. A review of the electronic database containing the aggregated monthly report of incidents, accidents, and grievances for the program was conducted onsite to support evidence of practice. Evidence of monthly management meeting agendas showing discussion of incidents/accidents was observed on site.

Consumer surveys are administered by the program staff and entered into Netmis as well as aggregated by the CQI team. The team meets quarterly to review findings of the satisfaction reports and reports their findings to the CQI Council. Strengths, weaknesses, and goals are reviewed and documented in the minutes and discussed at the meetings.

Outcome data is reviewed quarterly by the Outcomes Committee. Quarterly data captures select outcomes for the CINS/FINS program such as elopement, average length of stay, completers, execution of 30 and 60 day follow-ups, and satisfaction with the program. Benchmark outcomes data are reviewed by the Residential Director upon receipt and deficiencies are addressed immediately and communicated to staff via staff meetings as necessary. Quarterly reports are generated by the committee and submitted to the VP of QI to be discussed at the CQI Council meetings. Evidence of monthly management meeting agendas

showing discussion of outcomes data was observed on site.

NetMIS data is reviewed on a monthly basis by Residential Director and submitted to the Data Administrator (DA). Discrepancies and deficiencies are corrected. A review of the NetMIS Quality check report for the period 08/1/15-2/9/17 was conducted showing minimal missing data.

Monthly management minutes were up-to-date with documentation of QM information being discussed with detailed minutes regarding areas needing improvements or changes.

No exceptions noted as of the date of this QI visit.

1.06 Client Transportation

Satisfactory

Limited

Failed

Rating Narrative

There is a client transportation policy (SH 160) with an effective date of January 13th, 2016. The policy includes driver approval (to include documentation of a valid driver's license and approval through the agency's insurance agent); a Monthly Trip and Mileage Log, phoning to check-in; single and third party transport procedures.

The program has three vehicles – two mini vans and a Ford Explorer. Upon transport, documentation is made in the House Log Book and the single party transport log (when applicable). Phone contact is made by the staff member driving the vehicle upon departure from the shelter, arrival at destination, and upon return to the shelter. Single party transports are approved by a supervisor prior to departing. A client's history and recent behavior is considered prior to single party transport. Phone communication is maintained throughout the transport until the conclusion of the destination for single party transports.

A review of the transportation logs for the past six months was conducted. All transports are documented in the House Log Book. Documentation includes time of departure and arrival, names of clients being transported, and phone calls made to the shelter upon departure, arrival, and travel back to the shelter. A phone line is kept open so that call made by the staff member driving the vehicle can be received. Every attempt is made to avoid single party transports. A log is maintained specifically for single party transports. It includes the date of transport; times of departure from shelter, arrival to destination, arrival back to shelter; client name; signature of staff transporting youth; reason for trip/destination; supervisor approval and initials; mileage to and from the shelter.

No exceptions noted as of the date of this QI visit.

1.07 Outreach Services

Satisfactory

Limited

Failed

Rating Narrative

There is a Community Outreach and Education policy (CS 400) which was most recently reviewed on April 20, 2016. The policy states that staff shall seek opportunities to conduct ongoing community outreach and education to communicate the agency's mission, role, functions, capabilities, and the strengths, needs and challenges confronting children and families.

The program participates on state, county, district, and local boards; at community forums; service fairs; and with various community organizations. Program information is disseminated through verbal and

written means through radio, television, and newspaper media and through shelter tours. There is no designated outreach position and any staff may be used to interact with the community to provide outreach services.

The Shelter Director participates in a majority of the community meetings. If there is a development opportunity, then appropriate staff are identified to participate. Prior to the elimination of the position due to a lack of funding, a counselor (grant funded) attended meetings and participated on committees which address mental health and substance abuse issues.

Minutes, agendas, and staff participation is maintained in NetMIS and printed out and maintained in a log book. A separate file is maintained for DJJ Advisory Board agendas, minutes, and staff attendance. The program has verbal agreements which are honored by the established relationship with the organization. There is a written agreement with the US Department of Health and Human Services, dated June 9th, 2016, for the National Safe Place Network program to educate youth and adults about Safe Place services through community presentations and outreach.

Evidence of participation on the DJJ Advisory Board (1/11/17, 4/11/16) and Human Trafficking Task Force (9/16/16) was observed. Minutes and other verification of attendance demonstrated participation.

No exceptions noted as of the date of this QI visit.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

The program provides centralized intake and screening twenty-four hours per day, seven days per week, and every day of the year. Trained staff are available to determine the immediate needs of the family and youth. Each youth at the program receives an initial eligibility screening, CINS/FINS Intake Assessment, a needs assessment, and a service plan. The case management/counseling component consists a total of 17 counseling positions (15 Non-residential and 2 Residential) and a LCSW. The counselors are responsible for completing assessments, developing case plans, providing case management services, and linking youth and families to community services. Additionally, case management, individual, family, and group counseling services, substance abuse prevention education, and referrals to local community agencies are provided as needed.

The shelter program provides critical temporary shelter care services to youth meeting the criteria for CINS/FINS, DV and Probation Respite, Staff Secure as well as Domestic Minor Sex Trafficking (DMST). During the review period, the program did not serve any youth meeting the criteria for staff secure, Probation Respite, or DMST.

The program meets the needs of the youth while in care with the ultimate goal of reunification with their families. The facility has 24 beds available for both male and female youth in the CINS/FINS program and twenty-four hour awake supervision is provided for youth residing in the shelter.

As needed, YFA-GWH coordinates the Case Staffing Committee-- a statutorily-mandated committee that develops a treatment plan for habitual truancy, lockout, ungovernable, and runaway youth when all other services have been exhausted or upon request from the parents/guardians. The Case Staffing Committee can also recommend the filing of a CINS Petition with the court. Non-residential counseling services are provided by qualified Bachelor and Master's level staff who have access to a licensed Clinician. Case file reviews revealed that the counselors monitor the youth's and family's progress in services, provide support for the families, and monitor out-of-home placement as applicable.

The non-residential program covers three (3) counties: Hardee, Polk and Highland while YFA George W Harris residential program is located in Bartow, FL. The non-residential program has a total of 9 employees: 1 Office Administrator; 1 Program Supervisor; 1 Program Director and 6 counselors. Files were requested prior to the site visit for this Standard. There were a total of 31 non-residential files; five of which were for case staffing. Of the total 31 files requested, nine were reviewed for the indicators in this section. A total of three residential files were reviewed for the indicators in this section.

2.01 Screening and Intake

Satisfactory

Limited

Failed

Rating Narrative

Agency has a screening and intake policy, SH310 effective September 13, 2013, that meets the requirement of Indicator 2.01. There is no revision or review date listed on the policy.

Upon receiving a referral, the Centralized Intake Screening Form is completed within seven (7) working days. Eligibility screenings will be completed on all request for services and is available to families 24 hours a day. There is an emergency procedure in place if the youth/parent answers that the youth is currently suicidal or homicidal.

For this indicator, six (6) files were reviewed from the non-residential services and three (3) files were from

residential services for a total of nine (9) files. All youth were screened within 7 days of the referral. All files demonstrated youth/parent received information regarding available service options, rights and responsibilities, and grievance procedures. All files contained Acknowledgement of Receipt of Rights and Responsibilities signed by the parent, youth and witnessed. Possible actions occurring through involvement with CINS/FINS is provided via the Florida Network CINS/FINS parent booklet.

Exception:

The current policy reviewed onsite (SH 310) does not indicate that the program will provide youth and parents/guardians the following items as required: 1) available service options; 2) rights and responsibilities; 3) possible actions occurring through involvement with CINS/FINS; and 4) grievance procedures.

2.02 Needs Assessment

Satisfactory Limited Failed

Rating Narrative

There is a written policy, SH 320, which provides the procedures addressing the Needs Assessment that the agency completes for each incoming youth receiving services. The policy was last updated on September 13, 2016.

The Needs Assessment is a multi-dimensional process. Data gathered from the Needs Assessment provides a baseline measurement for the effectiveness of services and the family's ability to implement skills learned through interventions. Needs Assessments are initiated within 72 hours of admission for residential clients and completed within two (2) to three (3) face-to-face contacts. If the youth has a non-residential counselor, the Residential therapist/counselor shall coordinate treatment and work closely with the youth's non-residential counselor/therapist for purposes of continuity of treatment. An updated Needs Assessment shall be conducted every six (6) months or when otherwise indicated.

A total of nine (9) files were reviewed for six (6) files from the non-residential services and three (3) files were from residential. The needs assessments were completed on time in all of the files reviewed and were completed by staff with a Bachelor's or Master's degree. All of the needs assessments included a supervisor's review and the required signatures. Two (2) non-residential and two (2) residential files identified youth with elevated risk of suicide. Each of the files we referred for an Assessment of Suicide Risk conducted under the direct supervision of a licensed mental health professional.

Exception:

Policy and procedures does not include language to address completion by Bachelor's or Master's level staff and signed by a supervisor as required by the QI Indicator.

2.03 Case/Service Plan

Satisfactory Limited Failed

Rating Narrative

There is a written policy, SH330, signed with an effective date of September 13, 2013 that addresses Service Plan Development and Service Monitoring. The provider's policy has not been revised to replace the terminology "Psychosocial Assessment" with "Needs Assessment".

Service plans address the specific needs identified in the psychosocial assessment, centralized intake screening forms, Intake and NETMIS documentation and any other collaborative information. Service Plans will not focus solely on the youth. The service Plan and the Aftercare Plan will be developed with the youth and, if possible, the parent/guardian at the time of the Psychosocial Assessment no later than seven (7) working days following completion of the Psychosocial Assessment.

A total of nine (9) files were reviewed (six (6) files from the non-residential services and three (3) files were from residential). Eight of the nine files included individual goals. All nine files included: service type, frequency, and location; person(s) responsible; and target dates. Five of the files documented completion dates for goals achieved. Signatures of the youth, parent/guardian, counselor and supervisor were found in all of the files reviewed. It was observed that the parents were not contacted for service plan review or progress in the non-residential files reviewed.

Exceptions:

Policy and Procedures is not updated to reflect current QI indicator, citing Needs Assessment instead of Psychosocial Assessment.

Two (2) non-residential files and one (1) residential file did not have actual completion date for goals. The target dates for completion had expired and a new target date/completion date was not noted.

One (1) residential file did not individualize and prioritize need(s) and goal(s) identified by the Needs Assessment. The assessment summary in the section presenting problem/reason for referral states: "Youth came to GHYS by way of her father. He says his wife wants to leave him because of his daughter and he just want to give his wife a break and get help for his daughter". The service plan did not include nor identify the issues with father/his wife.

Six (6) non-residential files did not have documentation where the parent reviewed service plan every 30 days.

One residential file did not have documentation where the parent reviewed the service plan every 30 days.

2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

Rating Narrative

The provider has multiple policies and procedures that address case management and service delivery standards: SH330-Service Plan Implementation and Service Monitoring; SH350-Family Involvement; and SH370-Substance Abuse Education and Referral for Treatment. All of the above referenced policies and procedures were last signed and dated September 13, 2013 with no evident review or revision since that time.

The CINS/FINS counselor will utilize diligent efforts to engage the family in the solution of the youth's issues which lead to the referral for Residential or Non-Residential services. These efforts may require school or home visits in addition to telephone contact or correspondence or other venues as requested by the family. Engagement will be strength based and designed to develop a partnership with the family. If the Counselor is unsuccessful in engaging the family in services, she/he will document engagement efforts and will review the case with the Program Director.

A total of nine (9) files were reviewed for six (6) files from the non-residential services and three (3) files were from residential. Coordination of service plan implementation was evident in all 9 files reviewed. Staff monitored the youth/family's progress in services in 7 applicable files and monitored out-of-home

placement in 2 applicable files. Two of four applicable files showed referrals for needs identified. There was documentation to support referral for case staffing in one eligible file.

Exceptions:

Policies and procedures have not been reviewed/revised since 9/13/2013.

Three (3) of the non-residential Chart Supervision comments indicated referrals should be made; however, there is no documentation that referrals were made or coordinated for the youth/family.

2.05 Counseling Services

Satisfactory Limited Failed

Rating Narrative

The provider has Policy SH340 signed on September 13, 2013 that addresses the provision of or referral to needed services identified by the assessments. Services may include intensive crisis counseling and individual, group, and/or family counseling.

After an assessment has been completed and the family has participated in the development of the service plan, the program provides the needed services and/or coordinates with other community agencies to address these needs. All CINS/FINS services and coordination of services will be documented in the case record. Youth and Family Alternatives, Inc. provides a variety of services individualized for each youth/family.

For this indicator, six (6) files were reviewed from the non-residential services and three (3) files were from residential files for a total of nine (9) files reviewed. All files showed each youth and family receiving counseling services in accordance with the Case/Service Plan. All files showed counseling addressed the youth's presenting problems addressed in the Needs Assessment, Initial Case/Service Plan, and Case/Service Plan reviews. There is an on-going internal process that ensures clinical reviews of case records and staff performance.

No exceptions noted as of the date of this QI visit.

2.06 Adjudication/Petition Process

Satisfactory Limited Failed

Rating Narrative

The provider has Policy SH380 signed on September 13, 2014 that addresses Case Staffing and Adjudication. The program has an established case staffing committee and procedures for the staffing process.

When requested or if the CINS/FINS counselor is unable to assist in resolving the issues presented by youth/family, a case staffing is convened to review the case and attempt to obtain a solution. Once the case staffing is held, the Committee will attempt to develop a plan to resolve identified delinquency issues. For cases in which a plan cannot remediate the youth's issues regardless of the reason, the Committee may make a recommendation to the courts to adjudicate the youth delinquent and remand the youth into court ordered services including but not limited to shelter services.

Three files were reviewed. Progress notes indicate the counselor requested the case staffing and notification to the committee and family was provided no less than 5 days prior to the staffing. Other than

the youth/family, participation in the meeting included the required school representative and a DJJ representative and/or CINS/FINS staff. No other parties were present at the meetings. A written report was provided to the parent/guardian within 7 days of the case staffing outlining the recommendations made by the committee but there was no evidence of a new/revised service plans as a result of the case staffing.

Exception:

The three files reviewed did not include a new/revised service plan as a result of the case staffing.

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

There is a written policy, SH 250, signed effective on September 13, 2013 for the maintenance of CINS/FINS youth records.

Each case record will be maintained in an approved, standard order. Each record shall be marked "confidential". All case records contain "MEDICAL ALERT", and "ALLERGIES" labels located on the outside of the charts identifying any known medical problems/allergies for the youth. All case records are kept in locked, fire-resistant cabinets in a locked room at each site.

The program stores all case records in a locked room. While reviewing files that were brought in for the QI review, the Reviewer observed 2 files not marked confidential. The non-residential files that were transported to the program office were in opaque containers; however, the containers were not marked confidential.

Youth records were maintained in a neat and orderly manner so that staff can quickly and easily access information.

Exception:

Program policies and procedures need to be updated to include QI requirement that states "All records that are transported are locked in an opaque container that is marked confidential".

Standard 3: Shelter Care

Overview

Rating Narrative

YFA-GWH Shelter program provides temporary residential shelter care for male and female youth identified to be at-risk. The program has adequate space for all indoor and outdoor activities and is equipped with two separate residential quarters, one for each gender. The dormitories, kitchen, restrooms and common areas were observed to be clean during the visit. Each bedroom is furnished with beds, pillows, and bed covering and storage for youth belongings. Youth have access to a large yard for outdoor activities.

All youth who are admitted to the program receive a copy of the Shelter Handbook and an orientation to the facility. During the admissions process, each youth receives a new CINS/FINS intake screening to identify any medical, mental health, and/or substance abuse condition and this information is provided to the assigned clinical staff. The program provides individual, group, and family counseling, as needed. Group sessions are scheduled at least five times per week. Interagency Agreements have been established for the provision of substance abuse, mental health, and medical services. Case management and counseling services to youth in the Residential program are provided by Bachelors and Master's level counselors under the supervision of a Licensed Clinical Social Worker.

Shelter Care is designed to assure that all youth are safe and well cared for while residing in the shelter. This standard includes the shelter environment including the building, grounds and vehicles; the orientation of youth to the program including the shelter rules and regulations and their room assignment; the maintenance of logbooks for keeping a detailed description of all shelter actions and activities 24/7; the behavior management system used to both maintain a physically secure environment but to also influence youth to make healthy choices both in and out of the shelter; supervision of youth throughout the day and night within 3 daily shifts and offering a continuum of care; service delivery to special population; and finally, video surveillance for the purpose of accountability on all staff, youth, visitors and other personnel and to use in the event of allegations of mishandling of any situation. The Department of Children and Families has licensed GWH as a Child Caring Agency, with the current license for 24 beds, effective until December 18, 2017.

3.01 Shelter Environment

Satisfactory

Limited

Failed

Rating Narrative

The agency has written policies and procedures, H 410- Shelter Environment and SH 430 Daily Programming that address key elements of this indicator regarding maintaining a safe, clean and neat shelter environment. The policies were drafted and signed in September 2013 and there is no indication they have been revised or reviewed since that time.

The procedures are well documented. Highlighted practices include daily and safety inspections, cleaning and repairs, daily chores along with the documentation logs and Corrective Actions in addition to scheduling and faith-based activities.

Specific procedures include discussion of the maintenance of office areas, bedroom and bathroom areas, laundry and linen area, living areas, kitchen and dining areas, public areas, grounds and pest control, and garbage disposal.

During the tour of the facility, an inspection of the shelter environment was conducted. All findings meet the requirements of Indicator 3.01. The Disaster Plan was updated July 1, 2016 for the 2016-2017 fiscal year. The Fire Safety Inspection was completed on July 20, 2016 with 2 items not critical but for full compliance, which, to date, have not been done. The Residential Group Home Inspection Report was completed on November 22, 2016, which, required screens be placed in the windows of the dorms and this

corrective action was completed on February 2, 2016. The Health Department Food Service Inspection Report was completed on November 22, 2016 and cited the bottom shelf of the food storage being less than 6 inches above the floor. This was corrected during the inspection and a corrective action was completed. The agency has a current DCF Child Care License dated December 18, 2017.

The furnishings are neat and in good repair, there is no indication of insects, the grounds are impeccable, the bathrooms are clean and functional, there is no graffiti anywhere in the facility, each youth has a bed with all linens, lighting is adequate, and youth has locked and non-locked available storage. The program uses the Why Try curriculum and goes outside for recreation at least daily on school days and more often on non-school days. Youth are given the opportunity to participate in faith-based activities. Youth are given time to do homework and read. The daily schedule is posted and accessible to youth and staff.

While still meeting the requirements, it is worth noting that the availability of “a safe, lockable place to keep valuables” is not noted in the Policies and Procedures but is mentioned in the Shelter Handbook.

Exceptions:

There is no mention of the following in the provider's policies and procedures:

- Annual Health and fire safety inspections
- At least one hour of physical activity is provided daily

The recommendation by the Fire Chief on July 20, 2016 was for 2 items to be repaired. While not critical, to date these actions have not been completed.

3.02 Program Orientation

Satisfactory

Limited

Failed

Rating Narrative

The agency has written policies and procedures, H 420 – Shelter Care Requirements and SH 400 – Classification and Orientation that address all of the key elements of this indicator. The policy states that the clients will receive appropriate services and be protected in the shelter environment. The policy covers the rights as children in the State of Florida, grievance process, adequate supervision, safety of youth/staff, and higher level of supervision for necessary youth. The policy was drafted and signed in September 2013 and there is no indication that it has not been revised or reviewed since that time.

The procedures are well documented and include information on shelter admission requests, shelter admissions, abuse hotline, youth room assignment, shelter orientation, correspondence, grooming, laundry/linens/bedding, grievances, staffing levels, youth supervision and the alert system. Youth admitted to the shelter go through a new client orientation process consisting of specific 20 areas, encompassing all of the required documented on the Client Orientation Check List.

Three (3) client files were reviewed: 1 open and 2 closed. All files meet the requirements of Indicator 3.02. All 3 youth were oriented within the first 24 hours of admission. This orientation included signed receipt of the handbook; explanation of disciplinary action; grievance procedure; emergency/disaster procedures; contraband rules; physical/facility layout; a room assignment; and suicide prevention and alert notification where indicated. All required signatures by youth and parent/guardian were obtained, the daily activities were reviewed, and the abuse hotline number was provided and displayed.

No exceptions noted as of the date of this QI visit.

3.03 Youth Room Assignment

Satisfactory

Limited

Failed

Rating Narrative

The agency has a detailed policy and procedures, SH 400 – Classification and Orientation, for classification of youth to ensure the most appropriate sleeping room assignment. Much of this policy is restated in SH 420 – Shelter Care Requirements. The policy covers all youth receiving appropriate services and being protected including being interviewed upon admission to determine the most appropriate sleeping room assignment. Both policies and procedures were last signed on September 13, 2013.

The shift leader or designee on duty is responsible for reviewing the youth's case record and intake packet to assess risk or special needs in determining room assignment. Youth who are determined to be a potential threat will be separated from other youth. Room assignment takes into consideration the following: behavioral history, age, maturity level, individual needs, physical stature, gang affiliation, current alleged offense, level of aggression, ability to act responsibly, sexual misconduct/sexual predatory behaviors, demonstration of emotional disturbance, medical or physical disabilities, and special needs.

Three (3) client files were reviewed: 2 open and 1 closed. All files meet the requirements of Indicator 3.03. All 3 youth files classify youth as to review of history, status and exposure to trauma, age, gender, history of violence, disabilities, physical strength/size, gang affiliation, risk of suicide, sexually aggressive or reactive behavior, gender identification, alerts, collateral contacts and initial interactions/observations.

Upon interviewing two youth care staff, they mentioned many factors considered when choosing a room for a youth including the age and size of the youth and any alerts on the youth including physical aggression, sexual acting-out and the risk of suicide.

No exceptions noted as of the date of this QI visit.

3.04 Log Books

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure, SH 200 – Log Books. The policy states that logbooks shall be maintained to document daily activities, events and incidents in the program and reviewed by direct care and supervisory staff at the beginning of each shift. The policy was drafted and signed in September 2013, and there is no indication that it has not been revised or reviewed since.

The procedures are documented for the following areas: (1) Logbook entries and highlights to impact security and safety of facility, staff or youth with each entry being written briefly, legibly and in ink to include: dates and times, youth/staff name(s), brief statement and name of person making entry; (2) Error recording; (3) Review of logbook; and (4) Retention of logbook.

One youth care specialist demonstrated the procedure for writing in the log book and discussed the weekly review by the program director and the hand-over of both the logbook and information about the previous shifts so the current shift is aware of the shelter environment they are entering.

The shelter maintains a permanent bound logbook that records all routine information, emergency situations and incidents pertinent to shelter activities. The agency requires all staff to utilize the log book for the purposes of signing in and signing out. Three (3) different types of logbooks during the review period were inspected: one logbook used when the youth are not in the dorms and 2 additional logbooks used for the dorms, 1 for girl's dorm and 1 for boy's dorm.

The logbook pages contain the date or dates of the entries on that page and each entry has a time and signature. Any entry changed or crossed out is neat and initialed. The writing is very legible. Effective communication among staff from shift to shift was well documented in the log book along with vital information such as security or safety of program and the welfare of the youth are highlighted for quick

reference. The log book reflects staff review the logbook of the previous two shifts and that the staff is signing in and signing out on each shift. Supervisory reviews were also conducted and provide information and any recommendations for staff.

There were no exceptions noted for this indicator at the time of this QI visit.

3.05 Behavior Management Strategies

Satisfactory Limited Failed

Rating Narrative

The program has a detailed written description of the Behavioral Management System (BMS) RM 780 – Behavior Management. The policy’s effective date is April 26, 2000 and the last reviewed date is November 1, 2011.

The policy states that the behavior management techniques are proactive and emphasize positive and preventative measures with physical restraint to be used as a restrictive behavior management only in emergency situations and only to protect a youth from imminent harm to self or others. Seclusion, mechanical and chemical restraint is strictly prohibited.

The procedure discusses 10 identified steps in behavior management program including the introduction of the program at intake, signed acknowledgement of the system by parent(s) and youth which are placed in the file, integration of the program in order to recognize and reward for positive participation, consequences for violation that will be and will not be used, training of staff and alerting director regarding non-routine actions and consequences. There is also a comprehensive description of the physical restraint approach.

According to the procedure and interviews with youth care staff and the agency’s Vice President of Prevention services, the program developed a system called Youth Development System (YDS) to manage behavior in the shelter. This approach includes pieces of Advancing Youth Development (AYD) and Character Counts. The youth advance by levels and are positively reinforced in the shelter. In addition, staff is trained in Managing Youth Behavior (MAB). Youth and Family Alternatives, Inc. has 2 trainers which train new staff within the first 120 days. Youth care staff are also trained in WHY TRY which they utilize when interacting with youth, although this system is not mentioned in the Policies and Procedures. The BMS uses a variety of awards/incentives to encourage participation and completion of the program. The Shift Leader provides feedback to staff and informal evaluations of their use of the BMS.

In the review of three residential files, it was confirmed that staff does explain the (BMS) during program orientation and obtain receipt of acknowledgement of the consumer handbook.

No exceptions noted as of the date of this QI visit.

3.06 Staffing and Youth Supervision

Satisfactory Limited Failed

Rating Narrative

The agency has a written policy and procedure, SH 520 – Staffing Levels and On-Call/Scheduling, to ensure staffing ratios are maintained in accordance with the youth population and shelter census. The policy was drafted and signed in September 2013 and there is no indication that it has not been revised or reviewed since that time.

The procedures are divided into subtopics of Ratios and On-Call duties and responsibilities. The Ratios

section discusses the need for both male and female staff working at all times, with a staff:youth ratio of 1:6; when to staff part-time employees; and documentation of staff in the logbook. On-Call procedures include how to reach the on-call staff and circumstances in which to contact them.

The practice in the shelter exceeds the standard in that the shelter maintains a 1:6 ratio at all times except when the census exceeds 12 at which time the director is contacted to make staffing decisions. The staff schedule is provided to staff and located on the clipboard that is used by each shift lead throughout the day and night. The staff roster is also located on the clipboard as is any phone numbers that may be needed throughout the shift. There is a list of all youth care workers' names and cell phone numbers posted to reach these staff when additional coverage is needed.

The agency is equipped with a functional surveillance system that includes 22 cameras that are well positioned for adequate monitoring of youth whereabouts. Although the system's recording was functional, the data back-up was not available for 30 days when reviewed onsite.

A random selection of overnight checks was conducted and verified staff's observation and documentation of bed checks every 15 minutes while the youth are sleeping.

The program meets all requirements of both staffing and youth supervision. The program exceeds the requirements in that it does not state that overnight staffing ratio can be reduced to 1:12.

There were no exceptions noted for this indicator as of this QI visit.

3.07 Special Populations

Satisfactory

Limited

Failed

Rating Narrative

There is a policy in place, SH 660, dated April 1st, 2016. The policy states that the shelter shall provide services to special populations defined as Domestic Violence Respite, Domestic Minor Sex Trafficking, Probation Respite, and Staff Secure for youth ages 10 through 17 who have been charged with an offense of domestic violence (including youth who have been previously adjudicated for other issues) specifically designed to provide a safe alternative to secure detention for youth with pending or adjudicated charges for domestic violence.

Youth are screened by the JAC and referred to the shelter as appropriate for domestic violence respite. Youth do not stay in the shelter beyond 21 days. Data is entered into NetMIS and JJIS with-in 24 hours of admission and 72 hours of release. Documentation is entered into the file if the youth transitions to CINS/FINS or probation respite, if applicable. The youth's case plan reflects goals for aggression management, family coping skills, and other interventions designed to reduce violence. Services are consistent with all other CINS/FINS program requirements.

The program did not have any applicable youth files since the last onsite QI visit for probation respite, staff secure, or domestic minor sex trafficking. Three files for youth who were referred with a domestic violence charge were reviewed. All were closed files. All youth referred and admitted had a pending domestic violence charge. Two of the youth resided in the program for less than 21 days and one youth was transitioned to a CINS/FINS placement prior to residing in the program for 21 days. Two youth had case plans that included goals that focused on aggression management, family coping skills, and other interventions such as stress management to reduce the recurrence of violence. One youth's case plan also included goals related to substance abuse and one youth was referred for neurological testing. One youth was in the program twice – the first time for three days and the second time for less than one day and did not have a case plan. An assessment was completed on the youth and included a referral for

counseling services to address aggression and violence issues.

No exceptions noted as of the date of this QI visit.

3.08 Video Surveillance System

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure, RM 660 Video Surveillance. The policy states the purpose of the video surveillance to provide a secure environment, protect its facilities, and enhance the safety of youth/staff/visitors while remaining sensitive to privacy as defined by law. The policy's effective date is September 27, 2012 and the last reviewed date is October 1, 2015. The policy is not signed.

The procedures outline 8 of the 9 components required for the posting, usage of video recording, camera locations, limited staff access, and saving of video footage. The surveillance system is equipped with 22 cameras and captures and retains video images recorded with day, time and location in a resolution that enables facial recognition. The system has a back-up battery that is automatically utilized during a power-outage. Cameras are placed inside, as well as outside the building. Video surveillance is only accessible by designated personnel and is reviewed at least every 14 days and noted in a logbook for that specific purpose.

Observation of the video surveillance system was conducted during the visit. Recording of the data was available for the period January 20 through February 9th, less than the 30 days required. The overnight staff maintains 2 logbooks: 1 for girls and 1 for boys. They utilize a timer to remind them every fifteen minutes to do bed checks. The bed checks are done timely and match the entries in the logbooks. Random dates reviewed demonstrated supervisory review of a random sampling of overnights a minimum of once every 14 days. Noteworthy is that the camera system is only accessible by the program director. No one in the facility of the agency knows the password or has access.

Exceptions:

The procedure does mention the system maintaining a minimum of 30 days or the use of a back-up power source.

As of the date of the QI visit, the system saves a rolling 20 days of data but is capable of saving 30 days if reconfigured. Currently, data prior to 20 days was not accessible.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

YFA-GWH shelter has written policy and procedures related to the admission, interviewing and room assignment of youth admitted into the program. Upon admission program staff completes the intake via an individual interview with the youth. An initial intake assessment is completed to determine the most appropriate room assignment in relation to the youth's needs and issues, the current population of the facility, the physical space available, and staff's assessment of each youth's ability to function effectively within program rules and expectations. When making youth room assignment, consideration is given to each youth's physical characteristics, maturity level, history (including gang or criminal involvement), propensity towards aggression, and apparent emotional or mental health issues.

Staff receiving the youth at the time of admission notifies the program director, counselor, or team leader of any youth admitted with special needs, mental health issues, substance abuse issues, medical needs or security risk factors as well as those at risk of suicide.

At the time of this annual review the part-time licensed registered nurse (RN) position was vacant and has not been filled since September 2016.

The program uses the Pyxis Med-Station system for storage and distribution of medication and has 6 super users. Topical and injectable medications are stored separately from oral medications. A locked refrigerator is maintained for the sole purpose of storing medication requiring refrigeration. Medication distribution records for each youth are maintained in a binder which is stored in a locked medication cabinet in the locked medical room.

4.01 Healthcare Admission Screening

Satisfactory

Limited

Failed

Rating Narrative

The shelter maintains a policy and procedures, SH 600, for Health Care Admission Screening and ongoing monitoring. The policy was last reviewed and updated on September 23, 2013. The program's policy has an effective date of September 23, 2013. (There is no recent review or revision date noted for this policy.)

The program's policy mandates that shelter staff completes the CINS/FINS Intake Assessment Form and the Health Screening Form to screen youth for medical, mental health, and substance abuse concerns and identify health related conditions at the time of admission and provide ongoing monitoring as well as appropriate care for medical health issues.

Staff will evaluate the youth's acute needs to determine whether the youth is suffering from a condition or contagious disease/illness that may create a risk to shelter youth/staff. Whenever possible, the youth's parent/guardian or caseworker will be actively involved in the condition and scheduling of follow-up medical appointments or care. However, if the youth's guardian or caseworker is unable or unwilling to provide for the youth's medical appointments, the shelter will ensure the youth's needs are met.

Five youth records were reviewed; all contained documentation verifying youth entering the shelter received screenings for health related conditions at the time of admission. Three records were applicable for youth admitted with medications.

Each reviewed record contained a comprehensive health screening form which addressed and inquired about youth's mental and medical health status. Each record addressed chronic medical issues; none of the records found the parent/guardian to be involved in the coordination and scheduling of follow-up for medical appointments. Each record also contained specific procedure addressing the youth referral process.

If the program staff identify a youth with medical conditions, the program uses a color-coded medical alert

which includes the posted alert and the youth on the allergy alert board posted in the medical room.

There were no exceptions noted for this indicator as of this QI visit.

4.02 Suicide Prevention

Satisfactory
 Limited
 Failed

Rating Narrative

The shelter maintains a policy and procedures, SH 610, which was last reviewed and updated on September 13, 2013. The shelter's policy addresses suicide prevention and mandates all youth receive a suicide screening during the initial intake and screening process using the six questions on the CINS/FINS Intake Form Risk Screening section. The program's policy has an effective date of September 23, 2013. (There is no recent review or revision date noted for this policy.)

If the youth answers "yes" to any of the six suicide screening questions on the CINS/FINS Intake Assessment, the staff will then complete the Evaluation of Suicide Risk Among Adolescents (EIDS). A suicide assessment is then completed by a qualified professional within twenty-four hours. Youth awaiting an assessment are placed on constant sight and sound supervision. If at any time during the screening or at any time during the youth's stay at the shelter any staff observes or believes a youth presents as an immediate threat to themselves or others, the youth will be placed on one-to-one supervision and staff will immediately call 911 and/or follow Baker Act procedures.

The shelter uses two different levels of supervision. The most intense level is One-to-One Supervision. This level is used for youth while waiting for removal from the program by law enforcement or the guardian for the purpose of Baker Act assessment. One staff member is to stay within an arm's length of the youth at all times while on one-to-one supervision. The second level of supervision used is Constant Sight and Sound Supervision. This level of supervision is for youth who are identified as being at risk of suicide but are not expressing current suicidal thoughts or threats. During both levels of supervision staff must document observations of the youth at five minute intervals. Documentation must be reviewed by a supervisory staff each shift and must be placed in the youth's file.

Three applicable records were reviewed for youth placed on suicide precautions. Each reviewed record found all three youth answered YES to one of the six questions on the CINS/FINS intake form. In each case, shelter staff followed the policy and procedure by completing the Evaluation of Suicide Risk Among Adolescents (EIDS). In each case, a suicide assessment was completed by a qualified professional within twenty-four hours. Each of the reviewed records contained documentation verifying each youth awaiting an assessment was placed on constant sight and sound supervision. In all three records, the youth was removed from suicide precautions and placed on standard supervision. There was documentation in the log-book each time a youth was placed on and removed from suicide precautions. There was also documentation observed in the log book between each shift change of all youth on suicide precautions.

There were no exceptions noted as of this QI visit.

4.03 Medications

Satisfactory
 Limited
 Failed

Rating Narrative

The program has a policy and procedures to ensure safe, uniform medication control and management. The shelter utilizes the Pyxis Med-Station 4000 Medication Cabinet. The policy was last reviewed and updated on December 21, 2015.

The shelter maintains six Super Users assigned for the Med-Station. Staff that have access to the Cabinet

have been delineated in writing and have been trained on its use. Staff using the Medication Cabinet have to enter a password as well as their finger print to gain access. Two staff credentials are required to open the Medication Cabinet.

All youth medication is stored in the Medication Cabinet. All topical medications are stored in a separate drawer in the Medication Cabinet. The shelter has a system in place for refrigeration of medication if needed. No medication required refrigeration during the time of review.

After the youth's information is entered into the system, a bin within the Cabinet is assigned to the youth. The youth's medication is placed in that bin and once it is closed it can only be opened during assigned medication times or for inventory purposes. All Schedule I (general prescribed) and Schedule II (controlled/narcotics) medications are counted three times per day (once on each shift) by two staff members. When an inventory is completed the staff will log into the system and choose which medication to inventory. When the medication is chosen the appropriate drawer and bin will pop open, staff must then count the medication and enter the number into the computer system. If it is a controlled medication, a second staff member must also enter their initials and finger print to verify the count. If the count is inaccurate, alarms within the Medication Cabinet will sound. The inventory must be completed and the amount must be entered into the computer system in order to close the bin the medication is in and close the drawer. If the count is not entered, the door on the bin will not close. These inventories are documented in the Medication Cabinet and also documented on the medication inventory log sheets maintained in a binder in the same room as the Medication Cabinet.

The shelter doesn't maintain or provide over-the-counter medication. When a youth has a medical complaint the parent is notified. If the parent can't be located, then the youth is transported to the local medical facility.

The youth's prescription medication log sheets reviewed documented the youth's name, date of birth, any allergies, side effects of the medication, dosage, instructions, and medical conditions. Each log sheet is documented when a medication is given along with staff signature, youth signature, and perpetual inventory with running balance. A cover sheet was located for the youth that included a picture of the youth. All prescription medication log sheets reviewed for the youth documented that all medication was given at prescribed times. These inventories are documented in the Medication Cabinet and also documented on the medication inventory log sheets maintained in a binder in the same room as the Medication Cabinet. There was one youth currently in the shelter on medication.

Exception:

The shelter's policy and procedure directs sharps are maintained in a box, in a locked cabinet and are inventoried weekly and perpetually. However, there isn't any supporting documentation after November 8, 2016 to validate the practice is ongoing.

4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

Rating Narrative

There is a written procedure, SH 640, for the Medical and Mental Health Alert System. The alert system is also noted in the Health Care Admission Screening and Ongoing Monitoring policy. The program's policy was last reviewed on September 23, 2013. (There is no recent review or revision date noted for this policy.)

Information concerning a youth's medical condition, allergies, common side effects of prescribed medications, food and medication contraindication is to be effectively communicated to all staff through an alert system utilizing a general alert sheet as part of the intake packet with a second copy to be maintained in a medical alert binder. 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 record that documents each alert the youth is on and the reasons for the alert. The alerts are also documented on the outside front cover of the youth's record. The alerts are also noted and highlighted in the facility log books.

There were six youth records reviewed. Each record documented alerts identified during the youth intake process and documented on the Intake Screening and Assessment form. Reviewed records contained an alert sheet in the front of each record. Observation of random records reviewed for the QI review found alert stickers on the front cover of each record that documented the appropriate letter applicable to each alert identified.

There were no exceptions noted for this indicator as of this QI visit.

4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

Rating Narrative

The program has a written policy and procedures, SH 650, in place which addresses comprehensive process for the provision of episodic emergency care. The policy was last reviewed and updated on September 23, 2013. (There is no recent review or revision date noted for this policy.)

The program's written procedure for emergency medical and dental care requires the program to maintain a knife-for-life, wire cutters, and first aid kit on the residential unit. Episodic emergency drills must be conducted on each shift at least quarterly to focus on varying emergency situations to include detailed debriefing, critiques, and corrective action/follow-up if necessary. All instances of first-aid and emergency care must be documented on a running episodic or first aid/emergency care log to provide information essential for the identification of need for additional resources and/or clinical trends. Parents/guardians are to be notified of all episodic and emergency care. All instances of youth requiring transfer off-site due to emergency situations are to be critiqued by the program supervisor and the critiques shared with the director of program operations. The agency keeps a daily log separated by the month of all episodic/emergency care.

The shelter had three incidents applicable for episodic emergency care in the last six months. Of the three incidents one was applicable for notification of the Central Communications Center (CCC). The CCC was notified within the required two-hour time frame of the caller gaining knowledge of the incident. Each incident had documentation of parent's being notified or attempted to be notified.

In each case, discharge instructions and follow-up care were documented on the incident report and the Episodic log.

All shelter staff are current in training in CPR/First Aid and the use of the knife-for-life. The location of the knife-for-life and wire cutters, and First Aid kits are located in the kitchen, copy room, medication room, and monitoring station.

There were no exceptions noted for this indicator as of this QI visit.