Florida Network of Youth and Family Services Quality Improvement Program Report

Review of YFA-George W Harris

on 09/23/2015

CINS/FINS Rating Profile

Standard 1: Management Accountability	
1.01 Background Screening	Satisfactory
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Satisfactory
1.05 Analyzing and Reporting Information	Satisfactory
1.06 Client Transportation	Satisfactory
1.07 Outreach Services	No rating

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/Petitiion Process	Satisfactory
2.07 Youth Records	Satisfactory

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

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

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

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

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

Overall Rating Summary

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

Rating Definitions

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

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

Review Team

Members

Ashley Davies, Lead Reviewer and Consultant, Forefront LLC

Felicia Wells, Program Director, Youth Advocate Programs

Janet Valdez, CINS/FINS Supervisor, Children's Home Society

Leah Saker, Treatment Counselor, Hillsborough County Children's Services

Persons Interviewed

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

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

0 Maintenance Personnel
2 Program Supervisors
0 Other

Documents Reviewed

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

8 Health Records
4 MH/SA Records
3 Personnel Records
5 Training Records/CORE
4 Youth Records (Closed)
4 Youth Records (Open)
0 Other

Surveys

5 Youth | 9 Direct Care Staff | 0 Other

Observations During Review

- [ ] Intake
- [x] Program Activities
- [ ] Recreation
- [ ] Searches
- [x] Security Video Tapes
- [x] Medical Clinic
- [x] Medication Administration
- [x] Posting of Abuse Hotline
- [ ] Tool Inventory and Storage
- [x] Toxic Item Inventory and Storage
- [ ] Discharge
- [ ] Treatment Team Meetings
- [x] Social Skill Modeling by Staff
- [x] Staff Interactions with Youth
- [x] Staff Supervision of Youth
- [x] Facility and Grounds
- [x] First Aid Kit(s)
- [ ] Group
- [x] Meals
- [ ] 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

The Residential Director has been Vice Chair of the local DJJ Board for the last five years.

The agency has attempted to hire a nurse as part of the new protocol for the Pyxis Med-Station, but has been unsuccessful. They have completed three interviews and extended one offer to hire, however the individual denied the offer.

The agency is in the process of scanning all old files into the "cloud" to be kept electronically.

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

Standard 1: Management Accountability

Overview

Narrative

Youth and Family Alternatives' organizational structure at the Executive level includes George Magrill, President and Chief Executive Officer; Ken Conley, Senior Vice President for Administration and Andy Coble, Vice President of Prevention Services. At the time of this on-site quality improvement program review, the YFA Residential program employs a Residential Director, two Office Specialists, six Youth Development Specialist (YDS) Team Leaders, three Residential Counselors, one Life Skills Specialist, and six Youth Development Specialists.

The non-residential program employs a Program Director, a Program Supervisor, five counselors, and a therapist. At the time of the on-site program review, the agency position vacancies include seven vacant YDS part-time positions.

The agency operates a Risk Prevention and Management Team Meeting that reviews various issues while reviewing incidents every quarter. This team is comprised of various YFA staff members. Youth and Family Alternatives, Inc. is accredited by the Council on Accreditation (COA).

1.01 Background Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There were two new staff hired since the last on-site review. Both staff were appropriately screened prior to their hire date. Both staff received an eligible rating. There was one staff applicable for a five year re-screening. The staff received a re-screening within the appropriate time frame.

The Annual Affidavit of Compliance with Level 2 Screening Standards was submitted on January 15, 2015.

1.02 Provision of an Abuse Free Environment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

All staff are required to adhere to a code of conduct. There were no instances of management taking disciplinary action against staff relating to violations of the code of conduct.

There were nine employee files reviewed. All files had documentation of the employees acknowledging the code of conduct and reporting procedures for the Florida Abuse Hotline.

There were five youth surveyed—all acknowledge they know the number to the abuse hotline, staff is respectful, and they use appropriate language.

There were nine staff members surveyed—all reported they have not heard another staff advising youth they could not call the abuse hotline. Eight of the nine staff members stated they have not heard a staff use profanity when speaking to the youth. All nine staff members have never observed a staff member using threats, humiliation, or intimidation when talking to the youth.

The shelter has a grievance process in place. Grievance procedures are explained to the youth during the intake process. Grievance forms were observed in the shelter and readily available to the youth. The agency reported there have been no grievances filed since the last Quality Improvement review. Out of the five youth surveyed, four of the youth acknowledged knowing about the grievance process and rated it as very good.

1.03 Incident Reporting

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There is a written policy in place. There were four Central Communication Center (CCC) reports in the last six months. Three of the four incidents were reported within the required two-hour time-frame. The remaining incident was reported approximately thirty minutes late. There was documentation that all four CCC reports were closed and follow-up communication and tasks were completed as required by the CCC.

1.04 Training Requirements

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency uses Relias, an on-line computer based training and tracking system. All staff training files are maintained on the Relias system. In addition, the agency still maintains a training file for each staff (with hardcopies of all training hours and certificates). The agency's goal is to eventually go paperless and maintain all training on Relias only.

There was one staff training file applicable for first year training requirements. The staff documented more than the required number of training hours with 139.75 hours. All required trainings,

as well as, additional trainings were covered.

There were four staff training files reviewed for annual training requirements. All four staff documented more than the required number of annual training hours—42, 42, 43.5, and 45.5 hours respectively. All required and recommended trainings were covered.

1.05 Analyzing and Reporting Information

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

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

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

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

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

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

The agency has instituted a feedback process for the peer review and CQI plans. This involves the coordination of the QI process, the monitoring of compliance, and follow-ups to see if improvements have had the desired result. This information is shared freely with program supervisors.

Subcommittees of the QI Council keep detailed minutes of their meetings. Plans and results are tracked. There is documented evidence of the enforcement of training related to issues identified through the QI process. The review of incidences afterward displays that the agency monitors its success.

The committees have identified three areas of concern within the shelter and developed CQI Worksheets to address the issues. The worksheets identify the issue and desired outcome. The issues identified for residential were for the Consent for Release of Information to be completed and signed in all applicable files, the service/treatment plan to be reviewed and signed every 30/60/90 days, and group notes to be completed at least five days a week. A team of reviewers came to the program and reviewed all youth files for these issues. The issues were identified and corrective actions were put into place. A follow-up review is scheduled to ensure recommendations were implemented. Supporting documentation from the file reviews was attached to the CQI Worksheet. The issue identified for non-residential was the service plans in the files were not being reviewed/signed every 30/60/90 days. Again all files were reviewed and issues were identified. Supporting documentation was attached to the CQI Worksheet and a follow-up review was scheduled.

1.06 Client Transportation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Due to this indicator being new as of August 2015 the program was still in the process of developing a final policy and procedures. A draft of the “Policies and Procedures for Client Transportation” was presented to this reviewer. The draft did address approval of drivers, maintaining a 3rd party, transportation of a single client, logged documentation of transportation, list of authorized drivers, and agency’s insurance policy.

The logbook for the vehicle was reviewed. Information documented contained name of driver, date, mileage, number of passengers, purpose of travel, and location. The time and ratio of staff to clients can be verified by the logbook. The driver calls in and reports the time and location to staff at the facility. If needed the phone records can also verify time and location of driver. Copies of valid driver’s licenses were provided for all authorized drivers.

1.07 Outreach Services

☐ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

At the time of review, the agency did not have a written policy for this indicator. The agency provided documentation of minutes and attendance at the DJJ Board and Council meetings. The Program Director is the Vice-Chair of the DJJ Board.

The agency provided a binder titled “Interagency Agreements”. The binder was neatly organized with interagency agreements categorized by service. The most recent agreement was dated August 1, 2012 and the earliest was dated February 11, 1998.

This reviewer recommends the “Interagency Agreements” binder be updated to: remove unsigned agreements, remove outdated agreements, remove duplicates of documents, and update Interagency Agreements (some agreements were 10 plus years old).

The agency provided documentation of outreach events, presentations, and meetings.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

The agency is contracted to provide residential and non-residential CINS/FINS services to youth and families residing mainly in Hardee, Highlands, and Polk counties. The program consists of a Non-Residential Program Director, a Non-Residential Program Supervisor, five counselors, and a therapist.

The counselors work closely with the schools in each county served and in return the schools have given the counselors space to use free of charge. The counselors are responsible for the case from screening to discharge.

2.01 Screening and Intake

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has policy and procedures in place which reflect the provision of centralized intake services providing shelter services accessible 24 hours, seven day a week.

There were six files reviewed—three residential and three non-residential. There were five out of six screenings conducted within seven calendar days of intake.

The program provides residential and non-residential services to the community. All six files contained a copy of the available service options and rights and responsibilities of the youth and parents/guardian. There were signatures on the documents by the youth and parent/guardian indicating these documents were provided at the time of admission/intake. Grievance procedures were provided to the youth/parent in the same brochure; however, there is no direct form in the file to indicate the youth or parent/guardian actually received a copy of this. It is suggested the receipt of the grievance procedures is also documented in the file.

2.02 Needs Assessment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There were six files reviewed—three residential and three non-residential.

The needs assessments were initiated within 72 hours of admission in all three residential files reviewed. The needs assessments were completed within 2-3 face-to-face contacts (following the initial intake) in all three non-residential files reviewed. All cases were under six months of services therefore no updates of the needs assessments were necessary. The needs assessments were completed by a Bachelor's or Master's level staff and signed by a supervisor. One youth was identified with an elevated risk of suicide as a result of the needs assessment and a suicide risk assessment was conducted by a licensed mental health professional (providing recommendations). During the needs assessments there were diligent efforts to include the families in the solutions to the youth's social/emotional concerns.

2.03 Case/Service Plan

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There were six files reviewed—three residential and three non-residential.

All case plans were developed within seven working days following the completion of the needs assessments. The plans were developed based on the needs identified during the assessment.

The case plans included the identified needs(s) and goal(s), the type, frequency, and location of services provided. The plans were developed with the youth and family members, and all signatures were included—parent, youth, counselor, and supervisor. And all of the case plans reviewed included the date of initiation.

The case plans were reviewed as evidenced in progress notes or 30, 60, 90 day reviews on the case plans for the residential files. None of the cases were open for over six months.

2.04 Case Management and Service Delivery

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There were six files reviewed—three residential and three non-residential.

Only two of the six cases reviewed were case management cases. The case managers provided direct services to meet the youth/family needs identified during the assessment. All requirements were met in this section. Documentation was made of the case manager's efforts to meet service delivery, including meeting with family members/youth and monitoring progress. In both cases there were no out-of-home placement.

There were four cases reviewed that were counseling cases. The youth and family received counseling services in accordance with the treatment plan as evidenced in progress notes. Group counseling was provided at least five days a week and documented in progress notes or the group sign-in log. Individual/family counseling was offered to the youth and caregivers.

2.05 Counseling Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy and procedures in place to ensure that youth and families receive counseling services in accordance with the needs identified during the assessment process.

Youth and families received counseling services in accordance with the youth's case/service plan. Youth and families received counseling services in accordance with the developed treatment plan. All the cases reflected the coordination of all the components. Non-residential files provided services in the community—including youth school, home, and community. Chronological notes were maintained to reflect youth's progress.

Supervisors ensured clinical reviews of the case records as evidenced by signature of clinical supervisors on the needs assessments, treatment plans or as per the counselor's documentations at 30/60/90 days. Non-residential files also include a written feedback form upon review of the supervisor.

The shelter offers individual/family counseling services. Counselors met with the youth as planned and if the youth or caregiver were not available or canceled, documentation in the progress notes was recorded. Counselors maintained chronological case notes on the youth's progress as evidenced in the file.

The shelter provided group counseling five days a week (evidence provided in progress notes or group log sign-in sheets). If the youth was not available for group or group was rescheduled notes were made on the sign-in sheet. However, this documentation was not recorded in the youth's file.

Closed files reflected aftercare plans, as well as, a copy of the referrals made at the time of discharge to continue services and prevent involvement with the delinquency and dependency system.

2.06 Adjudication/Petitiion Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy and procedures in place to ensure that a case staffing committee meeting is convened to review the case of any youth or family that is in need of services.

There were three case staffing cases reviewed.

All cases included evidence that staff initiated the case staffing meeting and not the caregiver. As a result of the case staffing committee meeting there was evidenced that two of three parents participated in the meeting and one parent participated by phone. Staff reported the parents that attend case staffings are provided with the copy of the revised or new service plan at the end of the staffing. The parent that participated by phone was visited at the home by the counselor five days later and a copy of the revised service plan, as per staff report, was provided to the parent during the home visit. The case staffing files reviewed were not recommended for court intervention.

2.07 Youth Records

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy and procedures in place to ensure confidential records are maintained for each youth receiving services in the program.

All records are marked "confidential" and kept secure. The shelter files are kept in a locked office or in a locked filing cabinet. All youth records were maintained in a neat and orderly manner and contained a "chart protocol" specifying where information is located. Records were organized according to the programs Chart Protocol.

Reminder: It is a new requirement this year that all records transported are locked in an opaque container that is marked confidential.

Standard 3: Shelter Care

Overview

Rating Narrative

The George Harris Youth Shelter is located in Bartow, Florida. It is one of three (3) shelters that Youth and Family Alternatives operates in the state. The other two (2) residential youth shelters are located in New Port Richey and Brooksville. The Bartow shelter is a well-designed facility that is clean, nicely furnished, attractively landscaped and well maintained. There were no signs of graffiti, property damage or any hazardous or dangerous conditions during this site review. A comprehensive tour of the facility was conducted to determine the environmental conditions of the facility and the living conditions for the youth.

This residential shelter operates twenty-four hours a day, 365 days a year and is licensed to serve up to twenty-four residents for runaway and emergency shelter services. The youth shelter is contracted to serve both CINS/FINS youth and children placed by the Department of Children and Families (DCF).

The youth shelter utilizes effective documentation practices in the agency's program logbook. The agency has also provided new Youth Development training to staff members. At the time of this on-site Quality Improvement (QI) review, the shelter had five CINS/FINS youth. Youth in the shelter at the time of this on-site review responded to an online survey. These residents reported that they feel safe and that they had not witnessed or experienced any adults threatening any residents.

3.01 Shelter Envonment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency's inspections were reviewed and up-to-date. The license was current and visibly posted. The Disaster Plan is current and a copy is located at most exits for easy access. Evidence of monthly fire drills was available. The agency conducts them monthly on each of the three shifts.

The living areas were neat and clean. The bedrooms/bathrooms were clean and neat. The furniture was in good repair. Each youth had their own closet and clothes drawers. The youth's bed linen was complimentary (comforter/sheets). However, personal touches were a minimal. Each room had an emergency escape route posted. The laundry room was well organized and immaculate. The youth are able to have personal items (money, jewelry, etc…) secured in the medication room. Money can also be locked up for safe keeping.

In each of the living quarters (boys/girls), dining room and common/great room the lighting was appropriate and furniture/walls were free of graffiti. There are bulletin boards with posted informational signs for the youth (daily activity schedule, menus, rules, ABUSE Hotline, etc...). The activity schedule/programming is posted in the bedroom area as well as common/great room. It is well documented and identifies the activity along with the approach, character and outcome. There is evidence of a 4-week meal cycle which is posted in several areas. The facilities grounds and exterior are well kept and maintained. Exterior lighting appears to be in order.

The vehicles were locked and clean of debris. The three vehicles viewed contained a first aid kit, fire extinguisher and flashlight. In one vehicle there was no sign of a glass breaker/seat belt cutter, however one was obtained from an inoperable vehicle owned by DCF and was put in the current vehicle.

Chemicals were stored securely along with the MSDS listing each item. One container of Windex was not clearly labeled (the bottle was labeled Simply Green). Weekly signatures were visible, however a suggestion would be to date the signature at the time of inventory.

3.02 Program Orientation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency's orientation process appears to be seamless. Three residential youth files were reviewed. Each file contained a Client Orientation Checklist that listed key points (general rules, grievance procedure, contraband, visitations, etc...). The staff and youth both initialed and signed, with the exception of one of the three files reviewed in which there was no parent/guardian signature on a separate Intake Record House Rules form.

Also to note, one youth was admitted on Monday, 9/21/15, and there are forms not signed by the Supervisor and Shift Leader as of 9/23/15. There is indication that the youth received a youth handbook at intake as there is a form that they sign along with staff. Although the Client Orientation Checklist indicates that a review of the Search/Contraband Policy is explained to the youth there is no indication that a list of contraband was provided to the youth. However, a document listing contraband items was located on the lobby counter and posted in the living areas. A suggestion would be to include the list in the admission material.

3.03 Youth Room Assignment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The three youth files that were reviewed contained an Admission Sleeping Assignment Form. Information obtained during the screening, intake and admission were documented (i.e., age gender, size, gang affiliation, and other risks). Although there is a Sexual Orientation question on the Centralized Intake Screening Form, it is not listed on the Admission Sleeping Assignment Form. In two of the three files it was recorded that the youth's sexual orientation was "not known/determined". Therefore, it is unable to determine if this indicator was reviewed as part of the sleeping assignment determination. It is suggested that this indicator be added to the Admission Sleeping Assignment Form.

There are is indication that an Alert System is in place and is being utilized.

3.04 Log Books

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy and procedure for Log Book utilization. The staff utilize three log books (staff, girl's dorm and boy's dorm). The staff log book contained pertinent information regarding the general shift occurrences, issues, youth case management, visits, activities/events, location of staff, and notes to the staff. The staff log books were well documented by the Youth Development Staff/Specialists. There is clear indication that Incidents are well documented and follow-ups were noted. The notations are informative (visits, appointments, locations) with dates, times and signatures and appeared to be in the real time. The counselor's documentation is well written and detailed to the subject at hand.

There is indication that the staff are reviewing the previous two shifts at the time they sign in. There was evidence of Supervisory reviews being completed; however, some were more detailed than others. A recommendation would be to ensure that feedback in regards to the previous week's notations is provided (i.e., corrections, recommendations or follow-ups). There were some instances where general notes to the staff were not signed by the writer. There were instances of blank lines at the end of the page or after notations that need to be marked through (voided).

3.05 Behavior Management Strategies

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency utilizes Advanced Youth Development (AYD) as their Behavioral Management System (BMS). It was reported that they will also be employing MAB (managing aggressive behavior) in the near future. AYD training is provided to all the staff and was held as recently as September 2015.

The training material provided supported the use of levels (Orientation, Education and Graduation) and the times frames a youth could progress. The levels coincide with the youths' daily point sheets. The agency's BMS appears to provide for incentives, skill building, and logical consequences to the youth. It was reported that the monitoring and feedback of staff's utilization of AYD is done either on the spot or at staff meetings.

3.06 Staffing and Youth Supervision

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency maintains the minimum staffing ratios as required by the standard (1-6 awake, 1-12 sleeping). Staff (Youth Development Specialist) schedules reflect 2 staff (M/F) on the overnight 12-8 shift, and 3 staff each on the 8-4 and 4-12 shift. Staff schedules are provided to each staff member and is located on the staff clip board, as well as, posted on the Youth Development Specialist desk counter. A staff roster is accessible and located on the staff clip board and includes names and phone numbers.

Overall, the staff are conducting the physical observations of the youth while they are in their bedrooms and appear to be in real time. However, there were some inconsistencies with the duration of time in between the checks (some in excess of 15 minutes up to 25 minutes).

3.07 Special Populations

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There are four identified Special Populations in this section: Staff Secure, Domestic Violence Respite, Probation Respite, and Domestic Minor Sex Trafficking. The agency has policies and procedures for two of the four Special Populations. These policies and procedures are for Staff Secure and Domestic Violence Respite. Although the agency has not provided services to the two other special populations—Probation Respite and Domestic Minor Sex Trafficking—it is recommended policies and procedures be developed for this population.

There is a written policy for Domestic Violence Respite. The agency advised reviewer they do not take youth ages 8-9. There were three files reviewed in this area. All files had evidence of prior approval; pending DV charge, and evidence of being screened by JAC/Detention. The length of stay was less than 14 days and case plans reflected goals focusing on aggression management. The files showed documentation of all other general CINS/FINS program requirements.

The agency reported they have not had any staff secure youth since the last Quality Improvement review.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

Youth and Family Alternatives (YFA) has screening systems and processes to detect general health and mental health risks presented by prospective residents. This process requires that each resident that meets CINS/FINS eligibility requirements be screened by staff members for the severity of potential health and mental health issues. Designated trained YFA residential and non-residential staff members utilize agency screening forms that include the general screening form, CINS Intake form, Psycho-Social Assessment and the Evaluation of Imminent Danger for Suicide (EIDS). The CINS intake form includes a health screening section that is required to be completed by staff members. The agency also utilizes a Suicide Risk Assessment instrument that is conducted on youth that indicate a positive “hit” on the CINS Intake form. The agency's staff members consult directly with the Program Director who is a Licensed Clinical Social Worker (LCSW). All YDS staff members at the youth shelter are trained on the suicide risk screening process and utilize the CINS Intake form to screen for potential risks prior to placing all youth on sight and sound supervision status.

The agency has fully implemented the Pyxis Med-Station 4000 Medication Cabinet. All youth medication is stored in the Medication Cabinet. 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 on-site or off-site first aid or medical care. Staff members are trained on safety and first aid training topics as confirmed by documentation in training files.

4.01 Healthcare Admission Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy for Health Care Admission Screening and Ongoing Monitoring last reviewed and updated on September 13, 2013. Upon admission to the shelter, Youth Development Staff (YDS) use the CINS/FINS Intake Assessment Form and the Health Screening Form to screen youth for medical, mental health, and substance abuse concerns. 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.

There were six youth files reviewed for Healthcare Admission Screening. In all six files the CINS/FINS Intake Assessment Form was completed at admission. One of the six youth documented the youth was on medication. The medications and the reasons for the medications were listed. The other five youth did not document any medical related issues.

4.02 Suicide Prevention

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy for Suicide Prevention in place that was last reviewed and updated on September 13, 2013. A suicide screening is completed during the initial intake and screening process using the six questions on the CINS/FINS Intake Form Risk Screening section. If the youth answers "yes" to any of the six questions 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. Staff must also ensure there is communication between shifts regarding youth who are on suicide precautions through the alert system and communication log book.

There were three youth files reviewed. All three files documented the CINS/FINS Intake Assessment form was completed during the initial intake and screening process. All CINS/FINS Intake Assessment forms were signed by a supervisor. All three files also documented the EIDS was completed during the intake process and the youth were placed on constant sight and sound supervision until assessed by a qualified professional. All three files documented an assessment of suicide risk was completed by a qualified professional within twenty-four hours. All assessments were completed by a master’s level counselor and a telephone conversation was documented with a Licensed Clinical Social Worker (LCSW) on each assessment and signed the next time the LMHC was on-site.

In two of the three files, the youth was removed from suicide precautions and placed on standard supervision. One file documented the youth was to remain on constant sight and sound supervision and assessed again at a later date. There was documentation the next day that the counselor completed another suicide assessment and talked to the LCSW and the youth was removed from suicide precautions. All three files documented five minute observations of the youth were maintained the entire time the youth was on precautions. 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.

4.03 Medications

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place for medication storage, access, and inventory. At the time of the review the policy was in the process of being updated to include the new Pyxis Med-Station 4000 Medication Cabinet.

The agency has fully implemented the Pyxis Med-Station 4000 Medication Cabinet. All youth medication is stored in the Medication Cabinet. 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. 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 topical medications are stored in a separate drawer in the Medication Cabinet. All over-the-counter medication is stored in a separate locked box, in a locked cabinet, in the same room as the Medication Cabinet. There are eight 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.

The shelter has a system in place for refrigeration of medication if needed. There was no medication that required refrigeration during the time of review.

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. Sharps are maintained in a box, in a locked cabinet and are inventoried weekly and when used. Over the counter medications that are accessed regularly are inventoried by maintaining a perpetual inventory, and also weekly.

There was one youth currently in the shelter on medication. The agency still maintains hard copies of all documents relating to the medication process, as well as, enters all information into the Medication Cabinet system. 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.

4.04 Medical/Mental Health Alert Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There is a written procedure 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 alert system consists of the letters A through H with each letter representing a different alert. A form is placed in the front of each youth's file that documents each alert the youth is on and the reasons for the alert. The alerts are then documented on the outside front cover of the youth's file so it is easy for staff to glance at the file and know what alerts each youth has.

There were six youth files reviewed. All files documenting alerts were identified during the intake process and documented on the Intake Screening and Assessment form. These alerts were also documented on the alert system sheet in the front of each file. There was also a sticker on the front cover of each file that documented the appropriate letter applicable to each alert.

4.05 Episodic/Emergency Care

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There is a written policy in place. The agency keeps a daily log separated by the month of all episodic/emergency care. There were five incidents reviewed. Each incident had documentation of parent's being notified or attempted to be notified. The CCC was notified, as needed, for each case and discharge instructions and follow-up care were documented.

The shelter has a knife-for-life and wire cutters located in the kitchen, copy room, medication room, and monitoring station. All staff held current CPR and first aid certifications.