
# Florida Network of Youth and Family Services Quality Improvement Program Report

Review of YFA-New Beginnings

on 11/07/2012

# CINS/FINS Rating Profile

| **Standard 1: Management Accountability** | |
|---|---|
| 1.01 Background Screening | Limited |
| 1.02 Provision of an Abuse Free Environment | Limited |
| 1.03 Incident Reporting | Limited |
| 1.04 Training Requirements | Limited |
| 1.05 Interagency Agreements and Outreach | Satisfactory |
| 1.06 Disaster Planning | Satisfactory |
| 1.07 Analyzing and Reporting Information | Limited |

Percent of indicators rated Satisfactory:28.57%
Percent of indicators rated Limited:71.43%
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 | Limited |
| 2.04 Case Management and Service Delivery | Satisfactory |
| 2.05 Counseling Services | Limited |
| 2.06 Adjudication/Petitiion Process | Satisfactory |
| 2.07 Youth Records | Satisfactory |

Percent of indicators rated Satisfactory:71.43%
Percent of indicators rated Limited:28.57%
Percent of indicators rated Failed:0.00%

| **Standard 3: Shelter Care** | |
|---|---|
| 3.01 Youth Room Assignment | Satisfactory |
| 3.02 Program Orientation | Satisfactory |
| 3.03 Shelter Environment | Limited |
| 3.04 Log Books | Limited |
| 3.05 Daily Programming | Limited |
| 3.06 Behavior Management Strategies | Satisfactory |
| 3.07 Behavior Interventions | Satisfactory |
| 3.08 Staffing and Youth Supervision | Limited |
| 3.09 Staff Secure Shelter | No rating |

Percent of indicators rated Satisfactory:44.44%
Percent of indicators rated Limited:44.44%
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:53.57%
Percent of indicators rated Limited:42.86%
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, Principal Consultant, Forefront Consulting LLC

Linda Sessions, MSW Youth Programs Manager, Tampa Housing Authority

Mark Shearon, Shelter Program Manager, Arnette House,Inc

Becky Linn, Prevention Specialist, Dept. of Juvenile Justice

Tracy Smith, Program Manager, Hillsborough County Government

## Persons Interviewed

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

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

0 Maintenance Personnel
2 Program Supervisors
6 Other

## Documents Reviewed

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

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

## Surveys

04 Youth | 06 Direct Care Staff | 0 Other

## Observations During Review

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

## Comments

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

## Strengths and Innovative Approaches

Rating Narrative

The 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 Marion and Sumter service regions. The agency has a total of three (3) youth shelters that provide CINS/FINS services. The New Beginnings shelter is located in Brooksville, Florida. The agency as a whole has multiple interagency agreements with local community stakeholders and partners. The agency places a high degree of importance on creating opportunities and that promote getting the word out through its street outreach and community partnership programs. A large part of these efforts go to promoting its residential and non-residential CINS/FINS services. The agency has community partners in key areas that 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. However, the agency did not appear to have the requested documents prepared at the beginning of the review. All of the staff members were cooperative with the monitoring team throughout the onsite review.

The Youth and Family Altrnatives (YFA) agency has an agency-wide Street Outreach component that markets all of the agency's service offerings all three 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 Outreach staff members conduct presentations to various entities, organizations, human service agencies. Agency information is also presented to interested persons and/or groups, community provider meetings and at community events. The agency also distributes information cards and brochures. Youth and Family Alternatives promotes the National Safe Place Program and secures numerous safe place sites throughout their service area. The program has grant funds the Department of Health and Human Services to conduct street outreach activities to support these efforts. Through this grant, materials such as hygiene products, blankets, tee-shirts, snacks and bottled water, as well as information about the services provided at the shelter, are provided to at-risk youth.

In addition, the agency has recently completed a 5 Kilometer fund raising event on October 23, 2012 called the Run for New Beginnings. This event took place in October 2012 during Runaway Prevention Month agency reports that the event was highly successful and recorded over 200 runner participants. The agency has staff members that participate in local prevention organizations and partnerships that include participation in Mid-Florida Homeless Coalition, Citrus County Schools, McKinney Vento Transportation Assistance program, Hernando County Sheriff's Office and many others.

The agency-wide outreach efforts include the use of the internet and online social media outlets. The agency has posted an informative video 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.

# 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 Youth and Family Alternatives - New Beginnings (YFA-NB) Residential program employs a Program Director, four (4) Shift Leaders, one (1) Counselor II, nine (9) Youth Development Specialists (YDS), and an Office Specialist. The Non-Residential Program includes a Program Director and two (2) Counselors. At the time of the onsite Quality Improvement program review, the agency position vacancies include 1 vacant full-time YDS Team Leader, 1 vacant Therapist position, 1 vacant full-time YDS Full-time position, 1 YDS Cook/Transporter and 1 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, 2012.

## 1.01 Background Screening

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure in place. A sample of eight (8) files were reviewed onsite to assess the agency's adherence to this indicator. All 8 personnell files reviewed contained screenings that were completed prior to the staff member's date of hire. However, two (2) of the 8 files reviewed were for 5 year rescreenings. Both employee rescreenings were not completed prior to the rescreening date.

Two (2) out of 8 personnel files reviewed were 5 year rescreenings. Both staff member rescreenings were not completed prior to the rescreening date. One (1) staff hire date was 2/12/02; original screening date 2/7/02; 5 yr rescreening date 3/1/12. This was completed 3 weeks after the hire date. The other staff hire date 1/4/07; original screening date 1/3/07; 5 yr rescreening date 3/1/12. This was completed almost 2 months after the hire date.

## 1.02 Provision of an Abuse Free Environment

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

The agency has a policy on Abuse and Neglect that indicates that requires all staff members to identify and report all suspected incidents of abuse or neglect. Staff are to take all measures necessary to ensure the safety of the youth. Staff must inform youth about the toll free number to reports abuse that incldues the Florida Abuse Hotline. This policy also requires staff to inform residents of the abuse contact numbers, client rights within a specific time frame following admission to the youth shelter. Staff members to redocument certain information in the youth's file accordingly.

The agency binder contained documentation of eight (8) DJJ CCC Incident reports, thirteen (13) resident Grievances and nine (9) documented internal agency incident reports. A review of the aforementioned reports was conducted onsite. Of these documented incidents, 8 were DJJ CCC incidents, two (2) involved medication errors, several runaways, a medical injury and incidents of inappropriate resident behavior(s). One incident cites a failure of staff to conduct proper overnight bedchecks that lead to 2 youth engaging into 2 reported instances of non-consensual sex acts. These incidents were reported by one of the youth involved. At the time of this onsite reivew, a representative of the DJJ Office of the Inspector General was conducting an investigation of the allegations reported in this incident, parties involved and available video camera footage. Outcome of the investigation is pending at this time.

Of the reported grievances, three (3) lack evidence of documented follow up by agency superviors/managment regarding youth reporting various issues. In these cases, management reviewed all grievances with in 72 hours or less and verbally discussed the incident with each youth and almost all staff members documented in each grievance.

## 1.03 Incident Reporting

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

The agency has a Risk Management policy on Incident Reporting for staff members/employees that perform general work duties and provide services under its CINS/FINS contract with the Florida Network of Youth and Family Services. There is a specific policy and procedure that requires all staff members to report all incidents that involve the health and safety of YFA clients, staff or visitor; has caused damage to YFA property; and that places YFA at risk or cause media coverage or negtive public reaction. This policy also has several corresponding policies and procedures and reference documents.

A review of all incidents that occcured over the last six (6) months was conducted (May 1, 2012 to November 5, 2012). The agency maintains all incidents in a 3-ring binder for storage of all internal and external incidents. At the time of this review, there are a total of seventeen (17) internal and DJJ CCC incidents filed in the binder. Of these, eight (8) are documented as DJJ CCC incidents and nine (9) are internal agency incidents.

All incidents documented on the the agency forms indicate that the agency reported all incidents within the 2 hour reporting requirement.

A total of fifteen (15) incidents were found in the agency's incident reporting binder. However, 2 additional incidents were initially missing from the incident binder. These missing incidents were later located and provided on site during the program review. One (1) of the two (2) incidents initially missing was later were provided onsite prior to the end of the onsite program review. However, a review of this incident found that it contained inaccurate times and a vague description of the incident in comparison to information reported to the DJJ Central Communications Center. This incident report appeared to have been created onsite during the QI review.

Incidents documented in the agency logbook are vague and contains limited information related to a detailed expalination of incident. In addition, a significant or serious incident occurred on October 25, 2012 is vaguely documented in the agency logbook on October 26, 2012.

A total of thirteen (13) Grievances were found in the agency's Grievance binder. Of these, three (3) Grievacnes did not contain evidence of any follow up as required by the Supervisor, Program Director or designee.

## 1.04 Training Requirements

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

The program has a written policy and procedure in place. The policy states that copies of all certifications and/or sign in sheets are filed in each employee's training file. However, there were no sign-in sheets in any of the files reviewed. The agency keeps an agency-wide individual training log in the file and in some cases there may be an in-house inservice training log in the file. In most cases the training logs were not accurate. There were trainings that was listed on the sheet, which backup documentation could not be found. The agency has a standard 72 hour residential site orientation that offers a variety of training.

There were six (6) training files reviewed. Four (4) of the 6 files reviewed were for the first year training requirements. One staff member only had 47.25 hours of of training for the first year. All 6 files were missing their suicide prevention training.

Three (3) of the 6 files reviewed did not have CPR/FIRST Aid training (2) or CPR (1) expired on 4/13/12.

One of the first year training requirement did not have eighty (80) hours of training. The staff only had 47.25 hours of training. Their start date was 5/18/11.

All 6 files reviewed were missing their suicide prevention training. Three (3) of the 6 files reviewed were missing their fire safety training. Five (5) staff did not have their cultural competency training completed. Two (2) staff files are missing evidence of their CINS/FINS core training.

## 1.05 Interagency Agreements and Outreach

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy for Interagency Agreements and Outreach. A review of the agency's policy found that the agency found that the policy was effective on May 1, 2000. The policy has had no specific updates since that date. The agency maintains a binder containing numerous agreements. An onsite review of these documents revealed the following information:

- Universal Agreement for Florida Network dated June 2010. No updates since that date. However, review of the Florida Network web site found the current form. The agency, YFA has access to this and can download the current form for compliance.
- Agency Partner Agreement for MFIN dated June 2009
- Citrus School Bd. – agreement dated 7/13/11

- Mid Florida Homeless Coalition – agreement dated 6/20/12 (includes Citrus/Sumter/Hernando Counties)
- Sumter County School Bd. – agreement dated 6/19/12

No additional partnership or agreement documentation was found in the agency inter-agency agreement binder. In addition, no agreements or partnerships relevant to the following areas including parenting classes; law enforcement; medical; mental health; and therapeutic or outside counseling services were found.

A review of Outreach and promotional entries made in to the Florida Network NETMIS data base were documented. From the period of June 10, 2012 thru November 05, 2012 a total of fifty (50) activities and events are listed. Of the 50 activities, nine (9) were for five (5) kilometer race planning and preparation. The agency Office Assistant reported that the Vice President of Prevention is the designated person for coordination of outreach activities and events for this site.

## 1.06 Disaster Planning

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written Emergency Preparedness Plan dated Fiscal Year 2012/2013. The following items listed in the agency's current plan include Emergency Evacuation guidelines in the event of disasters; Procedures to follow; Secure transportation; Conditions qualifying for evacuation; Facility evacuation identification; Necessities procedures for evacuation; and Network notification.

In addition, Staff Training Regarding Disaster Preparedness Procedures were reviewed. A total of eight (8) training files were reviewed during this onsite program review. Of these 8 files reviewed, five (5) staff members had evidence of completing the Disaster Preparedness Procedure Training.

## 1.07 Analyzing and Reporting Information

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

The agency has a comprehensive approach to address this Analyzing and Reporting Information indicator. The agency currently has an annual Quality Improvement Plan and Risk Management policies and procedures. The agency's Risk Management policy requires that the agency review and critique all incidents. Incidents are to be discussed and documented in meeting minutes or another appropriate format. In addition, incidents can also be reviewed by the Agency-wide Quarterly Aggregate Incident Report Data. The agency references several resources to assist them with assessing areas of performance and risks that include current incidents, accidents and trends. The agency also has a plan to have major risks reviewed during its Continuous Quality Improvement (CQI) Team or Council comments. These meetings are designed to ensure that major incidents are reviewed with key staff at staff meetings. Meeting minutes are to reflect that incidents were discussed and quarterly information is reviewed and forwarded to Senior Level Leadership and CQI Team Leader. The aforementioned information is provided on a monthly and quarterly basis. Agency processes are to also track training topics and hours completed by staff members on a quarterly basis.

The agency is a current active member of the Council On Accreditation (COA). The agency utilizes COA information and assessment tools and applies these self assessment measures into their own strategies.

The agency has several program areas that require attention such as staffing and youth supervision. At the time of this onsite review, the agency does not have any examples of reviewing internal issues related to these areas. However, the agency has made recent efforts to revise its Medication Policy and Practice and implemented an updated policy on this issue. The agency also plans to introduce and train Direct Care Staff members on a new Medication Distribution Log prior to the end of the 2012 calendar year.

Beyond the medication distribution, the agency did not have concrete examples to demonstrate how internal oversight measures lead to actual examples of them implementing an intervention to address a problem. For example there are no recent examples of the agency identifying staffing issues, youth supervision, training topics and hours of all staff as internal issues that require attention. Nor is there any documented follow-up plans that demonstrate that the agency has analyzed the contributing factors or root causes. At the time of this onsite QI program reivew, this agency location could not provide recently documented measures it implemented to address any recent major operational or program issue that included implementing a plan/intervention, setting training, reviewing practice and conducting reviews over a period to test whether the intervention was effective.

# Standard 2: Intervention and Case Management

## Overview

Rating Narrative

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

The program provides non-residential services that are provided at the agency's office, local schools, and at the offices of other community based organizations. The non-residential staff members are still using the Why Try program at the Sumter Youth Center that is used to address family issues with both youth and parents. The program works on issues ranging from anger management, communications, removing negative labels and the duration of this program is four (4) weeks. The non-residential staff has also been trained on Trauma Informed Care based Pillars of Character that focus on youth Development and Outcomes. The agency has also worked to provide non-residential staff members with various topics for staff to use to conduct various groups with youth. At the time of the Quality Improvement review, the program has provided non-residential services to thirty-two (32) families over the last 6 months.

## 2.01 Screening and Intake

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policy on their Screening and Intake process. The policy indicates that it was reviewed on March 6, 2009. The policy fully describes the agency's intake process and accessibility to services. The policy requires that the intake screening process must occur within seven (7) calendar days by a trained staff member using the NetMis screening form. A total of seven (7) files were reviewed to determine if the agency meets 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. Further, all files indicate that parents were informed of all service options and rights and responsibilities. Also all files had evidence that the service recipients received information regarding CINS Staffing, Petition and Adjudication process. Additionally, all client files contained evidence that they received information related to the Grievance process.

## 2.02 Psychosocial Assessment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy that addresses the requirements of this indicator. A review of this policy indicates that it was last revised by the agency on March 6, 2009. The agency has a process in place for completion of Psychosocial Assessments of youth admitted o residential shelter. This onsite review of this indicator included seven (7) youth files. Of the files reviewed, the following information was found:

- Youth (A) intake 08/21/12 no signature of supervisor
- Youth (B). intake 11/04/12 no signature of supervisor- may not have had sufficient time for supervisory review
- Youth (C) intake 10/26/12 no signature of supervisor
- Youth (D) intake 08/20/12 signed by both counselor and supervisor
- Youth (E) intake 11/02/12 no signature of counselor or supervisor
- Youth (F) intake 10/23/12 no signature of counselor or supervisor, however, treatment plan signed by counselor and supervisor, however, not signed by youth or guardian
- Youth (G) intake 10/12/12 signed by both counselor and supervisor

Of the 7 files reviewed, three (3) were not signed by the supervisor, 2 were not signed by the counselor or supervisor. However, the treatment plan in one (1) of these was signed by both the counselor and supervisor, however, no signature was found for the youth or parent/guardian. Two (2) files reviewed were signed by both the counselor and supervisor. An additional review included verification of Psychosocial Assessment being completed by both Bachelor's or Master's level staff members. All other documents provided by the agency contained no issues and was found to be acceptable.

## 2.03 Case/Service Plan

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

The agency has a policy that addresses the requirements of this indicator. A review of this policy indicates that it was last revised by the agency on March 6, 2009. The agency has user friendly forms and a comprehensive system designed to capture client needs and goals, as well as, indicate the necessity of services (type, frequency and location).

Non-residential program - After reviewing three (3) files, two (2) active, one (1) closed, this reviewer found that counselors and supervisors are consistent in identifying responsible parties, completing target and completion dates. The client case plans were all completed within 7 days of the psychosocial completion date. All involved parties signed the case plan, thus, exhibiting best practice. In addition, the case files indicates the programs diligence in completing the 30/60/90 day reviews in a timely manner.

Residential **-** Four (4) files were reviewed (2-active, 2-closed). The case files dates were within seven (7) days of the completion of the pychcosocial assessment. Counselor and supervisor consistently sign all files, and all case plans were initiated within seven (7) days of the psychosocial.

Non-Residential program - While the client files all include 1-2 goals identified in the psychosocial assessment, there were other key issues that were not addressed on the case plan. Example: Presenting problem - Truancy - The goals include going back to school, completing school work, getting up on time. However, the pyschosocial indicated there was a recent death of a close family member, and that the youth stated she was overweight and didn't like to go to school because she was self-concious about her body. These issues that are essential to a youth's motivation to attend school were not addressed in the case plan. DJJ standard 2.03 requires that programs address identified needs, thus, the staff must be diligent to address all presenting problems not just those that qualify them for the program.

Case progress notes and signatures indicate that case file reviews were done, however, there are no specific notes indicating whether there was any progress, additional goals or a revised plan. This reviewer advises that counselors include all identified problems in the case, specifically those that could be barriers that hinder the client's overall success.

Residential **-** This reviewer discovered several deficiencies with documentation. Three (3) of the four (4) case plans reviewed did not accurately address the presenting problems. Ex. It was documented that a client obtained a battery charge, however, neither anger management or conflict resolution were listed as a goal or an obective. In one (1) of the cases, a client was re-admitted to the shelter due to another family conflict , however, there was no evidence of an updated case plan. This reviewer spoke with the counselor who confirmed that a new case plan should have been initiated for this client, as per their policy and procedure manual.

This reviewer found several missing signatures. Three (3) of four (4) files were missing the youths' signature, Three (3) of four (4) files were missing the parents' signature. All four (4) files were missing target and completion dates.

## 2.04 Case Management and Service Delivery

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy that addresses the requirements of this indicator. A review of this policy indicates that it was last revised by the agency on March 6, 2009. Based on the available documentatation, it is apparent that case management services are provided to each youth in both the residential and non-residential programs. The case files that were reviewed indicated that a counselor/case manager was assigned to each client. There was eveidence of coordination of services for the youth and families, as it relates to their participation with the admitting program.

Non-residential - The reviewer found the program to be supportive to the family, as evidenced by progress notes and signatures of the youth and parent. The case files indicated that proper referrals were made to the case staffing committee in two (2) of the three (3) files reviewed. The files and supporting documents confirmed that the youth and their families were assisted by program staff during the case staffing process, as evidenced by the staff signatures on the hearing sign-in sheet, progress notes that include notification of the meeting dates and times and discussion regarding the process.

Residential - The documents support that the youth and their families are supported by their assigned counselors and services are implemented. The forms reviewed are designed to capture case management efforts and the program is structured such that supportive services could be provided.

Non-residential**-** The reviewer observed and confirmed in conversation with the program director, that there were no referrals to outside agencies, thus, providing necessary aftercare services. This reviewer advised that the program would venture out to connect with the community partners and/or organizations to conduct focus groups.The purpose of the focus groups would be to discuss how they can combine

their resources to engage youth and create positive and productive learning environments for them either before entering or once discharged from the program. This reviewer suggested that local agencies can assist with creating a mentoring program, a computer training program or a work readiness program.

Residential - There is no clear evidence to confirm that services are coordinated with the youth and their family, as evidenced by missing youth and parent signatures. In two (2) out of four (4) files there are no recent progress notes to indicate consistent and/or progressive service delivery.

## 2.05 Counseling Services

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

The agency has a policy that addresses the requirements of this indicator. A review of this policy indicates that it was last revised by the agency on March 6, 2009.

Non-residential - The program consistently met all requirements for this indicator without exception.

Residential - A review of the documentation indicates that youth and their families receive counseling services in accordance with the youth's case plan. Individual case files are maintained on each client, and the confidentiality laws are upheld, as evidenced by files being stamped "confidential". The program provides individual, family and group counseling (psycho-educational by direct staff & outside vendors).

Non-residential -No exceptions noted.

Residential - Residential program counselor mentioned that there is a breakdown in communication between the residential and non-residential programs, as it relates to clients that are admitted to the shelter. It appears that the clients and their families are being engaged by counselors from both programs, which tends to be confusing and counter productive for the parent, the youth and the counselor.

In two (2) out of four (4) files there are no recent progress notes to indicate consistent and/or progressive service delivery.

A review of group documentation revealed groups were not consistently conducted five days per week. The program conducted between two and four groups per week, as stated by a program counselor.

## 2.06 Adjudication/Petitiion Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy that addresses the requirements of this indicator. A review of this policy indicates that it was last revised by the agency on March 6, 2009. The agency consistently met all requirements for this indicator without exception. All case files and supporting documentation indicate that youth and families are properly referred to the case staffing committee, regularly scheduled hearings are held, and the case staffing committee is notified in a timely manner. Documentation was submitted confirming regular communication between program staff and the case saffing committee, court officials and the family. The case file documents confirmed that the family receives a copy of the committee's recommendations and program staff explained that the reason behind the recommendations is discussed at the hearing. In addition, the family is given the option to call their counselor for further clarification.

**Residential -** None of the files reviewed were case staffing files.

## 2.07 Youth Records

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Non-residential & Residential **-** All records were maintained in a neat and orderly manner, the files included cover pages that indicated where to find specific documents. All files were clearly marked "confidential", program staff confirmed that the files were kept in a locked file cabinet.

# Standard 3: Shelter Care

## Overview

Rating Narrative

The Youth and Family Alternatives – New Beginnings (YFA-NB) Runaway and Youth Crisis shelter is located at 18377 Clinton Boulevard in Brooksville, Florida. This residential shelter operates 24 hours a day, 365 days a year and is licensed to serve up to twenty-four (24) residents for runaway and emergency shelter services. The youth shelter is contracted to serve both CINS/FINS youth and children placed by the Department of Children and Families (DCF).

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 Youth Room Assignment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

A process is in place that includes classification for Room Assignment that is designed to screen youth in order to make the most appropriate sleeping room assignment. a review of seven (7) files found that each youth was assessed to determine proper room assignment. The form used for room assignment includes the following items:

- Physical characteristics such as size and weight
- Maturity level as well as chronological age – younger clients separated from older clients
- Level of aggression, attitude, etc.
- Potential susceptibility to victimization, based on history, disability, etc.
- Prior delinquency history, gang involvement, sexual misconduct
- Only youth of same sexes share rooms

Of the 7 files reviewed, each file was generally organized in a uniform manner and stored in a secure location. All files contained an alert when a youth is admitted with applicable special needs and risks such as risks of suicide, mental health, substance abuse, physical health or security risk factors.

## 3.02 Program Orientation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy that addresses the requirements of this indicator. The program has a policy on Program Orientation that was last reviewed by YFA on March 6, 2009. This policy describes the Program Orientation procedure to be followed all staff members.

The program has a process in place for orientation of youth into the program. A checklist is utilized by staff members and it is included in the youths' client files. This onsite review resulted in the following: handbook delivery, discipline, grievance procedures, emergency/disaster procedures, contraband rules, alerts, dress code rules, etc. In addition, the handbook also covers items reviewed during orientation.

Also, further review of the handbook found the Abuse Hotline Number listed on Page 10 of the Shelter Handbook. A sample of six (6) youth files were reviewed onsite to assess the agency's adherence to this indicator. Each file consistently maintained the aforementioned orientation items and this indicator was found by the reviewer to be acceptable.

### 3.03 Shelter Environment

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

At time of the review, the review team was informed by the Program Manager that the facility had recieved a face lift by getting new paint inside and out. In addition, all bathrooms had also been repainted. Upon inspecting the facility it was observed that the cleanliness of the facility was poor. The grounds of the facility appear maintained and there is no apparent damages outside. The furniture throughout the facility appears all to be in working order and every client appears to have clean useable linens. Clients do have a secure place where they can place personal belongings in.

Upon walking around the facility it was observed that two (2) of the emergency exit lights are not working. In several of the bathrooms urine was observed on the toilet seat along with hair. In one (1) bathroom the light fixtures were not working and a flashlight was placed in the bathroom in case someone needed to use it it appears. In the kitchen the refrigrators were dirty with liquid of some sort on the bottom of each of them. The stove top in the kitchen needs to be clean. The kitchen area also has deteiorating pieces of ceiling tiles sitting on top of the rolled up aluminum door in the kitchen. The pantry in general is not organized, appears untidy and boxes are stacked next to the hot water heater. The organization and cleanliness of the laundry room the cleaniness can be improved. The lint filter was not cleared and need to be cleaned. Staff members must be reminded to clean the lint filter after using the dryers. Upon inspection of the Agency vehicles, they were found to be filthy. The vehicles have trash throughout the vehicles and small pieces of debris on the inside of the vans. The minivan was initially missing the fire extinguisher, but was found in a office later by a YDS staff member.

At the time of this onsite review, the initial perception of the facility was that the youth shelter appeared to be neat and orderly from the outside. The review team found certain interior areas of the facility that were unsanitary, unorganized and required maintenance. The agency appeared to have put little or limited effort preparing for the shelter environment and ensuring that general areas of the shelter interior were clean, organized and operational.

Unsanitary food storage areas can lead to foodborne illnesses or serious pest control problems, unclean bathing areas can result in fungal infections and not disposing biohazard waste can present a broad range of serious health issues. It is strongly recommended that the agency address these areas and install an onging and consistent systems to monitor the status of these aforementioned areas.

### 3.04 Log Books

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

Upon time of the review the agency had a logbook present and update. The logbook entries are dated and timed according to Standards. On-coming supervisors review the logbook at the begining of each shift as well as the Program Director makes weekly entries.

Not all entries in the program logbook are clear and informative. Incidents are briefly mentioned, vague and leave alot to the imagination. Agency YDS staff do not review the logbook on a regular basis. Staff making the entries need to slow down and make their entries legiable for everyone to be able to read. Also, the spacing between words need to be addressed so that will help with clearification. When counselors or other directors make entries those should be highlighted to be easily recoginized to anyone reviewing the log. Alerts are listed in the logbook but not clearly identified from shift to shift.

Rating Narrative

Upon review the Agency has a schedule posted in the main hallway. The schedule is clear and meets the requirement for providing Clients the opportunity for a variety of activities through out the waking hours.

The schedule is only posted in the main hallway and was not found posted in any other location in the facility. A Best Practice consideration is to post the schedule in multiple locations throughout the facility so that the Clients have access to it at any time. Upon reviewing a total of twenty-three (23) weeks of the Group Log books, there were only five (5) out of the 23 weeks that the reviewer could confirm that the agency actually provided 5 or more groups in a week.

### 3.06 Behavior Management Strategies

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Agency has worked closely with the Florida Network Trainer Tom Popadak to develop a new Behavior Modification program in March of 2012 that uses points and levels to reward Clients for appropriate behaviors. The program clearly lists behavior expectations for both the staff and

the clients. The review team member assigned to this indicator reviewed the NBYS Meeting Agendas for last year and the Behavior Plan has been discussed during regular staff meeting and that information has also been discussed at the Management Level and incident reports were reviewed.

As with any new program and with the turn over that this agency has experienced it requires constant training and re-training of staff. Also, Best Practice would be that the Behavior Management plan be placed throughout the agency such as in the dormitory area and also in the dayroom. Continuing, the rewards and levels should be posted for everyone to see not just having to ask staff for that information. The Review Team was informed that due to recent painting the Behavior Management Plans were taken down and have not been posted back up yet. Also, eight (8) staff training files were reviewed and six (6) out of the 8 staff members had recieved training on the new Behavior Management system.

### 3.07 Behavior Interventions

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The Agency does have policy and procedures for Behavior Interventions that meet all required standards. Upon interviewing the Program Director she states that the agency does have the training required by the Florida Network however they continue to be a hands off faciliity. After reviewing eight staff training files in was observed that only five (5) of the staff had recieved the Physical Intervention training. Five (5) client charts were reviewed and all 5 charts did have the consent for Behavior Intervention Letters signed by the Parent/Gaurdian.

### 3.08 Staffing and Youth Supervision

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

At the time of the review, the agency clearly has policies and procedures in place to meet Administrative Code related to Staff Supervision. Staff Supervision comes to Staff Supervision and also having a staff on of each gender for each shift. Staff schedules were reviewed as well as interview with the Program Director.

Upon reviewing the logbook and the CCC incident reports the staff should monitor their duties and ensure one staff is on the floor at all times during the overnight hours to ensure proper supervision is maintained. The agency is currently under an Administrative Review for lack of supervision and there are four (4) recent staff disciplinary actions that are related to staff supervision issues. Verbal altercation with a Client(10/30/12), 3hrs late for shift(5/27/12), No Show for shift(5/24/12), Sleeping on shift(7/1/12).

The agency did not provide evidence or documentation to indicate that internal measures had taken place to address the root cause of supervision deficiencies. At the time of this onsite QI program review, a open investigation was being conducted by a Safety and Security Investigator with the Florida Department of Juvenile Justice.

### 3.09 Staff Secure Shelter

☐ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

At this time onsite QI program review, this agency is not listed as a Staff Secure Program. This indicator is not applicable.

# 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-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 sights 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 agency has a written policy and procedure in place to address the requirements for the Healthcare Admission Screening indicator. A review of this policy indicates that it was last revised by the agency on March 6, 2009. The policy states that a CINS/FINS Intake Assessment form and the Health Screening form are completed upon admission by the Youth Care Staff. A review of seven (7) files was conducted and all files contained the screening forms which were conducted on the same day as the youth intake. All files contained evidence of the date of the healthcare screening.

The preliminary health screening of all 7 client files indicated that the agency screening process documented evidence of the following in each file reviewed onsite: Screening for Current Medications; Existing medical conditions; Allergies; Recent Injuries or Illnesses; Observation for evidence of Illness, injury, pain or physical distress, difficulty moving, etc.; Observation for presence of scars, tattoos, or other skin markings; Diabetes; Pregnancy; Seizure Disorder; Asthma; Tuberculosis; Hemophilia (bleeding disorders); Parental Coordination of Medical Appointments; Head injuries; and Screening for Medical referrals. All youth with medical conditions had evidence of the appropriate alerts documented in their respective client file. Additionally, the program has procedures to include a detailed process and a mechanism for necessary follow-up medical care for CINS/FINS clients with chronic medical conditions.

## 4.02 Suicide Prevention

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

A review of the agency policy related to the Suicide Prevention indicator was conducted onsite during the program review. A review of this policy indicates that it addresses the requirements contained for the Suicide Prevention indicator. The agency's suicide risk assessment has been approved by the Florida Network of Youth and Family Services for 2012. The Program has a written Master Plan that details their suicide prevention plan and response procedures. The agency uses a Suicide Assessment form on all youth that receive a "Yes" response on the Suicide Risk Screening section (questions 1-6) in the CINS Intake form. The agency's Suicide Assessment form includes general demographics on all clients. The form also has sections that include Method of Assessment; Current Suicide Risk Indicators; Current Mental Health Status; Degree of Dangerousness Youth Presents to Self; Summary of Findings that the Conclusion; Recommendations Regarding Suicide Precautions; Recommendations for Treatment of Follow-Up; Conferred with Other Staff Regarding Recommendations; and Parental/Guardian Notification.

A review of four (4) residential files were conducted onsite. In all 4 files, a suicide risk screening was completed during the screening and intake process. In all 4 cases, the youth had a "yes" response to the identified questions and proper procedures were followed. For the residential cases this included being placed on Sight and Sound (S&S) supervision until an additional Suicide Assessment could be conducted by a staff member supervised by a licensed professional. In these cases, the youth was removed from S&S supervision only after the case was staffed with the licensed professional. Review of the Professional Log an S&S Logs supported that these procedures were followed. A review of the sight and sound supervision counts was conducted and evidence of times of was documented as required. Documentation to step down or remove the youth from sight and sound supervision was found in the agency program logbook as required.

Of the six (6) staff surveyed, 100% were aware of the procedures for working with youth who express suicidal thoughts. All staff members

documented on survey responses that they were knowledgeable of the youth's health and mental health alerts. All staff members also documented and identified that they were familiar with the location of safety and emergency equipment located in the residential facility.

An exception to the aforementioned findings found that the one file reviewed onsite contained evidence that the assessment was reviewed by the clinician, but did not have evidence of the actual date that the assessment was reviewed. All assessments reviewed by the licensed authority should contained legible documentation of the clinician's signature, credentials and date of review.

## 4.03 Medications

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

The agency has a comprehensive policy on Medications. The agency's current policy is labeled Medication Control and Management. The current Medication policy was last approved by the Agency President on January 28, 2012. The agency's policy contains written general content that addressed the secure storage, access, inventory and documentation of records in accordance with the DJJ Health Services Manual.

Onsite observations found that all medications in the shelter are stored in a separate, secure area, which is inaccessible to shelter residents. All medication was stored in a double locked cabinet located near the Youth Development Specialist Work Station. Oral, topical and over-the-counter medications have designated shelves that are labeled for separate storage. However, an over-the-counter medication was found stored on the same shelve as oral medications. This was corrected onsite. There were no injectable medications on site, or identified as needed for any youth during the time of the onsite review. The shelter has a system in place for refrigeration of medication if needed. At the time of this onsite QI review, there was no medication that required refrigeration.

Controlled medications are locked in a cabinet behind two (2) locks. At the time of this review, there were no CINS/FINS youth that were on Controlled medication. The agency maintains a Medication Distribution Binder that houses the medication distribution record forms for each resident on medication. The agency does provide limited over-the counter medication non-Aspirin. The agency only distributes non-Aspirin on an as needed basis.

Sharps are maintained in a locked cabinet. At the time of this onsite review, the sharps maintained at the shelter consisted of a nail cutter, razors and pill cutter. Scissors are secured and stored in the Program Director's office. Inventory counts on sharps are conducted on a perpetual basis when the sharp is provided to a resident. The agency provided the previous 6 month inventories back to the last six (6) months. A review of inventories of scissor and razors was conducted. It was found that agency sharp counts are being counted on a weekly basis. Currently, agency sharps are updated when razors are given to residents and when the razor inventory is re-stocked/replenished.

The program utilizes two (2) Medication Distribution Records (MDR). One (1) MDR is specific to the YFA agency called the Prescription Medication Log (PML) Sheet and the other is a DJJ Medication Administration Record (MAR). All staff members distributing medications are non-licensed health professionals. Only staff members that are licensed health professionals are permitted to use a Medication Administration Record (MAR).

A total of four (4) client medication records were reviewed onsite. In general, there are examples of the DJJ MAR containing partially completed fields/sections necessary to deem the record as being completed as required. Several sections/fields on each DJJ MAR are not complete or not completed correctly. In addition, three (3) of the four (4) client PML or MDR forms did not include a picture of the client on medication so that staff can confirm that they are provide medication assistance to correct youth.

The first client's New Beginnings PML sheet is completed and has several incomplete fields. These missing fields include Doctor's Name; Case Number; Existing Medical Conditions; Possible Side Effects; Known Allergies. Further, the staff assisting in the delivery of this medication did not document the remaining number of pills on the form. In addition, this client's DJJ MDR is also incomplete and lacks documentation of Physician's name, Allergies, Side Effects, Start. A second client has a completed PML, but documentation on the MDR is not completed as required. This client refused their medication on several occasions. This is marked on the PML, but this client's MDR is not reflecting refusals and other fields correctly. A third client has a completed PML, but documentation on the MDR is not completed as required. This client's MDR did not consistently include initials for the youth and staff on this document. A fourth client has a completed PML, but documentation on the MDR is not completed as required. This client's MDR does include Allergies and Side Effects, but lacks documentation of Month/Year, Physician's name and Stop date. In addition, this client was very low on their medication. A low medication alert form was issued several days ago (11-03-2012). The agency reported that they had notified the parent. The parent confirmed understanding the agency's request to obtain and deliver the youth's prescription medication. The youth was on their last Anti-Depressant pill on the day 2 of this onsite review.

The agency has made recent efforts to revise its Medication Policy and Practice and implemented an update policy on this issue (January 2012). The agency also plans to introduce and train Direct Care Staff members on a new Medication Distribution Log prior to the end of the 2012 calendar year.

At the time of this onsite review, the agency is utilizing two (2) Medication Record Logs or Forms. This appears to cause some staff confusion, as well as duplication. This also leads to staff members not fully completing the documentation of medication information on both forms for each client on a consistent basis.

The reviewer also observed two (2) bio hazard waste bins that were full to capacity and required disposal through an approved waste disposal outlet. Staff members failed to update the medication count on a client's file. Liquid cough medicine was found stored on same shelf as prescription medication. Sharps are counted on a perpetual basis when they are provided to a resident. However, sharps are not counted and documented weekly as required. Over-the-counter medications are counted on a perpetual basis when they are provided to a resident. However, over-the-counter medications are not counted and documented weekly as required. The agency maintains a pill cutter and cuts pills in halves on an as needed basis. All pills that require spiltting should not be performed by staff members. Pill splitting should only be conducted by a pharmacy or licensed Nurse or Pharmacist.

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

At the time of this onsite program review, the agency did not have a posted list of staff that are designated in writing to have access to secured medications and limited access to controlled substances (narcotics). This list was provided onsite during the review. The list staff authorized to distribute medications was not signed by the Program Director or another designated individual.

## 4.04 Medical/Mental Health Alert Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policy called the Medical and Mental Health Alert System that was reviewed by YFA on 3/06/09. This policy describes the procedure to be followed in order for the agency to have an effective alert system that ensures information concerning a youth's mental, medical and health condition is communicated to staff.

A review of seven (7) files found that medical and allergy alerts are indicated on the interior and exterior of each youth files. Of these 7 files, each file was consistently marked as required by the policy. A label titled Medical Alert was posted in addition to a red label titled allergies. The interior of the youth file contains a legend identifying the code used for medical alerts. In addition, a tour of the facility was completed and the alert board located outside of the director's office was reviewed. The information posted was consistent with the alerts documented in the active files reviewed. Further, the reviewer observed the medical alert board located in the medication room.

The reviewer observed the food allergy alert board located in the kitchen. This food allergy alert board contained alert information that was consistent with what was documented in the youth's file. The reviewer also observed information documented in the program logbook. This review included verification of log book and youth intakes to confirm comments relevant to medical/allergy issues with youth at intake. Two (2) youth intakes were indentified in log books and Medication alerts/classification was included as required. In addition, if needed, staff members review information for certain precautions, alerts, etc. in the Lippincourt Nurse's Drug/Prescription Guide located in the medication room.

At the time of this review, this medical alert board contained alert discrepancies that were not consistent with what was documented in the youth's file. A staff leading the tour noted that youth information was removed in error.

## 4.05 Episodic/Emergency Care

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The Agency has clear Policies and Procedures in place for Episodic/Emergency Care. The Program Manager keeps an Episodic Care Log on her computer to keep track of the Incidents as well as the Local incident reports are kept in a binder.

Local incident reports were reviewed dating back to May of 2012. There were multiple incidents reported during that time frame with only one of them requiring medical attention for a broken toe. Upon reviewing that incident report it was not completed totally and what was completed was not correct. According to the Program logbook the client was transported to the hospital at 6:25pm and returned at 9:20pm but the DJJ CCC was not called till 11:20pm. However, it does not show on the incident report nor the logbook that the parent was ever contacted. Program Manager stated that she believes they were, but it is a training issue with the staff that is being addressed.