



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of YFA-New Beginnings

on 11/05/2014

CINS/FINS Rating Profile

Standard 1: Management Accountability

1.01 Background Screening	Satisfactory
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Limited
1.05 Analyzing and Reporting Information	Satisfactory

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

Standard 3: Shelter Care

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

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

Standard 2: Intervention and Case Management

2.01 Screening and Intake	Satisfactory
2.02 Psychosocial Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management and Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petition Process	Satisfactory
2.07 Youth Records	Satisfactory

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

Standard 4: Mental Health/Health Services

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

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

Overall Rating Summary

Percent of indicators rated Satisfactory:95.83%
Percent of indicators rated Limited:4.17%
Percent of indicators rated Failed:0.00%

Rating Definitions

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

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

Review Team

Members

Keith Carr, Reviewer, FOREFRONT/FNYFS

Ashley Davies, Lead Reviewer and Consultant, Forefront LLC

Linda Sessions, Program Manager, Tampa Housing Authority



Mark Shearon, VP of Quality Assurance, Arnette House

Persons Interviewed

- | | | |
|------------------------------------------------------|--------------------------|-------------------------|
| <input checked="" type="checkbox"/> Program Director | 0 Case Managers | 0 Maintenance Personnel |
| <input type="checkbox"/> DJJ Monitor | 3 Clinical Staff | 2 Program Supervisors |
| <input type="checkbox"/> DHA or designee | 0 Food Service Personnel | 0 Other |
| <input type="checkbox"/> DMHA or designee | 0 Health Care Staff | |

Documents Reviewed

- | | | |
|-----------------------------------------------------------------------|----------------------------------------------------------------------|----------------------------------------------------------------|
| <input checked="" type="checkbox"/> Accreditation Reports | <input checked="" type="checkbox"/> Fire Prevention Plan | <input checked="" type="checkbox"/> Vehicle Inspection Reports |
| <input checked="" type="checkbox"/> Affidavit of Good Moral Character | <input checked="" type="checkbox"/> Grievance Process/Records | <input type="checkbox"/> Visitation Logs |
| <input checked="" type="checkbox"/> CCC Reports | <input type="checkbox"/> Key Control Log | <input checked="" type="checkbox"/> Youth Handbook |
| <input type="checkbox"/> Confinement Reports | <input checked="" type="checkbox"/> Logbooks | 5 Health Records |
| <input checked="" type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 5 MH/SA Records |
| <input type="checkbox"/> Contract Monitoring Reports | <input type="checkbox"/> PAR Reports | 9 Personnel Records |
| <input type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 9 Training Records/CORE |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 5 Youth Records (Closed) |
| <input checked="" type="checkbox"/> Escape Notification/Logs | <input type="checkbox"/> Sick Call Logs | 5 Youth Records (Open) |
| <input checked="" type="checkbox"/> Exposure Control Plan | <input type="checkbox"/> Supplemental Contracts | 0 Other |
| <input checked="" type="checkbox"/> Fire Drill Log | <input checked="" type="checkbox"/> Table of Organization | |
| <input checked="" type="checkbox"/> Fire Inspection Report | <input type="checkbox"/> Telephone Logs | |

Surveys

- 4 Youth 5 Direct Care Staff 0 Other

Observations During Review

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

Comments

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

Strengths and Innovative Approaches

Rating Narrative

Youth and Family Alternatives, Inc. (YFA) promotes a broad range of service offerings to youth and families in need in the Citrus, Hernando, Lake, and Sumter service counties. The agency has a total of three (3) residential youth shelters in Florida that provide CINS/FINS services in Brooksville, Bartow, and New Port Richey. The New Beginnings shelter is located in Brooksville, Florida. This Brooksville service location provides both residential and nonresidential services to youth and families that reside primarily in Citrus, Hernando and Sumter Counties. The agency as a whole has multiple inter-agency agreements with local community stakeholders and partners.

During the entrance conference the Shelter Director reported there have not been many changes in staff over the last year. It was also reported numbers and referrals have been high, for both residential and non-residential services. This increase in numbers was attributed to additional non-residential staff being hired. The agency currently has at least one full time staff member in each county served. They have had an overwhelming response from the schools in each county, with the schools giving counselors offices to work out of and internet usage. The counselors are readily available at the school each day resulting in the schools referring more and more youth. The counselors working in Hernando County have access to "Skyward", which is the schools on-line record system. The counselors have the ability to review the youth attendance records. The agency is currently working on staff in the other counties receiving access to this system.

The agency has made improvements to the shelter over the past year. They have installed new floors, painted, and completed some plumbing renovations. The shelter appeared fresh, clean, and clutter-free, creating a welcoming environment for the youth.

The agency has hired two new staff with a domestic violence background to put an emphasis on youth being referred to the shelter with domestic violence charges. There have been some new Youth Development Specialist (YDS) hired, a new Team Leader, new life skills staff, and a part-time YDS who is waiting for background clearance. The shelter will have nine (9) full-time YDS and a shift lead on all three (3) shifts.

The shelter has been dealing with a bed bug problem over the past several months. Recently, the shelter was evacuated and the building was tented and fumigated to rid the building of any remaining bed bugs. All fabric and cloth furnishings were disposed of and replaced. All bed linens were disposed of and replaced. It was also recommended by the pest control company, after the tenting was completed, that all wood bedroom furniture be replaced. The agency is currently in the process of trying to find new furniture to purchase for the youth bedrooms. The agency has a contract with Orkin, a pest control company, to conducted weekly inspections of the facility for bed bugs for the next 60 days and then monthly inspections for the next twelve (12) months. At the time of the on-site review the agency appeared to have the bed bug issue under control.

Standard 1: Management Accountability

Overview

Narrative

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

1.01 Background Screening

Satisfactory

Limited

Failed

Rating Narrative

There were nine staff members hired since the last on-site review. All nine employee files were reviewed to ensure a background was completed prior to the employee being hired. All nine staff had an eligible background screening completed prior to their hire date. There was one staff member requiring a 5-year re-screening and the re-screening was completed to the staff's anniversary date.

The Annual Affidavit of Compliance was completed and submitted on January 28, 2014.

1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

Rating Narrative

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

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

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

The shelter has had six grievances filed by youth in the last six months. Five of the grievances were related to a conflict between the same three youth. The last grievance was a youth wanting more food. All grievances were documented as being resolved, with the resolution documented, and signatures by the youth and staff.

1.03 Incident Reporting

Satisfactory

Limited

Failed

Rating Narrative

The shelter has had nine incidents reported to the Central Communications Center (CCC) in the last six months. Two of the incidents were medical incidents requiring the youth be transported to the ER, four of the incidents were medication errors, one incident was missing keys to a facility vehicle, and the last two incidents were related to the issue the shelter had with bed bugs. One of the nine incidents was documented by the CCC as "failed to notify CCC in a timely manner." This was the incident relating to the missing vehicle keys and was closed as "information only." The remaining eight incidents were reported in the required time frame and all required parties were notified. A CQI worksheet, with the issue identified and actions to be taken, was put into place for medication errors. Follow-up monitoring will be conducted by the CQI team to ensure the issues with medication errors are resolved. The issue the shelter had with the bed bugs was also recently resolved, the shelter was evacuated and fumigated and all bed linens, cushions, and fabric furniture were disposed of and replaced. The shelter also has a pest control company to monitor weekly for bed bugs for 60 days and then monthly for 12 months. It has also been recommended to the shelter replace the wood bedroom furniture and they are currently in the process of doing so.

The shelter also maintains a separate binder of incidents that are not reportable to the CCC. These incident reports were reviewed and appeared to normal incidents that occur within shelter settings. There were no incidents reviewed that should have been reported to the CCC and were not.

1.04 Training Requirements

Satisfactory Limited Failed

Rating Narrative

There were five employee files reviewed for first year training requirements, three staff were non-residential staff and two staff were residential staff. Three of the five staff documented more than the required 80 training hours during the first year of employment. The remaining two staff documented 62.75 and 50.5 hours of training during their first year. Only one staff documented all required training's were completed. One staff did not have Crisis Intervention training, two staff did not have Suicide Prevention training, one staff did not have the CINS/FINS core training, One of the two applicable staff did not have Title IV-E training, two staff did not have Fire Safety training, two staff did not have Mental Health and Substance Abuse training, one of the two applicable staff did not have Self-Defense training, two staff did not have Understanding Youth and Adolescent Development training, two staff did not have Confidentiality training, two staff did not have Child Abuse Reporting training, two staff did not have Professionalism training, two staff did not have Trauma Informed Care training, and three staff did not have Prison Rape Elimination Act (P.R.E.A.) training.

There were four employee files reviewed for annual training requirements following their first year of employment. None of the staff documented the required 40 hours of annual training, the staff documented 24.5, 17.5, 25, and 26.6 hours respectively. None of the staff documented all required training's were completed. Two staff did not document fire safety training, did staff did not have a current CPR or First Aid Certification, and three staff did not document Suicide Prevention training.

1.05 Analyzing and Reporting Information

Satisfactory Limited Failed

Rating Narrative

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

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

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

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

Monthly review of NetMIS data reports - Program management reviews monthly NetMIS data and clearly knows where the agency is in terms of

objective achievement at all times.

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

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

The committee's have identified three areas of concern within the shelter and developed CQI Worksheets to address the issues. The worksheets identify the issue and desired outcome. There were several issues identified during an audit of the residential charts. A CQI worksheet was put into place to correct issues found in the charts. Corrective action plans have been put into place and a follow-up will be scheduled to ensure recommendations are implemented. Supporting documentation from the file reviews was attached to the CQI Worksheet. The second CQI worksheet reviewed identified several issues found during the chart audit of the non-residential charts. Again all files were reviewed and issues were identified. Supporting documentation was attached to the CQI Worksheet and a follow-up review was scheduled. The third issue identified was related to medication errors. This issue was identified at the other two programs operated by the agency as well. The agency had the nurse from DJJ deliver a refresher training on the self-administration of medications in shelter settings. The shelter directors from all three shelters discussed practices at each shelter along with specific incident data to determine best practices. Each shelter is going to review and train medication control and management policy with all staff. CQI validation will occur at each shelter at 45 day intervals.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

Youth & Family Alternatives, New Beginnings program screens and assesses each youth and family referred for intervention services, to determine what, if any, services are needed. Services include screening, intake and assessment of the youth and family, case management services, determination of needed services, development of case service plans, referrals to services identified in the service plan, crisis intervention services, and follow-up contact at 180 days after the termination of the agency services. YFA - New Beginnings, has both a residential and non-residential component, they work cooperatively to serve youth and families in need. The atmosphere appears to be warm and friendly, management and staff present as cooperative, competent and committed.

The agency is contracted to provide residential and nonresidential CINS/FINS services to youth and families residing in Citrus, Hernando and Sumter Counties. The program provides non-residential services that are provided at the agency's office, local schools, and at the offices of other community based organizations.

The nonresidential component consists of a Non-Residential Master level Program Director and Program Supervisor. The program has assigned four (4) full-time Counselors to Citrus county one (1) Counselor in the Hernando county and two (2) Counselors in the Sumter county service region.

2.01 Screening and Intake

Satisfactory Limited Failed

Rating Narrative

Centralized intake processes are active and consistent for both the residential and non-residential programs. Six non-residential files and five residential files were reviewed for accuracy and completeness. All files contained proper intake forms, neatly placed in file, and signatures were complete. Available service options were identified, rights, responsibilities and information brochure information is consistently disseminated to youth and parents.

There were no materials that offered information to the youth and parents about possible CINS/FINS Adjudication process, CINS petition.

2.02 Psychosocial Assessment

Satisfactory Limited Failed

Rating Narrative

The needs assessment Psychosocial summary is very thorough, the format is easy to read. All psychosocial assessments reviewed were completed by a Bachelor's of Master level professional. A variety of screening and assessment tools are completed on each youth upon intake, including a face-to-face interview, a bio-psychosocial, the Alcohol Tobacco Other Drugs (ATOD), CINS/FINS Intake Assessment Form, Admission Risk and Safety Screen, Health Screening Assessment, Suicide Risk Assessments. All screenings and assessments completed on the youth are discussed and reviewed with supervisor. All eleven files were complete with signatures.

2.03 Case/Service Plan

Satisfactory Limited Failed

Rating Narrative

The program has a workable case/service plan that is used by both programs. Five (5) non-residential files reviewed included treatment plans complete with all components listed in the standard. All files were reviewed and signed by a counselor, parent, client and supervisor. The service plans for ten (10) of the eleven (11) files were completed within seven (7) days, as outlined by standard 2.03.

Five (5) residential were reviewed, one (1) of the five(5) the treatment plan was completed after seven (7) days. One of the files did not contain target and completion dates for the client, stated "TBD". Missing youth signature, stated "Runaway", however, the service plan was dated 5/3, the file states that the client was discharged on 6/9/2014.

2.04 Case Management and Service Delivery

Satisfactory Limited Failed

Rating Narrative

The assigned non-residential or residential counselor conducts weekly, bi-weekly or monthly, in-school visits, and attends any community visits needed by the family, such as school meetings, doctor's appointments, and shelter intakes. A referral sheet is available to provide to every family member at the intake of services, and on-going case management, as issues are identified. Residential program director states "211", and the internet are utilized to find available resources. The non-residential consultants attend all first-time shelter intakes, and assist with the monitoring of out-of-home placements. The non-residential consultants facilitate family visits when the youth is at the shelter. The shelter staff makes every effort to involve the youth's parents or guardians in the youth's treatment planning. In addition, the shelter staff coordinates with the non-residential consultants and supervisor regarding treatment planning and assessment and aftercare planning.

The five non-residential files reviewed did indicate thorough service delivery, however, there isn't evidence of case management services. Only one file contained a referral form for services.

2.05 Counseling Services

Satisfactory Limited Failed

Rating Narrative

The program consistently met all requirements for this indicator without exception. It is documented in the contact log and progress notes. Group sessions are provided five (5) days per week, in various forms, Ex. Educational - outing to the library. The program promotes family involvement in the planning and activities provided and the service plans displayed goals, tasks and specific objectives, including family counseling, to improve family relationships and to engage the family in the provision of youth's services. It is apparent there is an internal process that ensures clinical reviews of case records and staff performance for non-residential program.

2.06 Adjudication/Petition Process

Satisfactory Limited Failed

Rating Narrative

The program presented documentation confirming that an active case staffing committee convenes to review the case of any youth and family that warrants this attention. Two (2) youth were identified from the non-residential program, as having been recommended for this process. All case staffing notifications, to parents and the case staffing committee were sent within five (5) days of the scheduled staffing. A review summary was written prior to the staffing. Per the non-residential program director, the recommendations from the staffing serve as the revised treatment plan for the client.

2.07 Youth Records

Satisfactory Limited Failed

Rating Narrative

The program maintains confidential records of case files, as a locked file room was observed. The Non-Residential program director verified that files are kept in locked file cabinets in various county locations.

All six (6) non-residential files reviewed were neat, orderly, and marked "confidential".

Four (4) of five (5) residential files reviewed were neat, orderly, and marked "confidential".

Standard 3: Shelter Care

Overview

Rating Narrative

The New Beginnings Youth Shelter is located in Brooksville, 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 Bartow. The New Beginnings 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. At the time of this onsite Quality Improvement (QI) review, the shelter had six CINS/FINS youth. Youth in the shelter at the time of this onsite review responded to an online survey. These residents reported that they feel safe and that they had not witnessed or experienced any adults threatening any residents.

3.01 Shelter Environment

Satisfactory Limited Failed

Rating Narrative

The facility is very clean and well kept. You can tell that the Staff take pride in there facility. Youth rooms are very well kept and free of any graffiti. An egress map is posted in every youth room and through out the facility. A schedule of daily activities are posted in the main hallway and in the dayroom for all the youth to see and offers the youth plenty of meaningful and structured activities through out the day. The daily schedule meets all contractual requirements for activities.

3.02 Program Orientation

Satisfactory Limited Failed

Rating Narrative

Agency has a very clear and preciss plan in place for this standard. Youth recieve a handbook at intake that explains disciplinary actions, grievance process, emergency/disaster procedures, contraband rules and the facility layout. 7 youth files were reviewed. 5 open chart and 2 closed . 2 of the open charts the clients refused to sign the program orientation forms but it was clearly noted on the form and staff did sign for it. One of the closed charts did not have a program orientation form in the chart at all. There is signs posted around the facility so that if a youth forgets what they learned in there handbook they can be refreshed by they signs. Groups are also held weekly so staff and youth can discuss shelter rules and consequences.

Staff need to monitor the charts and ensure that all documentation is being completed per contractual requirements.

3.03 Youth Room Assignment

Satisfactory Limited Failed

Rating Narrative

Again the Agency has very clear precise policy in place to ensure that all requirements are met in this area. There is a very good form in the chart that shows all the things that are taken in account before a youth is place in a room. 5 open youth charts were reviewed for this standard and all the charts had all required documentation for this standard.

3.04 Log Books

Satisfactory

Limited

Failed

Rating Narrative

Logbooks were reviewed from July 26th, 2014 to present. Entries are clear and capture all contractual requirements. Entries are legible and most corrections are single lined and void. The Supervisors entries are present but not at the required time frames.

Per the standard Supervisors entries should be conducted at least once a week. Also, it is difficult to find important entries in the logbook in a hurry. Best Practice would be to start a color coding system for the different important entries to make it easier for staff to find.

Rating Narrative

The Agency has very clear and precise policies and procedures in place for their BMS plan. The Director has taken a lot of time with the input of the staff and youth to make this plan a very well tuned machine. Youth are given a handbook at intake that explains the BMS and there are signs posted through the facility reminding the staff and the youth about the BMS system. The system is set up on a level system that offers the youth the opportunity to advance to different levels as their behaviors allow them to. If a youth has some issues and slip in their behaviors they are placed on Reflection which allows the youth to spend time reflecting on their behavior and writing a response about what they did, what should they have done and what they will do the next time. Youth are also allowed to request a Deversion Circle which is a meeting with their peers and staff to discuss what they did and ask for suggestions of what they can do next time. The Director meets with the staff every 30 to 60 days to discuss the BMS system and how the staff member is doing with it and if they need to make any changes. The Director monitors the Shift Leaders and the Shift Leader monitors the YDS to ensure everyone is on the same page when it comes to the BMS. Youth have the opportunity to reward the staff with Kudos when they feel the staff is doing a good job as well as the staff can reward the youth also. Youth set goals on Sunday evening to work on for the week and on Friday night they review their goals with the staff and rewards are awarded then.

I reviewed six training files for the staff and only one of them did not have any training for the BMS system.

3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

Rating Narrative

The agency has a staff schedule that is readily available to all staff and meets all requirements that are set forth in the Florida Administrative Code. The agency does have some over night shifts that are covered by two female staff but the Program Manager states that they have a male staff in background screening that will correct this issue. There is a video camera system that is in place and has the capability to record and store up to two weeks of information.

The Agency does required bed checks per the Standard every 15 mins but it is the same time everytime. Best practice would be that the staff mix up the time occasionally.

3.07 Special Populations

Satisfactory

Limited

Failed

Rating Narrative

The Agency has clear and precise policies and procedures for the Special Population Standards. Upon interviewing the Program Director she states that the facility is not a Staff Secure Program and has not been utilized for any Probation Respite. They have served 6 Domestic Violence Respite youth since July 3rd, 2014. All of the youth had documentation that they were approved by the Network to be served as DV youth. All appropriate CINS/FINS paperwork was completed according to Contractual requirements. Of the 6 charts reviewed one of the youth refused any services, two of the youth D/C prior to a Case Plan being started, and the other youth just arrived to the shelter last night. Charts are very well organized but some of the copies of the documentation is very faded and should be monitored to ensure all documentation can be read.

Network approval letters are kept at the Agencies home office and Best Practice would be that a copy be placed in the youth's chart on site.

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 does not have a licensed staff member that works primarily at the New Beginnings youth shelter location. The shelter has access to the Vice President of Prevention Services, who is a Licensed Mental Health Counselor (LMHC), who reviews all suicide risk assessments and consults and reviews with staff regarding youth placed on elevated or sight and sound supervision status. All YDS staff members at the youth shelter are trained on the suicide risk screening process and utilize the CINS Intake form to screen for potential risks prior to placing all youth on sight and sound supervision status. The agency utilizes an effective color-coded general alert system that informs direct care staff of the youth's health, behavior or mental health status. The agency also documents any youth that has received onsite or offsite first aid or medical care. Staff members are trained on safety and first aid training topics as confirmed by documentation in training files.

4.01 Healthcare Admission Screening

Satisfactory
 Limited
 Failed

Rating Narrative

The agency has a policy called SH 600 Healthcare Admission Screening and Ongoing Monitoring. The policy contains the general components that outline the agency's approach to screening and documenting each youth's healthcare care at time of admission.

The review assessed a total of five (5) open case files and a total of three (3) closed case files. The review found all agency client files contain a uniform casefile format. The current file format includes a six (6) section folder that list individual sections. There are two (2) that list general demographics and risk that identify any acute health conditions and mental health issues. The first section includes information obtained by shelter staff at the time of intake. Section two (2) is the middle section of the file and includes contacts, reports received and medical records. In addition, the agency uses a customized Health Screening form to fully capture all health and mental health information. There are a total of three (3) areas in the client file that capture preliminary the past and current information on youth admitted with chronic medical conditions.

Of the 5 open residential files reviewed, all were organized in a uniform manner. Each file had evidence that the agency completed the health screening section of the FNYFS Intake Screening form, YFA Health Screening Form and Tuberculosis Symptom Assessment Questionnaire. The FNYFS Intake form asks several questions that identify all observable injury, illnesses and health-related issues. This document is completed as required by the agency. The second stage YFA Health Screening Form also acts as a redundant method of screening for existing acute health and medical issues. This document is also completed as required by the agency. The third stage Tuberculosis screening form is also completed as required. None of the 8 client files reviewed had documentation related to doctor's reports, and or miscellaneous medical information received.

4.02 Suicide Prevention

Satisfactory
 Limited
 Failed

Rating Narrative

The agency has a policy that is called Suicide Prevention SH 620. The policy contains components that indicate that the agency's policy meets the general requirements of the indicator. The agency utilizes a multi-step suicide prevention process that includes a detailed screening, placement, supervision, monitoring and step-down or referral. The agency's Youth Development Specialist are trained to perform all duties related to the suicide screening process. The agency utilizes Masters Level Counselors to review the screening process and conduct all suicide risk evaluations. The agency has a dedicated licensed Mental Health Counselor that is located in New Port Richey. The agency does have one registered family therapist intern and a registered mental health intern. The current suicide prevention process involves screening for risks associated during the telephone screening process. The agency YDS staff conduct an Evaluation of Imminent Danger Summary (EIDS). The

agency then screens for suicide risk question 1-6 on the CINS/FINS intake assessment. If there is a positive response on the aforementioned questions that agency administers a Suicide Assessment. The youth is then placed immediately on elevated supervision according to the score. The suicide assessment is conducted by Masters level staff. The results are discussed with the agency's LMHC. The youth's supervision status is documented in their file and in the Communication Log accordingly. There was evidence of the youth's supervision status being documented across all shifts until there was a supervision level change. Per the agency policy, the agency does document supervision on each youth and sight and sound status every five (5) minutes as required. Evidence documentation is captured on the agency's Sight and Supervision log and in the agency's Shift Pass Down notes.

All suicide assessments are completed in detail and the majority include evidence of review and consultation with the licensed mental health therapist.

The reviewer conducted an assessment on 6 randomly selected client files. All 6 files had evidence that documents that each youth was screened for Suicide Prevention. The agency utilizes a multi-step suicide prevention process that includes a detailed screening, placement, supervision, monitoring and step-down or referral. All suicide assessments are completed in detail and the majority include evidence of review and consultation with the licensed mental health therapist. The majority of supervision requirements related to sight and sound supervision and documentation by YDS and Shift Lead staff are completed as required.

There are exceptions documented for this indicator. Evidence of the review and signature by the agency's LMHC and credentials is inconsistent. Two (2) did not have evidence of a signature from the licensed mental health professional. One of the 2 cases in which there is a signature indicates that is over 3 months after the therapist's signature.

Some suicide assessment forms do not consistently document the date and time on the form of the consultation and LMHC's decision.

The sight and sound supervision form documents the time staff are conducting all checks. The form requires evidence of signature of all YDS staff conducting checks and a review by the designated Shift Lead or Supervisor. A review of these forms indicates that several instances in which staff and Shift Leads are not consistent signing that they have conducted and signed this completion of these supervision checks as required.

4.03 Medications

Satisfactory

Limited

Failed

Rating Narrative

The agency has a functioning medication distribution system. The current medication policy is called Medication Control and Management and was recently revised on May 29, 2014. The agency has a dedicated medication storage room. This dedicated medication room is located in the rear of the building and requires a key to enter the room. The room houses all prescribed, controlled and over the counter (OTC) medications. All medications are housed in a metal cabinet that is affixed to the wall. The medication cabinet is secured by two (2) pad locks. There are only three (3) locks available at any time to unlock the medication cabinet. The agency trains all staff to distribute medication. All staff are provided training by a Registered Nurse. The DJJ Office of Health Services delivered a training to the agency on June 26, 2014.

All medications housed in the metal medication cabinet are stored separately. Each medication is maintained in its original prescription bottle or box. The cabinet has 3 shelves in which to store medication or other related items. The shelves are labeled OTCs, Prescribed and OTC liquids. The cabinet contains plastic trays that slide into small drawers. Each drawer is assigned to a specific resident on medication. At the time of this onsite program review, the reviewer found that all medications were stored separately as required. All oral medication and topical medication are stored in their original boxes in the same plastic drawer. No medications were stored incorrectly.

The agency does maintain razors (sharps). At the time of this review, there were five (5) razors on site.

The agency has a refrigerator to keep certain medications at low temperature.

The agency has a medication verification process that is active and functioning. The agency uses a Prescription Medication Verification Form to document attempts to verify; verbal verification; name, date and time; comments; staff verifying medication and date and time.

The agency uses a Low Medication Alert Form to alert all staff of when a medication dosage has less than 14 days of medication remaining. This form is to be completed by Shift Lead on duty or designee and forwarded to the youth's assigned Counselor.

The agency uses a Medication Discharge Form to release or discharge medication to a youth's parent or guardian upon discharge or temporary release.

Some exceptions are noted for this indicator. The sharps are generally counted weekly. However, no sharps were counted during the month of September 2014.

A review of documented incidents related to medication distribution was conducted. This review revealed a total of four (4) medication error related incidents. Of these, all document that the agency contacted the dispensing pharmacy for advisement regarding potential side effects or illness. None of these cases resulted in either situation happening to the youth.

The agency has other items not associated with medication storage in the medication cabinet.

The agency disposal process is not consistent based on interviews with YDS and or other staff member.

4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

Rating Narrative

The agency has a general policy SH 640 that describes its practice related to its Medical/ Mental Alert. The current alert policy was last reviewed in May 2014. The policy requires the agency to operate a system that screens and identifies a youth's medical condition, allergies, and other issues related to past or current medical and mental health issues.

The reviewer conducted an assessment on 6 randomly selected client files. All 6 files had evidence that documents that each youth was screened for all medical and mental health condition and allergies. The majority of youth file indicate that they were properly placed on the correct program alert. The current alert system does contain necessary precautions, concerning prescribed medications, and other medical or mental health conditions. Interviews with staff indicates ample knowledge of the system and how it operates. The current system includes a legend that is place in each file with that corresponding code and description. Each file then includes the corresponding letter or written note on the outside of the front of the file to alert staff accordingly.

There is an exception noted. One client file did not indicate an H written in the designated space on the front of the client file for a medical issue related to Asthma.

4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy on Episodic/Emergency SH 650 policies and procedures. The current policy is documented as having an effective date on September 13, 2013. The current policy does not have a recent review or revision date. The policy requires that the have a comprehensive process for the provision of emergency and non-emergency care and that staff respond appropriately and timely to yourh healthcare and non-emergency events. All staff are required to have current training in CPR/First Aid and the use of emergency equipment (knife-for-life, wire cutters, first aid kit). The agency's first aid kits are maintained by ZEE Medical. ZEE Medical is a private company that provides fully stocked and also restock all contents in the agency's first aid kits.

The agency policy also requires that healthcare simulations be conducted on at least a quarterly basis. The policy states that these are to conducted on each sift and on various emergency situations. Each simulation is required to be documented and include type or emergency event/or drill; type of simulation; time of event or drill; any deficient practice and plan for retification. The policy further states that drills should be documented and critiqued and include corrective actions, education adn follow-up including timeframes for all said actions to take place.

Staff are required to contact parents/guardians in the event that medical treatment is required. The assigned counselor must complete all required documentation in the youth's file. The agency maintains record of all actual emergency events on an electronic document table that is updated by the Program Director. The current Episodic/Emergency Care document includes a total of four actual emergency events. This document records ????? The agency also maintains a binder of mock emergency drills. The records reviewed on site reveal that the agency has completed a total of tso (2) drills over the last 6 months.

The agency's policy requires that the the agncy contact the parent/guardian in the event that any medical care or treatment is required. The assigned counselor/therapist is to completed appropriate documentation in the youth's file.

A review of the actual emergency event documented by the agency was conducted by the assigned reviewer. This review revealed that the agency policy requires that the time and name of the parent/legal guardian contact and attmpts will be logged in the Communication Log Book by the Shift Lead. Notes from the log book indicate that both incidents are documented as required.

