



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of YFA-New Beginnings

on 10/15/2013

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	Limited
4.04 Medical/Mental Health Alert Process	Satisfactory
4.05 Episodic/Emergency Care	Satisfactory

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

Overall Rating Summary

Percent of indicators rated Satisfactory:91.67%
 Percent of indicators rated Limited:8.33%
 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 D. Carr, Lead Reviewer/Florida Network of Youth and Family Services

Paula Friedrich, Operation and Management Consultant II, DJJ

Stacy Welton, Vice President, Family Resources



Fern Ellenwood, Assistant Director, Sarasota YMCA

Tom Popadak, Training Director, Florida Network of Youth and Family Services

Margaret Vickers, Director, CDS Behavioral Health Care

Persons Interviewed

- | | | |
|--|--------------------------|-------------------------|
| <input checked="" type="checkbox"/> Program Director | 5 Case Managers | 0 Maintenance Personnel |
| <input checked="" type="checkbox"/> DJJ Monitor | 1 Clinical Staff | 4 Program Supervisors |
| <input type="checkbox"/> DHA or designee | 7 Food Service Personnel | 9 Other |
| <input type="checkbox"/> DMHA or designee | 0 Health Care Staff | |

Documents Reviewed

- | | | |
|---|--|--|
| <input type="checkbox"/> Accreditation Reports | <input checked="" type="checkbox"/> Fire Prevention Plan | <input checked="" type="checkbox"/> Vehicle Inspection Reports |
| <input checked="" type="checkbox"/> Affidavit of Good Moral Character | <input checked="" type="checkbox"/> Grievance Process/Records | <input type="checkbox"/> Visitation Logs |
| <input checked="" type="checkbox"/> CCC Reports | <input type="checkbox"/> Key Control Log | <input checked="" type="checkbox"/> Youth Handbook |
| <input type="checkbox"/> Confinement Reports | <input checked="" type="checkbox"/> Logbooks | 12 Health Records |
| <input type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 8 MH/SA Records |
| <input type="checkbox"/> Contract Monitoring Reports | <input type="checkbox"/> PAR Reports | 13 Personnel Records |
| <input checked="" type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 4 Training Records/CORE |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 11 Youth Records (Closed) |
| <input type="checkbox"/> Escape Notification/Logs | <input checked="" type="checkbox"/> Sick Call Logs | 15 Youth Records (Open) |
| <input checked="" type="checkbox"/> Exposure Control Plan | <input type="checkbox"/> Supplemental Contracts | 7 Other |
| <input checked="" type="checkbox"/> Fire Drill Log | <input checked="" type="checkbox"/> Table of Organization | |
| <input checked="" type="checkbox"/> Fire Inspection Report | <input checked="" type="checkbox"/> Telephone Logs | |

Surveys

- 3 Youth 3 Direct Care Staff 0 Other

Observations During Review

- | | | |
|---|--|--|
| <input checked="" 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 checked="" type="checkbox"/> Recreation | <input checked="" type="checkbox"/> Toxic Item Inventory and Storage |
| <input checked="" type="checkbox"/> First Aid Kit(s) | <input checked="" type="checkbox"/> Searches | <input type="checkbox"/> Transition/Exit Conferences |
| <input checked="" type="checkbox"/> Group | <input checked="" 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 type="checkbox"/> Medical Clinic | <input checked="" type="checkbox"/> Social Skill Modeling by Staff | <input checked="" type="checkbox"/> Youth Movement and Counts |
| <input checked="" type="checkbox"/> Medication Administration | <input checked="" type="checkbox"/> Staff Interactions with Youth | |

Comments

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

Rating Narrative

The Florida Department of Juvenile Justice (DJJ) is the State of Florida's agency responsible for providing programming and services to reduce juvenile crime and increase public safety. According to Florida Chapter 984 the State must provide a continuum of services to prevent Status Offenders from entering the Juvenile Justice system. These services are typically referred to as Children in Need of Services and Families in Need of Services (CINS/FINS). The Lead Agency for CINS/FINS Services for the State of Florida is the Florida Network of Youth and Family Services (FNYFS). Youth and Family Alternatives, Inc. (YFA) provides CINS/FINS service through their contract with the Florida Network of Youth and Family Services, Inc., (FNYFS) on behalf of the Department of Juvenile Justice to provide residential and non-residential services for youth and their families in Citrus, Hernando and Sumter Counties.

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.

The agency has community partners in key areas that include local schools, law enforcement, local mental health and receiving facilities, local area businesses, faith-based organizations and various other community-based organizations. Youth and Family Alternatives in partnership with these community partners provide an array of services that help youth and their family to resolve family issues and increase family stabilization and unification.

Prior to the Quality Improvement (QI) team's on-site visit, the agency's personnel were notified of the monitoring visit and informed of all documents for the agency to prepare in advance for the onsite QI review. The agency provided the pre on-site information on the requested date prior to the review. All of the staff members were cooperative with the monitoring team throughout the two day on site review.

The Youth and Family Alternatives (YFA) New Beginnings (NB) agency has an agency-wide outreach component that markets all of the agency's service offerings all three (3) of its major service regions. The agency also has an active eighteen (18) member Board of Directors that provides leadership, support and promotes the agency's services throughout the service region. The agency's outreach staff members conduct presentations to various entities, organizations, human service agencies. Agency information is also presented to interested persons and/or groups, community provider meetings and at community events. The agency also distributes information cards and brochures. The Youth and Family Alternatives program promotes the National Safe Place Program and secures numerous safe place sites throughout their service area. The agency has a large Safe Place sign prominently posted on the front fascia of the residential shelter.

In addition, the agency is currently planning to host their annual 5 Kilometer fund raising event called the Run/Walk for New Beginnings on October 25, 2013. This event generally takes place during October which is Runaway Prevention Month. The agency reported that \$24,000 in sponsorship had been raised for the event to date and over 150 runner participants signed up in a week.

The agency-wide outreach efforts include the use of the internet and online social media outlets to promote its services, recruit volunteers and volunteer organizations and local community events. The agency has posted informative videos featuring its services on the YouTube website. Further, the agency has invested in producing professional full color marketing materials that include a tri-fold brochure, booklets and seasonal newsletters to market its services to eligible youth and families in Citrus, Hernando and Sumter Counties.

Strengths and Innovative Approaches

Rating Narrative

The agency hired a new Program Director on May 16, 2013. The director facilitated transition as the Non-Residential Service of the agency until July 1, 2013. The new director initiated this by acquainting herself with the staff. The director evaluated systems for established working systems and those that have not worked as well. The new director is working to see what ownership staff had taken of their jobs, the youth, the program, and process. The new director stated that she observed staff with great ability and potential, but needed empowerment. The agency has begun to develop implementing a plan for program improvement. The agency did this by talking to staff and found out their strengths; asked their opinion on what they thought was going well and what needed change; asked for ideas to make operational and program changes; and asked for obstacles that they perceived.

The YFA-NB program utilizes a Youth Development approach to enhance the effectiveness of interaction between staff and client and its Behavior Management System.

The agency is now using a Youth and Staff "Kudos" Board and reward system as recognition for outstanding youth behavior and staff work performance at the New Beginnings shelter. The YFA staff or peers can provide KUDOS on the board. KUDOS are read to youth by staff at each Friday's House Meeting following dinner. Rewards are placed on the KUDOS board by levels from which to be selected. Rewards are "paid out" over the weekend. KUDOS receives "tickets" put in a fishbowl for each KUDO. Tickets are drawn throughout meeting to give gift cards to staff. Staff is given written KUDO to keep.

Youth and Family Alternatives has expanded the number of non-residential counselors up to seven (7) case managers/counselors to increase the level of services provided to rural and outlying counties and regions in need of services.

The agency continues to operate their "Cook For Kids" program with local community organizations that come to the shelter to cook on site and provide weekly meals and mentoring for youth at the shelter.

The agency's new Program Director conducted her own series of program and operation assessments to determine the current status of New Beginnings. The new Director began learning what worked and what was lacking. The Director began learning the "residential" side of Quality Improvement. The agency provided opportunities for staff "buy in" and to have ownership of change. The YFA agency is still tweaking some of the processes. The agency has implemented new systems.

The agency developed a specialists system to meet or exceed Quality Improvement training requirements. The agency has specialist values that focus on her/his area of focus. The agency has created a new description for each specialty. The areas of specialty are Orientation Specialist (packet attached); Intake Specialist; Safety Specialist; Sharps Specialist; Laundry and Med rooms Specialist; Medication Specialist; Disaster Preparedness Specialist; Cleaning Specialist; Drill Specialist; Training Specialist; Title IV-E Specialist; Physical Activity Specialist; DOH / Van Specialist; Group Specialist; School Specialist; and FLN Standard Specialist.

The new director began to immediately train staff to use behavior management plan toward positive success for the youth. The YFA-NB program trained staff how to create groups relating to 6 Pillars of Character and 12 Developmental Outcomes. Staff began developing and presenting groups with purpose. Goals for groups are developed in advance by youth at Sunday night House Meeting and put on youth KUDOS board. This provides the opportunity to be used in redirection and/or group development topics for week.

The agency offers structured activities for all youth. The agency offers a working with a Literacy Coalition for GED program at shelter.

Standard 1: Management Accountability

Overview

Narrative

The organization structure of the Youth and Family Alternatives' company 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 Youth and Family Alternatives - New Beginnings (YFA-NB) Residential program employs Carolyn Kehr as their new Program Director.

Since the last on site secondary follow up visit for the 2012-2013 fiscal year, the Youth and Family Alternatives - New Beginnings CINS/FINS Program has undergone significant changes. The primary changes have occurred at the program's leadership level. The program has secured a new residential Program Director and appointed a new non-Residential manager, as well as other key program staff over the last six (6) months to improve program performance and consistency.

The agency's residential program has one Youth Development Team Leader, two (2) Youth Development Shift Leaders, two (2) Counselors, ten (9) FT/PT/On-Call Youth Development Specialists (YDS), and an Office Specialist. The Non-Residential Program includes a Program Director and three (3) Counselors for this service area. At the time of the onsite Quality Improvement (QI) program review, the agency position vacancies include 1 vacant full-time YDS Full-time position and 21 vacant Part-time YDS positions. The agency's Program Director reports that job offers have been made to all potential candidates for the aforementioned vacancies.

Youth and Family Alternatives, Inc. is accredited by the Council on Accreditation (COA). In addition, the program's Continuity of Operations Plan (COOP) was approved by the Florida Network in May/June 2013.

Staff were accessible and helpful during the review. All documents requested were provided. The agency's policy book is organized, detailed and consistent with FNYFS requirements.

1.01 Background Screening

Satisfactory

Limited

Failed

Rating Narrative

The agency has a comprehensive policy that is based on the FNYFS policy manual and the compents of this YFA policy addresses the requirements of this standard. The reviewer indicated that overall, the Personnel files were very organized and easy to find the needed information.

A random selection of client files was completed on site. A total of seven (7) YFA staff members were recently hired and reviewed for background screening verification. Of those 7 staff, all background screenings were rated eligible and all were completed prior to the hire date.

The agency did not have any staff that fell within the time frame for a 5 year rescreening.

The Annual Affidavit of Compliance with Level 2 screening standards was sent via FedEx to the Office of the Inspector General on January 25, 2013. This is within the required time frame. The Affidavit contained data on thirty-two (32) staff members both active and terminated.

There were no exceptions noted for this indicator.

1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

Rating Narrative

The agency has a comprehensive policy regarding the provision of abuse reporting and the provision of an abuse free environment. This policy meets the requirements of mandatory reporting.

The agency provided documentation of youth grievances were reviewed. There were several against other youth and several against staff. All were noted to have a resolution. Discussion with the Program Director confirmed that the issues "grieved" were addressed with the staff in supervision.

The Abuse Hotline numbers are posted throughout the common and youth living areas. The numbers are posted in red and very visible. The clients rights are posted in the same area. The youth have access to the grievance form in the main hallway. The staff reported that the youth will either give the grievance to a staff, can have an envelope if requested and are able to bring the grievance to the Program Director and slip under the door for confidentiality.

Youth online survey results indicated that there were no concerns with staff using profanity. Surveys also indicated that staff and youth are aware of the protocols for reporting to the abuse hotline.

The Program Director reported that there has not been any employee discipline related to employee violations of the abuse free environment and abuse reporting requirements.

Some exceptions were noted for this indicator. An inspection of the physical environment was conducted and it reveal some noticable graffiti on the client "kudo" board. This graffiti pointed out, the team leader had it immediately removed.

Online surveys completed by staff indicated that 2 out of 6 members staff surveyed have been noted to observe a co-worker using profanity when speaking to a youth.

1.03 Incident Reporting

Satisfactory

Limited

Failed

Rating Narrative

The agency has a comprehensive policy that is based on the FNYFS policy manual and the compents of this YFA policy addresses the requirements of this standard. The agency has a policy in effect that meets the reporting requirements and mandated time frames. Review of incident reports indicate the policy is being followed as required.

Incident reports were reviewed from May 2013 to the present. There were a total of nine (9) Department of Juvenile Justice (DJJ) Office Central Communications Center (CCC) incident reports that were reviewed. All required documentation was present in each reported incident. Many incidents were called into the DJJ CCC, but were listed as "non-reportable" or "information only".

The documentation of incidents was legible and clearly described the incident. In some instances, the use of documented/written abbreviations was at times difficult for the reviewer to interpret.

The YFA-NB Staff members that were interviewed were familiar with the documentation, reporting, and time frames.

There were no exceptions noted for this indicator.

1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

The agency policies and procedures comply with the inidcator requiring YFA staff members to receive training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions. All direct care CINS/FINS staff are required to have a minimum of eighty (80) hours of training for the first full year of employment and forty (40) hours of training each year after the first year due to the program being licensed by DCF. The policy and procedure requires completion of the following training in the first year as well as three (3) recommended training topics. The agency's required training includes:

- Program Orientation Training including agency, mission goals and objectives, agency philosophy CINS/FINS Core Training,
- Crisis Intervention Skills,
- Program Safety and Self Defense,
- Suicide Prevention,
- Sign and Symptoms of Mental Health and Substance Abuse,
- CPR and First Aid,

- Behavior Management,

- An in-service component, describing the specific on-the-job training completed, and

- Medication Distribution for Non-Licensed Staff.

The agency's recommended training includes:

- Emergency Response,

- Universal Precautions, and

- Cultural Competency.

Following the first year of employment, direct care staff training for residential staff are required to include refresher training on the use of available fire safety equipment, training necessary to maintain current CPR and first aid certification and suicide prevention. Agency policy exceeds this standards indicator in that the annual retraining on CINS/FINS Core is required.

Trainings are scheduled throughout the year, and have been provided by the Florida Network, local community resources, and various local provider personnel.

The program does maintain an individual training file for each staff as required by the standard and agency policies and procedures, and include an annual employee training hours tracking form and related documentation, such Florida Network of Youth and Family Services Quality Improvement Standards Children/Families In Need of Services as certificates. Printed training certificates were included in the files as documentation of each training completed, but sign-in sheets or training agendas are maintained by the office specialist and review of sign-in sheets supported the completed trainings in the files reviewed.

Files reviewed for this standard were for two (2) employees who completed their first year of employment within this review period, six (6) employees who were beyond their first year of employment and one (1) employee currently seven (7) months into his first year of employment. Two of the files were for non-residential staff and the remainder were for residential staff members.

Seven (7) of the 7 staff training files reviewed who were also listed as staff authorized to administer medications were all documented to have completed medication training.

The agency's Policy and Procedure on training (SH150) does not specifically identify Title IV-E procedures as a required training topic, but practice is that Title IV-E training is documented as part of the Residential Site Orientation topics that is to be covered in the first 10 days of employment.

An individual training plan is included in each training file, which were neatly organized in individual classification folders by year of employment, but the pre-printed training plan form indicates that first-year and subsequent-year part-time employees are required to complete fewer hours of training (60/20) than full time employees (80/40), which is in conflict with the standard and the agency policies and procedures. Recommendation is made to update the Individual Training Plan form to require the same hours of training for full-time and part-time employees as stipulated by the standard and the agency policies and procedures.

Although not included in the policy and procedure for training, the agency utilizes a Residential Site Orientation checklist that stipulates completion of 72 hours of onsite shelter orientation within the first 10 days of employment, which exceeds the standard and if adhered to in practice would be considered a best practice.

- Exception: The training file of one (1) of the two (2) employees completing their first year of employment within this review period (CC) did not complete the 72 hours of shelter orientation training until nearly eight months after starting employment.

- Exception: In this same file, two training topics listed as part of the site orientation training tiers (Security Requirements and procedures & Hygiene and Infection Prevention) were not initialed by the employee acknowledging completion of the training

topic but were initialed by the supervisor.

- Exception:The training file of the second employee completing their first year of employment within this review period (RP) indicated that the employee completed the 72-hours of Site Orientation training but the Site Orientation checklist, which had not yet been filed in the employees training file, was not signed by the employee nor the supervisor for the majority of training items in the last tier on the checklist.
- Exception:the agency policy and procedure requires annual training on CINS/FINS Core and two training files (LR and LS) were found to not have had this training.

A program recommendation is made for the program to either a) (Optimal) consistently adhere to completion of the 72 hours Residential Site Orientation checklist of on-site shelter orientation within the first 10 days of employment for all new hires or b) revise the form to stipulate completion of the 72 hours of all topics on the Residential Site Orientation checklist to a more achievable time period.

The file for an employee currently seven (7) months (54%) into his first year of employment has completed 39.5 hours or 49% of the required training hours to date which is slightly (5%) behind pace for completing the required hours by March 24, 2014.

- Exception: One (1) of five (5) training files reviewed for employees beyond their first year of employment did not complete the required minimum 40 training hours by the anniversary date, falling 4.5 hours short.

Of the remaining four (4) files, three (3) indicate that those staff are ahead of pace (6%, 6% and 30% ahead of pace respectively) to complete 40 hours of training by their anniversary date and one (1) is 23% behind pace. Of two (2) non-residential staff training files reviewed one indicated that the CPR and First Aid training is not current (the last documented in the file expired in 2010). Although both non-residential staff training files indicate that neither staff person completed the required 40 hours of training by their last anniversary, the completed current year-to-date trainings in the files demonstrate that one is 23% behind pace for completing 40 hours by February 19th and the other is 22% ahead of pace for completing trainings 40 hours by July 4th. An interview with the Office Specialist indicated that the program does not maintain a set training calendar, rather a monthly review of anniversary dates is performed and staff reminded of the training topics that need to be completed prior to their anniversary date. Community partners who provide training are contacted to determine Recommendation is made for the program to establish and maintain a 12-month training calendar plan that would allow for quarterly, bi-annual or annual scheduling of required training topics to ensure all staff members complete all training topics and minimum number of training hours in advance to their anniversary dates.

A program specific training plan tracking green sheet was included in the training files as part of the Training Plan for each staff member and calls for the signature of the employee and the supervisor but this form was found to be entirely blank in six (6) of seven (7) files reviewed. The training plan does not include any provision for projected completion dates for any training topic.

1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

The agency has a comprehensive policy that is based on the FNYFS policy manual and the compents of this YFA policy addresses the requirements of this standard. The program collects and reviews several sources of information to identify patterns and trends including case record review reports, review of incidents, accidents and grievances, customer satisfaction data, outcome data and NetMIS data reports within the frequencies required. The agency is a current active member of the Council On Accreditation (COA).

The YFA agency provided examples of reports with program specific and aggregated data as well as committee/workgroup minutes used during the review period to analyze information. Evidence of improvements/changes made from the analysis included revised procedures and staff meeting minutes documenting training conducted and implementation of new policies.

The agency has a very comprehensive multi-tiered system to address the Analyzing and Reporting Information indicator that can readily be sited as a best practice process for this indicator. The agency currently has an annual Continuous Quality Improvement (CQI) Plan based on fiscal year that includes goals and outcome measures for each team level. The agency maintains Risk Management policies and procedures that also relate to quality improvement. The agency's policy requires that the agency review and critique all incidents. Incidents are to be reviewed, discussed and documented in team meeting minutes. In addition, incidents can also be reviewed by the Agency-wide Quarterly Aggregate Incident Report Data. The agency utilizes several resources including CQI Council, Peer Review Teams, sub-committees and program management to assist them with assessing areas of performance and risks that include current incidents, accidents and trends. The agency plan includes having major risks reviewed during its Continuous Quality Improvement (CQI) Team meetings. These meetings are designed to ensure that major incidents are reviewed with key staff at staff meetings. Meeting minutes reflect that incidents were discussed and

quarterly information is reviewed and forwarded to Senior Level Leadership and CQI Team Leader.

Since the previous 2012-2013 follow up onsite review, the agency appears to have made significant efforts to revise some policies and practice and documented adherence to their policies and procedures resulting in demonstrated progress being made relating to incident reporting, youth contraband searches and the initiation of staff training curriculum development. The verification of completion of action steps for each issue identified on the CQI worksheet includes a high degree of accountability and time specific completion requirements. Although the signed CQI worksheets were offsite during this visit, CQI worksheets with typed completion information included were provided.

The agency provided staff meeting minutes, CQI worksheets with action step completion information and the October CQIC Validation Review as concrete examples demonstrating the internal oversight measures that have been implemented to address the previously identified issues. The Validation Review included results achieved as well as recommendations/plans for further improvement to demonstrate that the agency has analyzed the contributing factors or root causes and additional steps that might improve the process even further. The Validation Review results for each issue are planned to be attached directly to the corresponding CQI worksheet to facilitate ease of finding all information for each issue in one place.

No exceptions were noted for this indicator.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

The agency is contracted to provide residential and nonresidential CINS/FINS services to youth and families services. 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. The program has five (5) Masters level Counselors and two (2) vacant positions. The program is in process of filling all of their vacant positions, one is transferring from another service area and one is in background screening. 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 program addresses family issues with both youth and parents, anger management, communications, bullying, and truancy issues. Files clearly documented both Case Management and Counseling Activities. At the time of the Quality Improvement review, the program has provided non-residential services to fifty-one (51) families over the last 6 months.

The residential component consists of a Master level Residential Director an two residential Counselor. One counselor possesses a Master's degree and the other Bachelor's degree.

The program has access to Licensed Counselors (LMHC/LMFT) available for consultation of during suicide risk assessments and other clinical risks. Documentation of contact with the LMHC was well documented all but one residential file. Overall all files were well documented, neatly organized and consist across both non-residential and residential. During this review eight (8) total files were reviewed. The reviewer assessed four (4) non-residential and 4 residential client files (four active and four closed). It should be noted that this program is participating in a pilot project with the Florida Network involving Youth Development System. The Youth Development System has been incorporated in all aspects of the program. It was clearly identified in this section of the standards. Each youth has identified goals or growth objectives, development outcomes, and desired measurable indicators, referrals, location and frequency of treatment, target date, completion dates and responsible party. In addition an Aftercare Plan is developed at the time of the initial plan. The Aftercare Plan includes goals, type of services needs/post discharge, referrals, status at discharge, and responsible party/staff.

2.01 Screening and Intake

Satisfactory Limited Failed

Rating Narrative

The agency has a comprehensive policy that is based on the FNYFS policy manual and the compents of this YFA policy addresses the requirements of this indicator. A total of eight (8) files were reviewed using the CINS/FINS Standard 2.01 Screening and Intake Standard. The files indicated an array of referral sources utilizing the program's vast array of services. The files indicate that there the program is very accessible to the community they serve. The program provides a required eligibility screening within seven (7) calendar days by a trained staff member using the NetMis screening form. A total of eight (8) files were reviewed to determine if that the program met the requirements for this indicator. All files reviewed onsite indicate that each case met the eligibility requirements and were screened within 7 calendar days of referral, or documentation as to why not. Further, all files indicate that parents were informed of all service options and rights and responsibilities. Additionally, all client files contained evidence that they received information related to the grievance process

Of the eight (8) files reviewed none of them had evidence that the parent/guardian received the CINS/FIN Brochure describing Case Staffing, Petition and Adjudication process. Based on staff interviews, the brochures are available and provided but they do not documented it in the files.

Two (2) residential files had a Non Residential Bed Request form in the file in lieu of a screening form. Both youth were court-ordered into the residential program.

There were no exceptions noted for this indicator.

2.02 Psychosocial Assessment

Satisfactory Limited Failed

Rating Narrative

The agency has a comprehensive policy that is based on the FNYFS policy manual and the compents of this YFA policy addresses the requirements of this indicator. A total of eight (8) client files were reviewed using the 2.02 Psychosocial Assessment. All files had a completed psychosocial assessment that gathers and analyzes information for the youth receiving services. The assessment contains the elements

required by the standard. In addition, the counselor type up a summary of their findings, which is then signed by the counselor and supervisor. All four (4) residential psychosocial assessments were initiated within 72 hours of admission into the program. All four (4) non-residential psychosocial assessments were completed within two (2) to three (3) face to face contacts after the initial intake or updates. Seven (7) psychosocial assessments were completed by a bachelor's or master level staff and was reviewed at completion by a supervisor. All seven (7) files included appropriate signature. One (1) of eight (8) youth was identified with an elevated risk of suicide as a result of the psychosocial assessment. One (1) of eight (8) youth was identified with a high risk of suicide after the service plan was developed and was in need of a suicide assessment.

Some exceptions were noted during the review of this indicator. One (1) residential open file was completed but did not have the counselor or the supervisors signature on the psychosocial assessment. One (1) of the two (2) youth identified with an elevated risk of suicide recieved an assessment of suicide risk conducted under the direct supervision of a licensed mental health professional.

2.03 Case/Service Plan

Satisfactory Limited Failed

Rating Narrative

The agency has a comprehensive policy that is based on the FNYFS policy manual and the compents of this YFA policy addresses the requirements of this indicator. A total of eight (8) files were reviewed for standard 2.03 Case/Service Plan. The case/service plan is developed with the youth and family within seven (7) working days following completion of the assessment. The plan is developed based on information gathered during initial screening, intake and assessment. The plan included: identified need(s) and goal(s); type, frequency and location of service(s), person(s) responsible; target date(s) for completion; closed files had actual completion date(s); signature of youth, parent/guardian (when appropriate), counselor and supervisor and date the plan was initiated.

The case/service plans reviewed by the counselor, youth and parent/guardian (if availalbe) every 30 days for the first three months for progress in achieving goals and for making any necessary revisions to the case/service plan, if indicated. When the parent/guardian was not available to sign the case/service plan, documentation in the progress notes indicated telephone call made to them. It was also documented on the Service Plan Review form and the Chronological Contact form.

Some exceptions were noted regarding this indicator. Two (2) open residential case/service plans did not contain parent/guardian signature.

2.04 Case Management and Service Delivery

Satisfactory Limited Failed

Rating Narrative

The agency has a comprehensive policy that is based on the FNYFS policy manual and the compents of this YFA policy addresses the requirements of this indicator. A total of eight (8) files were reviewed to determine the agency's adherence for this indicator. All client case files reviewed had evidence of an assigned counselor to work with the client/family. All of the files have evidence that families were receiving referrals to needed services. One assessment showed the need for psychiatric services and a referral was made to Care Network for mental health services.

All eight (8) files showed documentation that there was coordination for service plan needs and that the progress in services was monitored. Two (2) of the client files showed that monitoring of out of home placement took place. The other six (6) client files were not applicable to out of home placement.

Interviews with agency non-residential staff and residential staff revealed that the case staffing committee is utilized as needed with families and that the staff are familiar with the process to make referrals. Clients that are court ordered for services have evidence that they have received case monitoring and include the review of the court orders.

Three (3) files were reviewed to show 180 day follow up. All showed that the data was collected. The reports are then sent to be filed in the closed files.

There were no exceptions noted regarding these cleint files.

2.05 Counseling Services

Satisfactory Limited Failed

Rating Narrative

The agency has a comprehensive policy that is based on the FNYFS policy manual and the compents of this YFA policy addresses the requirements of this indicator. A total of four (4) non-residential and four (4) residential client files were reviewed for this standard. The non-

residential services for this review are located in three (3) counties, Hernando, Sumter, and Citrus. The New Beginnings shelter has non-residential services on site. The shelter has one masters counselor and one bachelor level positions. The non-residential counselors are masters level There are three (3) licensed staff available to the clinical team.

All counseling files were well organized. The files all contained an intial service plan. Eight (8) files were applicable for review, and the documentation showed review of the service plan within the required time frame.

The shelter program includes individual and family counseling. Residential service cleint files showed evidence of least five (5) days per week of group counseling. One (1) youth's file contained twenty-nine (29) documented groups in 1 month. Another file showed eight (8) groups in nine (9) days of services.

Non-residential files showed evidence of clinical review of the files. This documentation showed a process between the counselor and the supervisor. There is also a peer review process in place as part of the agency's Quality Improvement.

The client files all contained a psychosocial assessment and a service plan.All files maintained case notes for the services provided.

There were no exceptions noted regarding this indicator.

2.06 Adjudication/Petition Process

Satisfactory Limited Failed

Rating Narrative

The agency has a comprehensive policy that is based on the FNYFS policy manual and the compents of this YFA policy addresses the requirements of this standard. The agency has three (3) case staffing committees, representing the 3 counties served. There are consistent staff and protocol in place to meet the requirements of this standard.

Review of the case staffing notebooks showed that notifications and documenation are maintained consistent to the requirements by statute and policy. 6 files of youth on petition were also reviewed.

It was reported that there were no parent requests for case staffing committees to be held within the 7 days from parent request.

Some of the case staffing committees are more active than others, however, all 3 maintain a committee that is representative of the community and the entities required to be on case staffing committee. Attempts are made to have the committee represented by other community professionals.

The case staffing committee works well with the DJJ attorney and the judges for the counties served. Petitions are filed as determined by the case staffing committee and follow the guidelines as determined by statute. The team works effectively to try and promote growth in the family without the need for petition filing.

The case staffing committee generates a plan for the youth and the family. This plan is then incorporated into the service plan for the youth and the family. In most cases, the family is present at this meeting and signs to document they are receiving the case plan.

There were no exceptions documented regarding the findings for this indicator.

2.07 Youth Records

Satisfactory Limited Failed

Rating Narrative

The agency has a comprehensive policy that is based on the FNYFS policy manual and the compents of this YFA policy addresses the requirements of this standard. All agency residential client files are kept in a locked file room. All non-residential client files are kept in a locked file cabinet in the offices which remain locked when no one is in the office. All close files are also kept in a locked room and a locked file cabinet.

The maintenance of files is neat and organized. The actual client files are organized, contain a file order sheet and are easy to access information.

Some exceptions were noted regarding the findings of this indicator. There were four (4) out of ten (10) files were not marked confidential. Staff identified this as an oversight and was able to correct immediately. Review of other files in the file room showed that they were appropriately marked confidential.

Standard 3: Shelter Care

Overview

Rating Narrative

The New Beginnings shelter facility is located in Brooksville, Florida. It is one of three (3) shelters that Youth and Family Alternatives operates in the reggio of the state. The the other two (2) residential youth shelters are located in New Port Richey and Bartow. The Brooksville shelter is a well designed facility that is clean, nicely furnished, attractively landscaped and well maintained. The shelter is conveniently located and is in a comfortable and safe location next to the Sherrifs office near Hwy 50 and Cortez Road.

The youth shelter is contracted to serve both CINS/FINS youth and children placed by the Department of Children and Families (DCF). At the time of this onsite Quality Improvement (QI) review, the YFA-NB shelter had both CINS/FINS and DCF residents in the youth in the shelter. Youth in the shelter responded to an online survey and reported that they feel safe and that they had not witnessed of experienced any adults threatening any residents. The shelter has an effective grievance process, with the forms available to the youth.

The agency has recently completed facility renovations to the youth shelter that include repainting the exterior and interior walls throughout the youth shelter. The agency has also retiled all showers and added a ceiling to floor screened porch seating area. At the time of this onsite review, the agency does not have a licensed staff member that works primarily at the YFA-NB youth shelter location. The agency has access to the Vice President of Prevention Services who reviews all youth or consults and reviews with staff regarding youth placed on elevated or sight and sound supervision status.

3.01 Shelter Envonment

Satisfactory

 Limited

 Failed

Rating Narrative

The agency has routine practices that ensure that the physical plant is clean, sanitary and organized to meet the requirements of this indicator. The New Beginnings shelter is a very clean, well designed and well maintained facility that provides a very welcoming and comfortable setting for youth. Shelter furnishings are in good repair and the grounds are attractively landscaped. Bathrooms and shower areas were clean, functional and free of any mildew or foul odors. Chemicals and sharps are securely stored, secure areas are locked and key control appears to currently be in compliance with safety standards. There was major evidence of facility damage or grafitti during this site visit.

The shelter is licensed by DCF as an 18 bed facility, with a separate wing for males and females and a staff observation area that separates them. There are 9 beds designated for males and 9 for females. All bedrooms have appropriate furnishings and required pillows/linens/bedspreads.

The shelter has posted weekday and weekend schedules that include a variety of activities for youth. Meals, recreation, education, group counseling and life skills training are all part of the daily activity schedule. The program promotes life skill development utilizing Youth Development outcomes that are targeted goals established during the assessment process.

Faith based activities are offered to youth who choose to participate.

There were some exceptions noted for this indicator. Agency documentation indicated that the van keys were lost or misplaced on two (2) occasions (May 6 and May 28, 2013). There was some initial evidence of graffiti found in the residential shelter. This was later removed on site during the program review by the agency.

3.02 Program Orientation

Satisfactory

 Limited

 Failed

Rating Narrative

The agency has a comprehensive policy that is based on the FNYFS policy manual and the compents of this YFA policy addresses the requirements of this indicator. The program recently implemented a new staff position that is known as the "Orientation Specialist". There is a separate orientation packet (folder) that includes an "Orientation Checklist" and is completed with each new client admitted to the shelter and then placed into the client's permanent case file. The orientation checklist contains all of the requirements listed in Quality Improvement standard 3.02.

A review of seven (7) open client case files indicated that six(6) of them had a completed client orientation checklist contained in the client case file. Six of the 7 youth files also contained documentation that they had completed the new client orientation packet recently implemented by the program.

There were some exceptions noted regarding the findings related to this indicator. One client case file did not contain a completed new client orientation checklist or orientation packet.

3.03 Youth Room Assignment

Satisfactory

Limited

Failed

Rating Narrative

The agency has a comprehensive policy that is based on the FNYFS policy manual and the compents of this YFA policy addresses the requirements of this indicator. As stated earlier in the report, the shelter is an eighteen (18) bed facility. Each of the bedroom doors are numbered and there is a bed A and bed B in each room. Youth are assigned a room by the staff conducting the intake based on established criteria consistent with the CQI standard and CINS Policy Manual.

The agency completes the CINS/FINS Intake Form during the intake process at the shelter as part of the room assignment process. All seven files had the form in the file however documentation was not complete on the room assignment in three (3) of the seven (7) files reviewed.

An interview of three (3) youth confirmed that each was assigned a room and bed at intake. There are two dry erase boards located in the facility in the administration area and the youth care staff observation station that also list the room and bed assignments for each youth currently at the facility.

An interview with the Program Supervisor and the Orientation Specialist revealed that the room assignment process is based on specific criteria and is consistent among all staff at intake. However, they did acknowledge that the documentation in the client case file was not consistent with the process in the three cases cited.

There were some exceptions documented related to findings observed for this indicaor. Of the seven files reviewed, three did not contain the room assignment section completed.

3.04 Log Books

Satisfactory

Limited

Failed

Rating Narrative

The agency has a comprehensive policy that is based on the FNYFS policy manual and the compents of this YFA policy addresses the requirements of this indicator. The program maintains a daily log book that documents all important program activities throughout each 24 hour period. Staff on each of the three shifts (12-8, 8-4, 4-12) document the number of youth and their various locations and activities of the youth currently at the facility.

A review of the log book for the past three (3) months revealed that all entries are written legibly in ink and are signed and dated by the staff entering the information. Errors are corrected with a single line and the word VOID written next to the entry along with the staff initials.

All staff are required to review the log book for the previous two shifts and document this in the log book when reporting to duty on each shift. A review of the log book for the past three months indicated that the practice was consistent with the requirements of the CQI standard. Important information is highlighted in yellow. The Shelter Director reviews the log book on a weekly basis and documents these reviews in red ink.

An interview with the Team Leader and the agency CQI Director also confirmed the process for reading, reviewing and signing the log book for all staff at the facility.

There were some exception noted related to the this indicator. A few of the errors were not corrected according to CQI Standards and agency policy requirements.

Rating Narrative

The agency has a comprehensive policy that is based on the FNYFS policy manual and the compents of this YFA policy addresses the requirements of this indicator. The agency has replaced the traditional Behavior Management System with a new and improved Youth Development System. This new system was implemented a little over one year ago by the agency at all three service delivery sites (shelters). The system is based on three basic curricula or schools of thought: Youth Development Outcomes, Positive Youth Development concepts and the name of the central focus of the system is based on Six Pillars of Character. The YFA youth development system focuses on promoting youth development rather than preventing problem behaviors or punishment for inappropriate behaviors.

There are three levels in the system: Orientation, Education and Graduation. Youth spend three days on the Orientation Level as they become familiar with program services, staff and rules and adjust to the residential shelter environment. Youth are promoted to Education Level for a period of seven days if they are successfully achieving their developmental goals established during the orientation and assessment process. Youth are approved to go on educational outings at this level.

Youth are then promoted to the Graduation Level for the remainder of their stay at the shelter as long as they continue to achieve positive developmental goals listed on their individualized service plan developed by the assigned counselor or case manager. Youth are allowed to go

on all outings and recreational activities at this level.

In addition the program has implemented a "Kudos" board as part of the reward system for both youth and staff at the facility. Staff and youth are encouraged to comment on each other's success and compliment others on their developmental achievements.

During this site visit there were 11 youth at the facility. One youth was interviewed about their current YDS level and confirmed that she had completed the Orientation Level and was currently on the Education Level. Three staff were interviewed about the system and its effectiveness. Each staff member expressed a positive opinion about the system and stated that it was an effective tool in promoting positive youth behaviors.

It was also noted that the Program Director stated during the entrance interview that the program is in the process of developing more tangible rewards and incentives for youth that achieve development goals and level promotions.

There were no exceptions documented related to this indicator.

3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

Rating Narrative

The agency has a comprehensive policy that is based on the FNYFS policy manual and the components of this YFA policy addresses the requirements of this indicator. The program has developed a staffing schedule that supports the operation of the facility 24/7/365 days a year. There are three, eight hour shifts that run from the hours of 8 AM to 4 PM, 4 PM to 12 AM and 12 AM to 8 AM. There are typically 2 staff on the overnight shift, and three staff on the 8-4 and 4-12 shifts.

Staff schedules were reviewed for past four weeks to evaluate compliance with the 1:6 and 1:12 staff to youth ratios required by DCF licensing and CQI standards. In addition an interview was conducted with the Team Lead to confirm the staff scheduling process and posting of youth care staff work schedules in the facility. The schedules are posted in the copy room, in the staff work area and in the Team Lead office.

It should be noted that the agency makes every effort to schedule male and female staff on each shift to ensure appropriate supervision across the 24 hour period and all types of program activities. Whenever there is a need for additional staff the roster of full-time and part-time staff is reviewed and staff are contacted to see if anyone is available to cover the vacant shift position.

In addition, the Team Lead and/or the Program Director are both available to provide coverage and there have been recent occasions or examples where evidence was provided to the review team that this had in fact occurred. However, due to the recent resignation of a male staff member on 10/5/13 there have been a few recent occasions on the overnight shift where two females were scheduled to work.

There was one exception documented regarding this standard. The agency has several instances where they have staffed two staff of the same gender on the same work shift.

3.07 Special Populations

Satisfactory

Limited

Failed

Rating Narrative

The agency has a comprehensive policy that is based on the FNYFS policy manual and the components of this YFA policy addresses the requirements of this indicator. The agency is not designated as an official Staff Secure agency and does not provide Staff Secure Shelter services.

The agency does provide Domestic Violence Respite care. Since beginning the new program began in April, 2013 the program has served three youth under this new funding stream. During this site review three DV client case files were evaluated by the review team for content and accuracy in accordance with the new CQI standard for the 2013-14 review cycle.

All of the requirements listed in CQI standard 3.07 were met in each of the three cases reviewed. DV charges were verified in each case and FN approval was documented in each case. Service plans were consistent with the DV charges and services.

There were some exception noted regarding the agency's adherence to this indicator. One youth exceeded the 14 day respite care period and was transitioned into the CINS/FINS program and evidence of this transfer was documented. The agency has DV respite procedures and practices in place and the policy is currently in DRAFT status and is under review by agency administrators.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

Youth and Family Alternatives (YFA) New Beginnings program 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-NB residential and non-residential staff members utilize agency screening forms that include the general screening form, CINS Intake form, Psycho-Social Assessment and the Evaluation of Imminent Danger for Suicide (EIDS). The CINS intake form includes health screening section that is required to be completed by staff members. The agency also utilized a Suicide Risk Assessment instrument that is conducted on youth that indicate a positive on the CINS Intake form.

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. Further, the agency's Vice President of Prevention Services is a Licensed Mental Health Counselor and is consulted regarding this sight's suicide risk screening and assessment process. At the time of this review, the VP of Prevention services is primarily responsible for conducting assessments to determine if these youth need to stay on this status or have this level of supervision reduced. The agency utilizes an effective color-coded general alert system that informs direct care staff of the youth's health, behavior or mental health status. The agency also documents any youth that has received onsite or offsite first aid or medical care.

4.01 Healthcare Admission Screening

Satisfactory

 Limited

 Failed

Rating Narrative

The program has a written policy in place that adheres to the standards. Six (6) client files were reviewed, four (4) opened files and two (2) closed files. All Six files contained the necessary admissions health screening document which addressed pertinent information as it relates to the youth's medical and mental health issues, as well as, the youth's physical appearance. Areas covered on the screening included, but, were not limited to the youth's need for medication, any existing acute or chronic medical conditions, allergies, recent injuries or illnesses. The document also included observations for evidence of scars and/or tatoos. The date of healthcare screening was included on the form as well.

One of the files noted that the resident has chronic headaches and experiences dizziness; however, there was not a sufficient explanation for the cause or follow-up care of the medical issues. The Director, Carolyn, was interviewed about the follow-up procedure, and stated that the youth had not complained of a headache since her intake, had she complained the staff would have given her an OTC med for the headache. As a precaution, whenever a medical risk is indicated the facility should ensure that a follow-up is completed, to identify whether or not any further evaluations are needed.

There was one exception noted regarding this indicator. In one of the files reviewed the program listed that the resident had eight (8) tatoos, but only gave the description of one (1) of the tatoos throughout the file.

4.02 Suicide Prevention

Satisfactory

 Limited

 Failed

Rating Narrative

The shelter had a detailed suicide risk plan that addresses the agency's suicide prevention and response procedures. In addition, the agency has one (1) staff member that is a licensed clinician. The agency's Vice President of Prevention is a Licensed Mental Health Counselor (LMHC). The suicide risk policy indicates that all residents admitted to the shelter will be screened for suicidal risk by the six (6) suicide risk questions on the CINS/FINS Intake form. In the event that the resident responds with a "Yes" to any of the 6 questions, a designated Youth Development Specialist (YDS) will immediately places the youth on sight and sound supervision. According to agency policy sight and sound supervision requires that the agency maintain direct supervision of the youth's location and their actions are recorded every five (5) minutes on his/her individual Sight and Sound Supervision form. A monitoring note is required to be documented in the Communication Logbook on every shift informing YDS staff members of the youth's supervision status.

The Youth and Family Alternatives Youth that screen positive on the suicide risk section on the CINS Intake form are then referred for further assessment. The program has two (2) levels of supervision: one to one supervision and constant sight and sound supervision. The current suicide risk policy encompasses all elements of the indicator and complies with the procedures outlined in the Florida Network's Policy and Procedure Manual for CINS/FINS. The agency uses an EIDS to evaluate whether the youth is to be placed on sight and sound supervision. Following the completion of the EIDS, the counselor completes a full Suicide Risk Assessment. The completed assessment is then discussed via telephone with the Counselor and the qualified mental health professional to determine the specific level of suicide risk. The results to maintain sight and sound status and or removal from supervision status are approved by the licensed staff and documented directly on the Suicide Risk Assessment. The licensed staff then signs the SRA at a later date in person. The SRA is also signed by the Counselor completing

the assessment and the agency's Program Director.

A total of five (5) files were reviewed (three open and 2 closed case files) contained documentation that indicated a suicide risk screening was completed during the initial intake and risk screening process. A total of four (4) out of 5 files contained documentation that indicated that suicide screening results were accurate and complete. All applicable youth were placed on sight and sound supervision until the assessment was completed and the assessment results were reviewed by telephone with a licensed professional or non-licensed staff under the direct supervision of the licensed professional. All 5 cases the level of supervision were not changed or reduced until approved by one of the agency's licensed staff members. Supportive documentation was reviewed to include precautionary observation logs and 5 minute checks. The agency's policy requires that a Monitoring Note are to be completed for every shift to inform all staff of the youth status and recorded in the Communication Logbook.

All requirements and counts for the 5 youth in the review sample contained evidence that supervision count are performed and documented as required. Each youth file contains a supervision counts with documented 5 minute intervals that include initials of the staff completing the count.

There were several exceptions noted for this indicator. A general observation is that the Suicide Risk Assessment tool should clearly document the name of the clinician and their credentials. One open case is missing evidence of a Suicide Risk Assessment (SAR).

Suicide supervision monitoring notes for 2 out of 5 youth on suicide supervision watch were not consistently documented in the logbook across all work shifts that the youth remained on supervision status. The youth documented as being on supervision watch are also not being consistently high lighted with a yellow marker as required.

There were a 4 out of 5 Sight and Sound Supervision count forms there were missing either a staff signature and or shift leader signature verifying counts were completed. However, all 5 minute counts are documented as required. It is recommended that the agency ensure that notes are reflected in the logbook per their agency's policy. The agency must also ensure that all supervision counts forms are signed by both the assigned staff member and Shift Leader. The agency should consider designating a person to sign all supervision count notes in the absence of a Shift Lead on the 4pm – 12am and 12am to 4 pm work shifts.

4.03 Medications

Satisfactory

Limited

Failed

Rating Narrative

The agency has a comprehensive policy that is based on the FNYFS policy manual and the compents of this YFA policy addresses the requirements of this indicator. The agency has a detailed four (4) page written policy that ins and addresses the storage, dispensing medication, over-the-counter medication, documentation, safe distribution, secure storage, limited access, inventory and disposal of medication in accordance with the DJJ Health Services Manual. The agency policies related to medication are called Medication Control and Management. The agency has revised its current policy and practice to incorporate the agency's ability to verify all youth prescribed medications entering the residential youth shelter. The agency provided a draft of it recently updated Medication Disposal policy and procedure. This policy will be incorporated into the agency's current policy manual once approved.

The program had a typed list of twenty (20) direct care staff members that are designated to have access to distribute prescribed and controlled medications. All medications in the shelter are stored in a designated separate resident dormitory area of the youth shelter. The medication room is adjacent to the dormitory and sleeping area and locked so that it is inaccessible to youth. This room features a separate locked half door with a top half that swings open to service clients on medications. The medications are stored in a wall mounted metal cabinet. This cabinet is equipped with double padlocks. At the time of the on site QI review, oral medications are stored separately from topical medications. Both oral and topical medication type are stored in a two (2) separate four (4) drawer plastic storage bins with 4 slots in each bin. The agency has a miniature refrigerator that is designated for medications that require refrigeration. At the time of this on-site review, there were no injectable medications that required refrigeration, on site, or identified as needed for any youth during the time of the review.

The agency maintains sharps that are secured in a double-locked cabinet behind a locked door. Sharps are required to be counted on a weekly basis and documentation is logged in a separate binder. At the time of this on site review, the agency maintains twenty-seven (27) razors. A review of the sharps binder was conducted for accuracy and completion.

The agency utilizes a Low Medication Alert Form for all youth on prescribed medications. The Shift Leader on Duty must forward this form to the Counselor whenever a client has less than seven (7) days of medication remaining. There was one file that had evidence of a completed Low Medication Alert form.

The reviewer requested closed files of residents that were required to take medication during their shelter stay to determine the agency's adherence to this indicator. The reviewer reviewed a total of four (4) closed and two (2) closed files. Of these cases all contained medication records that have evidence of the following information that includes picture, youth name; date of birth; medication dosage; side effects/precautions; staff/youth initials; staff signature; and title of each staff member who initials a dosage; and full printed name and signature of youth receiving medication on the medication record.

At the time of this onsite program review, there were two (2) CINS/FINS youth on prescribed medications in the youth shelter. One male youth is on two (2) prescribed medications. One medication is an oral medication (Mometasone-Furoate) and the other is a prescription topical

medication (Hydrocortizone). A female Domestic Violence respite referral had a total of nine (9) prescribed medications and one (1) topical medication. This case was extremely involved and required a great deal of accuracy and completeness. These 2 open files contained general information that included medication distribution logs, medication count forms, pictures and medication verification.

The agency is now conducting the verification of medication distributed in the residential shelter. The agency utilizes a new form called the Prescription Medication Verification Form to document their practice. The agency started this new practice in July 2013. The agency also uses a low medication alert form, whenever a resident has less than seven (7) days of medication remaining.

There were several exceptions documented regarding the agency's adherence to this indicator. The agency's Medication Release form was used incorrectly during the admission of one client in September 2013. In this case, one file used a Medication Release form at the time of admission instead at discharge. The Medication Release form releases New Beginnings from any further medication responsibility for the child.

One file is missing documentation of medication counts on Daily Medication Count form on the 8am-4pm work shift for a youth served in September 2013. This same file involves staff missing signature and time medication is given on the YFA Prescription Medication Log Sheet.

Two closed files are missing an initial of the youth and or the staff on at least one of the medication distribution forms.

One file on multiple medications did not have evidence that three (3) out of nine (9) medications prescribed for the youth were verified with the pharmacy that filled the prescription. This same file did not contain evidence in six (6) out nine (9) medication documentation log forms that do not indicate the reason the medication is being given. The concern here is related to potential contradictions.

The agency had a total of four (4) medication error incidents reported to the DJJ CCC in the last 5 months following the last QI on site review. Three (3) out of four (4) DJJ CCC medication incidents had evidence of written administrative follow up documented as corrective action.

At the time of this on site QI review, pictures of the clients do not include a name or any other client identification. It is recommended that the agency includes client identification information with the clients photograph.

The agency is required to document when sharps are counted on a weekly basis; when sharps are given out; and when disposed. The agency documentation found that the sharps binder contained some inconsistencies. The agency does not have evidence of sharps inventory counts being conducted during July 2013 and August 2013. In addition, there was minimal information found for sharps distributed in July 2013.

4.04 Medical/Mental Health Alert Process

Satisfactory Limited Failed

Rating Narrative

The program has a written policy in place that does adhere to the indicators as described in the Standards. During the review process observations were made which support that the proper procedures are being followed to ensure that residents medical/mental health alerts are communicated effectively to all staff, and to ensure the safety and security of all residents. The Alert Systems are located on the front of the youth's file, the medication room, and at the staff's desk. In addition, any food allergies are written on a communication board located in the kitchen.

The agencies Policies and Procedures states that during the intake assessment a medical alert and allergies label would be placed on the front of the youth's file once any medical, or mental health conditions are identified. There were inconsistencies in the processes of communicating alerts. The intake assessment of one (1) youth identified that the youth had medical conditions, this was not communicated on the Alert System/Service Provider list, and consequently, there was not a medical alert generated for the conditions. One (1) youth had seasonal allergies documented on the front label of the youth's file; however, there were no indicators on the Alert System/Service Provider List. One (1) file had discrepancies in three (3) locations of the file as it related to the youth's alerts. There were different alerts listed on the front label, as well as, two locations on the Alert System/Service Provider List, each listing totally different alerts. The interview of one staff member verified that the policy is in place; however, the process is not consistently followed. A more consistent follow through of the policies and procedures would eliminate any unforeseen mishaps as it relates to the proper care, and/or medical attention needed of the residents.

4.05 Episodic/Emergency Care

Satisfactory Limited Failed

Rating Narrative

The agency has a policy in place that does adhere to Standards. The training records that were reviewed included training documentation for CPR/First Aid. During the review of the medical alert locations; first aid kits, as well as the Knife-for-life and the Wire cutters were seen in their perspective places.

A review of the program's emergency drills showed that they were successfully completed, and actually exceeded the standard's requirements. Incident reports, as well as, CCC reports were reviewed. A very precise process with reporting issues that occur outside of the normal day-to-day activities of the program is followed. Documentation reviewed showed that the proper procedure was followed on 9/9/13, when a resident complained of having "chills". Resident's temperature was taken at that time, and again approximately one (1) hour later, in which the temperature was slightly elevated. At that time, the decision was made to transport the resident to receive medical care, a staff member did the transportation. Notifications were made to the Program Director, the resident's mother, and a CCC report was made. Three staff members were interviewed and each explained the process of Emergency, and Non-Emergency procedures.

No exceptions were found regarding the agency's adherence to the requirements of this indicator.