



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of YFA-New Beginnings

on 04/20/2017

CINS/FINS Rating Profile

Standard 1: Management Accountability

1.01 Background Screening of Employees/Volunteers	Satisfactory
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Satisfactory
1.05 Analyzing and Reporting Information	Satisfactory
1.06 Client Transportation	Satisfactory
1.07 Outreach Services	Satisfactory

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

Standard 3: Shelter Care

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

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

Standard 2: Intervention and Case Management

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

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

Standard 4: Mental Health/Health Services

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

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

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

Rating Definitions

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

Satisfactory Compliance	Non-systemic exceptions that do not result in reduced or substandard service delivery; or exceptions with corrective action already applied and demonstrated.
Limited Compliance	Exceptions to the requirements of the indicator that result in the interruption of service delivery, and typically require oversight by management to address the issues systemically.
Failed Compliance	The absence of a component(s) essential to the requirements of the indicator that typically requires immediate follow-up and response to remediate the issue and ensure service delivery.
Not Applicable	Does not apply.

Review Team

Members

Ashley Davies, Forefront LLC, Lead Reviewer/Consultant

Matthew Dickey, Tampa Housing, Data Specialist

Cara Dixon-Taliaferro, Thaise St. Petersburg, Case Manager

Tiffany Martin, Florida Network, Project Manager of Operations and Research

Melissa Johnson, Department of Juvenile Justice, Central Region Supervisor

Persons Interviewed

- | | | |
|---|--|---|
| <input type="checkbox"/> Chief Executive Officer | <input type="checkbox"/> Executive Director | <input type="checkbox"/> Chief Operating Officer |
| <input type="checkbox"/> Chief Financial Officer | <input checked="" type="checkbox"/> Program Director | <input checked="" type="checkbox"/> Program Manager |
| <input checked="" type="checkbox"/> Program Coordinator | <input checked="" type="checkbox"/> Direct- Care Full time | <input checked="" type="checkbox"/> Direct-Care Part Time |
| <input type="checkbox"/> Direct-Care On- Call | <input type="checkbox"/> Volunteer | <input type="checkbox"/> Intern |
| <input checked="" type="checkbox"/> Clinical Director | <input checked="" type="checkbox"/> Counselor Licensed | <input checked="" type="checkbox"/> Counselor Non- Licensed |
| <input checked="" type="checkbox"/> Case Manager | <input type="checkbox"/> Advocate | <input checked="" type="checkbox"/> Human Resources |
| <input checked="" type="checkbox"/> Nurse | | |
| 2 Case Managers | 0 Maintenance Personnel | 2 Clinical Staff |
| 1 Program Supervisors | 0 Food Service Personnel | 0 Other |
| 1 Health Care Staff | | |

Documents Reviewed

- | | | |
|---|--|--|
| <input type="checkbox"/> Accreditation Reports | <input checked="" type="checkbox"/> Fire Prevention Plan | <input checked="" type="checkbox"/> Vehicle Inspection Reports |
| <input checked="" type="checkbox"/> Affidavit of Good Moral Character | <input checked="" type="checkbox"/> Grievance Process/Records | <input type="checkbox"/> Visitation Logs |
| <input checked="" type="checkbox"/> CCC Reports | <input type="checkbox"/> Key Control Log | <input checked="" type="checkbox"/> Youth Handbook |
| <input checked="" type="checkbox"/> Logbooks | <input checked="" type="checkbox"/> Fire Drill Log | 5 # Health Records |
| <input checked="" type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 5 # MH/SA Records |
| <input type="checkbox"/> Contract Monitoring Reports | <input checked="" type="checkbox"/> Table of Organization | 14 # Personnel Records |
| <input type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 7 # Training Records |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 5 # Youth Records (Closed) |
| <input checked="" type="checkbox"/> Fire Inspection Report | <input type="checkbox"/> Telephone Logs | 5 # Youth Records (Open) |
| <input type="checkbox"/> Exposure Control Plan | <input type="checkbox"/> Supplemental Contracts | 0 # Other |

Surveys

3 Youth 3 Direct Care Staff

Observations During Review

- | | | |
|--|--|--|
| <input type="checkbox"/> Intake | <input checked="" type="checkbox"/> Posting of Abuse Hotline | <input checked="" type="checkbox"/> Staff Supervision of Youth |
| <input checked="" type="checkbox"/> Program Activities | <input type="checkbox"/> Tool Inventory and Storage | <input checked="" type="checkbox"/> Facility and Grounds |
| <input type="checkbox"/> Recreation | <input checked="" type="checkbox"/> Toxic Item Inventory and Storage | <input checked="" type="checkbox"/> First Aid Kit(s) |
| <input type="checkbox"/> Searches | <input type="checkbox"/> Discharge | <input type="checkbox"/> Group |
| <input checked="" type="checkbox"/> Security Video Tapes | <input type="checkbox"/> Treatment Team Meetings | <input checked="" type="checkbox"/> Meals |
| <input checked="" type="checkbox"/> Social Skill Modeling by Staff | <input type="checkbox"/> Youth Movement and Counts | |
| <input checked="" type="checkbox"/> Medication Administration | <input checked="" type="checkbox"/> Staff Interactions with Youth | |

Comments

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

Strengths and Innovative Approaches

Rating Narrative

The agency has recently purchased land across the street from the RAP House to start building affordable housing.

The Residential Director is now the Regional Shelter Director overseeing New Beginnings and the agency's other shelter RAP House located in New Port Richey. Each shelter now has a Residential Supervisor and Team Lead.

The agency recently received a grant through United Way to have a Case Manager visit the homes of habitual runaways for ten to twelve weeks after services end.

The shelter has served over 400 youth in the last year.

The agency has a full-time Registered Nurse who splits her time between RAP House and New Beginnings shelters.

Standard 1: Management Accountability

Overview

Narrative

At the time of this onsite program review, the Youth and Family Alternatives residential program employs a Residential Director, a Residential Supervisor, an Office Specialist, two Youth Development Specialist (YDS) Shift Leaders, one YDS Team Leader, two Residential Counselors, a Registered Nurse, and twelve Youth Development Specialists, both full-time and part-time. The agency operates a Risk Prevention and Management Team Meeting that reviews various issues quarterly. This team is comprised of various YFA staff members. Youth and Family Alternatives, Inc. is accredited by the Council on Accreditation (COA).

1.01 Background Screening

Satisfactory Limited Failed

Rating Narrative

The agency has a policy on Background Screening of Employees/Volunteers. The policy was last reviewed on March 30, 2017.

Prior to making an offer of employment, the applicant must submit to a background screening and be compliant with current Florida Department of Juvenile Justice Policies and Procedures. No offer of employment may be made prior to receiving an eligible rating from said screening. In addition, a letter will be mailed requesting a local law enforcement check to the appropriate county. A Florida Department of Law Enforcement Sexual Offender/Predator search will be completed on all applicants. A Department of Motor Vehicles driving history check will be completed on all applicants.

The agency will request federal criminal checks for all employees, interns, or volunteers within thirty days of their five-year anniversary with the agency.

On or about the beginning of January each calendar year, the agency will begin completing the Annual Affidavit of Compliance with Good Moral Character Standards.

There were fourteen staff hired since the last on-site Quality Improvement Review. All fourteen staff received a background screening with a rating of "eligible" prior to being hired. There were no staff who required a five-year re-screening during this review period. The Annual Affidavit of Compliance with Level 2 Screening Standards was submitted on January 24, 2017.

There were no exceptions to this indicator.

1.02 Provision of an Abuse Free Environment

Satisfactory Limited Failed

Rating Narrative

The agency has a written policy and procedure that addresses the key elements of the QI Indicator. The policy was last approved on 2/13/2016 and signed by the Chief Operating Officer and Vice President of Prevention Services. The agency shall provide an environment free of physical, psychological and emotional abuse. The agency has a code of conduct that prohibits the use of physical abuse, profanity, threats, or intimidation.

The written procedure includes a section for code of conduct, grievances, abuse and neglect reporting, client access to reporting, and allegations against staff. Staff is directed to follow the American Counseling Association (ACA) Code of Ethics and Standards and Practice. Any deviation from the policy shall be reported to appropriate management staff or other appropriate agency. All employees and volunteers are obligated to report any abuse and/or neglect to the Florida Abuse Hotline.

Clients are informed by staff that they have the right to have unimpeded access to the telephone in order to report if they have been mistreated. Any allegations against staff are reported to Abuse Registry, CCC, and Program Director/Manager immediately. The Program Manager/Director takes all necessary measures to ensure safety of the youth. Procedure closes by stating failure to follow the above procedure will result in disciplinary action.

There are signs posted of the Florida Abuse Hotline throughout the facility in both English and Spanish. The program maintains a record of child abuse hotline calls, although there have not been any. The program has a grievance form that is explained to the youth during the intake process. The grievance forms and bins are accessible to the children. Sixteen (16) grievances were filed; all sixteen (16) were addressed by staff and reviewed by the Program Director within a couple days of being submitted by the youth. All sixteen (16) grievances were checked off by the youth that they agreed with the resolution.

There were no exceptions for this indicator.

1.03 Incident Reporting

Satisfactory

Limited

Failed

[Rating Narrative](#)

The agency has a written policy and procedure that addresses the key elements of the QI Indicator. The policy was last revised on 10/20/2015 and signed by the President/CEO and Board Chair. The agency will document promptly any incident that is not consistent with normal or usual operation of agency programs or its facility. Injury does not have to occur.

The written procedure states the agency will comply with Incident Reporting requirements, including report all incidents to Central Communication Center (CCC) within two (2) hours of incident occurring or becoming aware of the incident.

There were nine (9) CCC reports in the last six months. All were reported within the two-hour time frame. There was documentation that all nine (9) were closed and follow-up communication and tasks were completed as required by the CCC. Agency documented all incidents on reporting forms and placed them in a program log. All reports were reviewed and signed by program supervisor/directors.

There were no exceptions for this indicator.

1.04 Training Requirements

Satisfactory

Limited

Failed

[Rating Narrative](#)

The agency has a policy on Training Requirements. The policy was last reviewed on March 31, 2017.

The agency provides a wide array of training opportunities to staff including the utilization of an online training system called Relias. Staff are responsible for completing their assigned trainings on Relias when required and for uploading any certificates into the system for approval. It is also the staff's responsibility to track their training hours each year and ensure they are meeting the requirements of this policy. In addition to Relias, staff are offered opportunities for in-person trainings internally and externally.

There were four training files for new hire training completed during the first 120 days of employment. All four staff received all training required within the first 120 days. Three additional training files were reviewed for training requirements for the first year of employment. All three staff documented more than

the required 80 hours of training with 162, 136, and 148.25 hours respectively. One staff member still had approximately two months left in the training cycle to receive additional training and hours. The two staff who had completed their first year of training had completed all required training.

There were three training files reviewed for annual in-service training requirements. All three staff documented more than the required 40 hours of annual training with 82.75, 61.75, and 60.75 hours of training respectively. All three staff documented all required training, as well as, additional training.

There were no exceptions to this indicator.

1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that addresses the key elements of the QI Indicator. The policy was last reviewed on 1/13/2015 and signed by the President/CEO and Chief Administrative Officer. Policy is agency shall implement and maintain a Continuous Quality Improvement (CQI) process.

The agency has a comprehensive Continuous Quality Improvement (CQI) Plan which includes contributions from committees, sub-committees, and other agency groups. The CQI Plan is supported by management at all levels with all staff encouraged to participate and reinforced by Sr. Leadership. CQI efforts focus on the process of gathering data, analyzing data, and looking for trends and patterns in the data. Data is reviewed monthly/quarterly for accuracy along with seeking continual improvement.

The agency has created a number of committees that meet regularly to review different aspects of the quality environment. CQI Council Meetings are held quarterly for management to review and communicate findings to staff and stakeholders.

The agency does quarterly reviews of case records through peer review groups. The reviewer completes a Review Tool for each case, which is then recorded on a master spreadsheet of all the cases reviewed. These are then reviewed for missing and/or incomplete data that can then be corrected.

Review of incidents, accidents, and grievances, along with customer satisfaction data, and outcome data are done quarterly at the CQI Council Meeting. Minutes and Data Reports from the meetings are kept in a log book. In the meeting minutes, evidence is shown that strengths and weaknesses are identified and improvements are implemented. Staff is informed and involved throughout the process.

Monthly review of NetMIS data is emailed out to the management team to review.

There were no exceptions for this indicator.

1.06 Client Transportation

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy on Client Transportation. The policy was last reviewed on February 14, 2017.

All staff that transport youth or who have the potential to transport youth will be approved drivers through Human Resources. Staff will utilize the "Monthly Trip and Mileage Log" each time they use the agency vehicles whether they are transporting clients or not. Staff will answer each of the questions on the log including the name of the driver, date, and time, whether the safety equipment is available, client initials traveling in the vehicle, the origin and destination of the trip, whether any tolls were incurred, and finally

the odometer readings at origin and destination. Staff will take the shelter phone with them anytime they are providing transportation and will phone or “check in” with the shelter once they have arrived at their destination.

Staff are to take an approved third party, on all situations that involve the transportation of a youth, whenever possible. Third parties are approved agency staff, volunteers, or interns. Staff will make every attempt to avoid single party transport situations; however, when this cannot be avoided staff will ensure that their supervisor or designee is aware and this will be documented in the log. In addition, staff will take into consideration the client’s history and recent behaviors before transporting. Finally, staff will ensure that the youth is sitting in the back row of the vehicle during a single party transport. Staff who are concerned about any safety issues during a single party transport will maintain an open line of communication with the shelter throughout the transport.

The agency has a list of approved drivers that was signed by the Vice President of Prevention. The list includes twenty staff from the shelter. All drivers have a valid Florida driver’s license and are covered under the company insurance policy.

The shelter maintains a Single Youth Transport Log. This log documents the date, the client name, reason for transport/destination, supervisor approval, supervisor initials, departure from/time of departure, destination and time of arrival, mileage to and from, and staff name. This log is filled out anytime a single youth is transported. In addition, there is documentation in the shelter logbook when the single youth transport begins and ends. The Residential Supervisor is notified prior to a single youth transport and approves the transport and initials the log. At this time, the Residential Supervisor takes into consideration the youth being transported, including the youth’s history and recent behavior. The staff on the transport keeps an open line of communication on a cell phone, with a staff member at the shelter, the entire time the single youth transport is taking place.

A Monthly Trip and Mileage Log is maintained for all other transports that are not single youth transports. This log documents the date, driver, safety equipment, number of youth, purpose, stops, and odometer start and end. These logs are maintained for the two vans the shelter uses for transports.

There were no exceptions to this indicator.

1.07 Outreach Services

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that addresses the key elements of the QI Indicator. The policy was last reviewed on 3/27/2017 and signed by the President/CEO and Board Chair.

Staff shall seek opportunities to conduct ongoing community and education to communicate the Agency mission, role, functions, capabilities, and the strengths, needs and challenges confronting children and families.

The agency has a community outreach policy that staff at all levels is formally assigned responsibility for community education. Staff is encouraged to join state, county, and district boards. Participate in community forums that deal with issues of youth and families, as well as needs assessments. Informing the community of services the agency provides. Attend DJJ circuit meetings and keep a copy of the meeting agenda, minutes, and sign-in sheet for their records. Keep a record of inter-agency agreements.

Agency provided a print out of attended events in the community from NetMIS. They also have a logbook that includes meeting agendas, minutes, sign-in rosters, and handouts from the events. Among the events that staff attended are Child Study Team Meetings, CINS/FINS Presentations, Community Alliance Meeting, DJJ Circuit Board Meetings, KCI Quarterly Meeting, Truancy Case Staffing, among others.

Agency has outreach agreements with Baycare, Bene’s Career Academy, Pasco Kids First, United Way of Hernando County, Lighthouse for the Visually Impaired and Blind, Pasco Sheriff’s Office Special Victims

Unit, Sumter County School Board, and Saint Leo University. All outreach agreements are up-to-date. There were no exceptions for this indicator.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

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

The agency is contracted to provide residential and non-residential CINS/FINS services to youth and families residing in Citrus, Hernando and Sumter Counties. The non-residential services are provided at the agency's office, local schools, and at the offices of other community based organizations. The non-residential component consists of a non-residential Master level Program Director and Program Supervisor. The program has assigned four full-time Counselors, two Counselors in Citrus County, one Counselor in Hernando County, and one Counselor in the Sumter County service region.

2.01 Screening and Intake

Satisfactory
 Limited
 Failed

Rating Narrative

The agency has written policy and procedures that addresses the key elements of the QI Indicator. The policy was last approved on 2/14/17 by COO and VP of Prevention Services. An initial eligibility screening begins at the time of the first contact, and no later than seven (7) days from the date of a youth being referred to services.

An eligibility screening is completed upon request for services and is available to families 24 hours a day. If a counselor is not available the Centralized Intake Screening Form will be completed by a Youth Development Staff or Support Staff. If it is determined the youth is in need of crisis, mental health or substance abuse services, the on-call supervisor will be contacted to assist with the family's immediate needs. For non-emergencies, the referral form and Centralized Intake Form may be given to the Program Director to determine if an intake will be scheduled or if youth will be placed on the waiting list. Upon intake youth and family will receive available services options, rights and responsibilities, possible actions occurring through the involvement of CINS/FINS and a description of the grievance process.

There were five residential files reviewed (three open and two closed). Of the five files, all had a Centralized Intake Screening Form completed and youth were admitted to the shelter within twenty-four hours of the completion of the screening. All files had a signed acknowledgement of Receipt of Rights and Responsibilities and Receipt of Notice of Information Practices.

There were four non-residential files reviewed. All four youth were screened within seven days of the referral. It was noted in one file that the family could not be contacted and the case manager elected to do the screening based on the information in the referral form. For all files reviewed, there were parent and youth signatures on the Rights and Responsibilities form.

There were no exceptions to this indicator.

2.02 Needs Assessment

Satisfactory
 Limited
 Failed

Rating Narrative

The agency has written policy and procedures that addresses the key elements of the QI Indicator. The policy was last approved on 2/14/17 by the COO and VP of Prevention Services. CINS/FINS Programs will conduct a full Needs Assessment, to be initiated in a timely manner, for each youth and family participating in services. This assessment evaluates a variety of issues faced by the family, not just the presenting problem represented by the youth.

Assessments are to be completed within 72 hours of admission. If a more intensive assessment is determined to be needed, a referral will be completed and documented in the case file. An updated needs assessment shall be conducted every 6 months or when otherwise indicated. The Needs Assessment will be completed within two face-to-face contacts following the initial intake if the youth is receiving non-residential services. Needs Assessments are completed by Bachelors or Masters level staff and signed by a supervisor. If the suicide risk component of the assessment is required (as a result of suicide risk screening), it must be reviewed (signed and dated) by a licensed clinical supervisor or written by a licensed clinical staff.

There were five residential files reviewed (three open and two closed). Of the files reviewed four Needs Assessments were initiated within 72 hours of youth being admitted into the program by a Youth Development Staff. A counselor completed all Needs Assessments and they were signed by a supervisor. In one file, there was a Needs Assessment utilized from a prior stay within the previous six months. The counselor; however, did provide updates for any information that had changed since the initial assessment. Only one file demonstrated an elevated risk of suicide as a result of the Needs Assessment. In this case, it was reviewed by a licensed clinical staff.

There were four non-residential files reviewed. All files reviewed contained documentation of completion of the Needs Assessments within two to three face-to-face visits. All Needs Assessments reviewed were completed by a Masters level counselor and signed by a supervisor.

There were no exceptions to this indicator.

2.03 Case/Service Plan

Satisfactory

Limited

Failed

Rating Narrative

The agency has written policy and procedures that addresses the key elements of the QI Indicator for Service Plan Development and Service Monitoring. The policy was last approved on 2/14/17 by the COO and VP of Prevention Services. All client case records shall contain a service plan. The service plan is a statement of goals, proposed actions and objectives developed in partnership with the youth and family. Service plans will be individualized and will include specific strategies for interventions, services and resources with a timeline for service delivery. An extension of the Service Plan is the Aftercare Plan and will be developed similarly to the development of the Service Plan.

Service plans will not focus solely on the youth. If the CINS/FINS program is unable to provide needed services, a written referral will be made by the counselor. For mental health or substance abuse referrals, the counselor will refer to either licensed or certified substance abuse mental health provider or to the local community mental health center. The service plan and the After-Care plan will be developed with the youth and, if possible, the parent/guardian at the time of the Needs Assessment and no later than seven working days following completion of the Needs Assessment. If service plan cannot be signed by the youth or the parent the counselor will document the reason for unavailability and will make efforts to review and obtain a signature as soon as possible.

Service plan will be reviewed every thirty days at a minimum for the first three months by counselor/parent or guardian and every three months thereafter. At the end of 90 days or at any time there are significant changes in the youth's progress and goals, a new Service Plan must be developed with the youth and

family. The Service Plan and aftercare plan are reviewed and signed by the program director.

There were five residential files reviewed (three open and two closed). All five service plans were developed within seven days of the Psychosocial Assessment. All files had individualized needs and goals, service type, frequency and location, persons responsible, target dates for completion, actual completion dates (where applicable), signature of youth, signature of counselor, signature of supervisor, and date plan was initiated. No files had a thirty day review since it was not applicable. Two of the five files had parent signatures. The remaining three files did not yet have the parent signatures due to the agency's practice for collecting the signature. Typically, parents are called by the agency intern who works three days per week to discuss the treatment plan. Additionally, parents can sign the treatment plan at the time of the discharge. All files that were missing a signature were files that had been opened within twenty-one days of the scheduled review and were still open.

There were four non-residential files reviewed. All files had individualized needs and goals, service type, frequency and location, persons responsible, target dates for completion, signature of youth, signature of counselor, signature of supervisor, and date plan was initiated.

There were no exceptions to this indicator.

2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

Rating Narrative

The agency has written policy and procedure that addresses the key elements of the QI Indicator for Case Management and Service Delivery as well as Family Involvement. The Case Management and Service Delivery policy was last approved on 2/14/17 by the COO and VP of Prevention Services. All clients shall be assigned a counselor to assist in the provision of needed or assigned services. Youth and Family Alternatives, Inc believes families should be engaged in assessment, planning, implementation, monitoring and follow-up care. Both residential and non-residential counselors and staff will encourage family input and involvement in decision making for the youth and family.

Each youth is assigned a counselor who will ensure the delivery of services through provision or referral. Case management process includes: establishing referral needs and coordinating referrals, coordinating service plan implementation, monitoring youths/family's progress, providing support for families, monitoring out of home placement, referrals to the case staffing committee, recommending and pursuing judicial intervention, accompanying youth and parent/guardian to court hearings, referral to additional services, continued case monitoring, and case termination with follow-up.

Substance abuse referrals must be made within five working days of the identification of need. CINS/FINS counselor will utilize diligent efforts to engage the family in the solution of the youth's issues which lead to referral for Res/ Non-Res services. Engagement will be strength based.

There were five residential files reviewed (three open and two closed). All files had a counselor assigned, service plans were implemented, all families progress was monitored, and support for families was provided. No files had out-of-home placement or referrals to case staffing. Also, no families were accompanied for court hearings or had referrals made. It is common practice for families to get referred to BayCare for additional services once the youth discharges from the program. Baycare is a local service provider of case management and mental health services. Baycare does not accept referrals so parent/guardians are provided contact information for Baycare for follow-up upon discharge or before services are discontinued with the CINS provider. Families are typically not referred to YFA non-residential services because of the need for more intense mental health services.

Both closed files had thirty day follow ups. However, the sixty day follow-ups were not able to be completed due to no response from parent/guardian. Both files had multiple attempts to complete the sixty day follow-up.

There were four non-residential files reviewed. Counselors are making referrals when necessary, providing support for families, and monitoring progress with services. These four files were open files therefore thirty day follow-ups were not applicable.

There were no exceptions to this indicator.

2.05 Counseling Services

Satisfactory

Limited

Failed

Rating Narrative

The agency has written policy and procedures that addresses the key elements of the QI Indicator for CINS/FINS Counseling Services and Family Involvement. The policy was last approved on 2/14/17 by the COO and VP of Prevention Services. An array of services shall be provided to youth and their families. Services are based on the needs of the family, for preserving the unity and integrity of each family, and to prevent the youth from entering the juvenile justice system.

Youth and families receive counseling services, in accordance with the youth's case/service plan to address needs identified during the assessment process. YFA counseling services reflect all case files for coordination between presenting problem(s), needs assessment, case/service plan, case/service plan reviews, case management and follow-up; maintain individual case files on all youth and adhere to all laws requiring confidentiality; maintain chronological case notes on the youth's progress and maintain an ongoing internal process that ensures clinical review of case records; youth management and staff performance regarding CINS/FINS services.

There were five residential files reviewed (three open and two closed). All youth received counseling services in accordance with the Case/Service Plan. Each youth received individual and family counseling (in instances where there was an absence of family counseling there was clear documentation that the parent was unable or unwilling to participate). There was also clear evidence of consistent communication with the youth regarding what they would like to discuss in a family session. Group counseling was documented at least five days per week (there was noted evidence of a wide range of group topics). Presenting problems were addressed in the Case Plan and Psychosocial Assessment. Case notes were maintained for all counseling services provided (counselor had clear documentation for what occurred in each session and what ongoing challenges may be present with both youth and family).

It is the practice of the agency to review files every thirty days for progress. None of the files reviewed were at the shelter for longer than thirty days. However, case notes and assignments from individual and family sessions noted progress of the youth and family towards goals.

There were four non-residential files reviewed. All files reviewed demonstrated that individual/family counseling is being provided and that presenting problems are addressed in the Psychosocial Assessment, case plan, and notes.

There is a chart supervision that documents clinical review of case records and staff performance. There is an internal process in the form of quarterly reviews of files and peer reviews during staff meetings during months outside of quarterly review.

There were no exceptions to this indicator.

2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

Rating Narrative

The agency has written policy and procedures that addresses the key elements of the QI Indicator for

Adjudication/Petition Process. The policy was last approved on 2/15/17 by the COO and VP of Prevention Services. In the event the CINS/FINS agency is unable to assist in resolving the problem, a case staffing committee reviews the case and attempts to obtain a solution.

It is the responsibility of the agency to request a case staffing committee. The case staffing committee may be reconvened for individual cases or maintained as a standing committee. Should a parent of an active CINS/FINS youth request a case staffing in writing, the committee shall convene within seven working days (excluding weekend and holidays). A case staffing committee should be convened to review a case of family or child who is in need of services or treatment if:

1. The family or youth is not in agreement with the services or treatment offered,
2. The family or youth will not participate in the services or treatment offered,
3. The agency counselor needs additional assistance in developing a case plan,
4. The family or youth have not demonstrated substantial progress in achieving goals specified in the service plan,
5. The services or treatment selected have not addressed the problems and needs of the Family or youth or
6. The parent/guardian requests, in writing, that a case staffing committee meeting be convened.

Case staffing committee must meet at locations which are central and convenient to the families and participants. If the family attends the case staffing they will receive a copy of the plan.

There were three files used to review this indicator (two open and one closed). In all files, the case staffing was initiated by the agency and notification to parent and committee occurred no less than five working days of the staffing. In each case staffing, there were representatives from the local school district, DJJ and CINS/FINS provider, State Attorney's office, mental health care provider, substance abuse provider, law enforcement, and DCF. All parents were provided a new plan for service and written report outlining recommendations and reasons behind recommendations as a result of the case staffing. The case staffing committee meets twice per month in Hernando County and monthly in Sumter and Citrus County.

There were no exceptions to this indicator.

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

The agency has written policy and procedures that addresses the key elements of the QI Indicator for Youth Records. The policy was last approved on 2/15/17 by the COO and VP of Prevention Services. The program maintains confidential records for each youth that contains pertinent information involving the youth and his/her treatment at the program.

All records are marked "confidential" and kept in a secure room or locked in a file cabinet that is marked confidential, which is accessible to program staff. All records that are transported are locked in an opaque container that is marked confidential. Youth records are maintained in a neat and orderly manner so that staff can quickly and easily access information.

There were fifteen youth files reviewed and all files were marked "confidential". Files are kept in a locked file room within locked cabinets marked "confidential". Agency has a solid black, locking bag that maintains one single file for transport. Agency has a solid black locking file cabinet that can be used to transport multiple files. The keys for both bag and file cabinet are stored in the Pyxis machine.

There were no exceptions to this indicator.

Standard 3: Shelter Care

Overview

Rating Narrative

The New Beginnings Youth Shelter is located in Brooksville, Florida. It is one of three (3) shelters that Youth and Family Alternatives operates in the state. The other two (2) residential youth shelters are located in New Port Richey and Bartow. The New Beginnings shelter is a well-designed facility that is clean, nicely furnished, attractively landscaped and well maintained. There were no signs of graffiti, property damage or any hazardous or dangerous conditions during this site review. A comprehensive tour of the facility was conducted to determine the environmental conditions of the facility and the living conditions for the youth. This residential shelter operates twenty-four hours a day, 365 days a year and is licensed to serve up to twenty-four residents for runaway and emergency shelter services. The youth shelter is contracted to serve both CINS/FINS youth and children placed by the Department of Children and Families (DCF). The youth shelter utilizes effective documentation practices in the agency's program logbook. At the time of this on-site Quality Improvement (QI) review, the shelter had eight CINS/FINS youth. The shelter has had no staff secure or probation respite youth since the last on-site review; however, has served domestic violence youth.

3.01 Shelter Environment

Satisfactory

Limited

Failed

Rating Narrative

The program maintains policy and procedure number SH3.01 to address shelter environment. The policy was made effective on 9/13/13 and was last reviewed on 2/15/17. The program maintains policy and procedure number SH430 to address daily programming. The policy was made effective on 9/13/13. The program maintains policy and procedure number SH480 to address youth outings. The policy was made effective on 9/13/13.

The program will conduct weekly safety inspections of all internal and external areas and equipment. There are procedures for pest control, garbage removal, and lawn maintenance. The weekly inspections will be documented in the Weekly Inspection log. Corrective actions will be communicated to the Program Director and maintenance issues will trigger a maintenance request form. Records of all maintenance requests and their completions will be maintained by FMX. The Program Director, Residential Supervisor or Team Lead will conduct random checks to ensure all buildings are in presentable condition at all times. The shift leader or designee will conduct a formal daily inspection of each of the wings at the shelter three times a day.

Daily chores in the living and sleeping quarters are to be done by assigned youth. Office areas are cleaned weekly by the occupants. Daily chores in the living and sleeping quarters are to be done by assigned youth. Office areas are cleaned weekly by the occupants. Youth laundry is washed nightly by youth development staff working the third shift. Youth are issued clean bed linen once a week on Sundays and provided clean towels daily. The grounds and lawn maintenance is maintained by the maintenance department on a regular schedule.

The shelter uses a master schedule for daily programming. There are three different schedules to address weekdays, weekends, and summers. The schedules are posted in areas accessible to youth and maintained to ensure the youth have structured activities throughout the day. The structured daily programming assists the youth in developing healthy social, emotional, intellectual, and physical development. Faith-based activities are made available to all shelter youth. The monthly activity schedule includes all projected off-campus activities and field trips as well as special events at the shelter. Youth are able to attend religious services on the weekend at a non-denominational church.

The annual health inspection was conducted on 1/25/2017. No violations were notated. The shelter has a fire prevention program and evacuation egress plan approved by the Brooksville Fire Department on

9/29/2015. The Hernando Fire and Safety Equipment Company inspected the system in the kitchen on 2/1/2017. The same company inspected all the fire extinguishers in March 2017. A Total Solution, Inc. Security and Fire Protection company inspected the shelter's sprinkler system on 2/2/2017. The annual fire inspections was completed on 3/2/2017 by A1 Alarm Systems. The Brooksville Fire Department conducted the annual County fire inspection on 7/7/2016. Monthly fire drills and mock emergency drills were conducted throughout the review period.

The furnishings throughout the shelter were in good repair. The shelter was clean and the well maintained. There was no graffiti observed and the shelter was decorated to make the youth feel comfortable. The youth bathrooms were clean and functional. The youth bedrooms were decorated and each bed was made with a pillow and bedspread. Youth personal belongings needing to be locked up would be stored in the medical room. The program contracts with Orkin Pest Control to ensure the shelter is free of insect infestation. Monthly facility inspections are completed by the office specialist. The facility inspections include all areas inside the shelter and the exterior of the shelter. The facility inspections are completed electronically along with any maintenance requests generated as a result of the inspection.

The shelter has a weekday and weekend schedule to assist youth in engagement in meaningful, structured activities. The two schedules include times for the youth to eat, complete hygiene, attend school, participate in leisure activities indoors and outdoors, physical activity, complete homework or read, and participate in groups. Weekend outings include going to the local park, YMCA, and library. Youth have participated in other outings such as bowling, skating, and attending events in downtown Brooksville. The activity schedule is posted in the day room area.

There were no exceptions to this indicator.

3.02 Program Orientation

Satisfactory

Limited

Failed

Rating Narrative

The program maintained policy and procedure number SH3.02 to address program orientation. The policy was made effective on 9/13/13 and was last reviewed on 2/28/17.

At the shelter, orientation to the program is to begin at the time of admission and completed within twenty-four (24) hours. If a youth enters the shelter during the third shift, a brief orientation can be provided at time of admission. This is at the discretion of youth development staff. The more comprehensive orientation is postponed until the following morning. The youth and youth development staff participating in the orientation process are to sign and date the Client Orientation Checklist. Staff have access to the Language Line if a youth does not speak English. Youth are provided a youth handbook and sign confirmation of receipt. A youth peer is assigned as the new youth's "buddy" to provide further orientation to the shelter. Youth rights and the grievance process are reviewed as part of the youth's orientation to the shelter.

All five (5) open youth files contained orientation checklists completed the day of the youth's admission to the program. The orientation document addresses: contraband items, disciplinary actions that can be taken if program rules are broken, dress code, access to medical and mental health services, procedures for mail, telephone and visitation, the grievance procedure, disaster preparedness instructions, along with a tour of the facility. All five (5) orientation checklists were signed by the youth and program staff. Two (2) files contained a signature sheet to support the youth's parent was provided a copy of the shelter handbook. This document was not required therefore, not in the other three (3) youth files. Recently the program implemented the use of signature pages for the youth and parent to acknowledge the receipt of the shelter information. The shelter handbook is comprehensive and addresses the rules and policies of the program including services the youth and family will be provided by the program. Staff receive training on the shelter intake and orientation process during their 72-hour orientation training.

There were no exceptions to this indicator.

3.03 Youth Room Assignment

Satisfactory

Limited

Failed

Rating Narrative

The program maintained policy and procedure number SH3.03 to address youth room assignment. The policy was made effective on 9/13/13 and was last reviewed on 2/28/17.

The youth development staff on duty is to complete the intake packet and Admission Sleeping Assignment document. The shelter on-call staff person and program director are to be notified of any behavioral history that jeopardizes the safety of others at the program. The Admission Sleeping Assignment document is reviewed with the shift leader or designee when assigning a youth to a room. If a special need is identified during intake, an alert code is assigned to the youth. The alert code is documented in the youth's file and the census board. Every effort is made to ensure youth are protected from the threat of harm and violence. Staff are to separate and/or segregate potentially dangerous youth from those who are not viewed as dangerous. The bed roster indicates the room and bed location for each youth.

All five (5) youth files contained a completed room assignment document. Staff gave consideration to potential safety and security concerns when making room assignments. The youth room assignment document was completed by staff after the youth needs assessment was completed in order to review available information about the youth's history, status, and exposure to trauma. Staff made room assignments addressing separation of younger youth from older youth and violent youth from non-violent youth. All five (5) youth required an alert be entered into the program's alert system. A comparison of the alert board with the alerts in the five (5) files indicated all the information matched.

There were no exceptions to this indicator.

3.04 Log Books

Satisfactory

Limited

Failed

Rating Narrative

The program maintained policy and procedure number SH3.04 to address log books. The policy was made effective on 9/13/13 and was last reviewed on 2/28/17. The policy is to maintain log books in the shelter to document daily activities, events, and incidents in the program.

At the beginning of each shift, the oncoming youth development staff and the oncoming supervisor shall review the logbook for the previous two shifts to become aware of unusual occurrences or problems. The program director or designee shall review the logbook weekly and note any corrections, recommendations, or follow-up required. All entries in the logbook should be dated and signed by the person making the entry.

A review of the logbooks for the past six (6) months supported staff document information pertaining to safety and security issues consistently. Information documented in the logbooks included activities the youth engaged in, transports, and youth temporary releases and return to the shelter. All entries were legibly written in ink without erasures and white-out. Staff initialed and dated all entries. Each shift concluded with a summary which included pertinent safety and security information along with resident counts. The supervisor conducted weekly reviews which included corrections or recommendations the

staff should follow.

There were no exceptions to this indicator.

3.05 Behavior Management Strategies

Satisfactory

Limited

Failed

Rating Narrative

The program maintained policy and procedures number RM 780 to address behavior management. The policy was made effective on 4/26/00. It was revised on 11/01/11 and was last reviewed on 4/18/17.

The youth and parent/guardian shall be informed of the behavior management program at intake, including the use of physical restraint in an emergency situation. The youth and parent/guardian must sign an acknowledgement form indicating they are aware of the behavior management program. All direct-care staff receive training in the use of Managing Aggressive Behavior (MAB) curriculum.

The program has a behavior management program based on levels and time frames. The program has three levels and each have their own requirements, goals, and privileges. The program is based on the six pillars of care: responsibility, respect, caring, citizenship, fairness, and trustworthiness. The program uses a variety of incentives to encourage participation in the program. The youth have the opportunity to earn New Beginning Bucks for going above and beyond program expectations. The bucks can be spent in the program store. Items in the program store include: candy, soda, jewelry, clothing and shoes, bags, and games. If youth choose to not follow program rules, they can lose privileges such as participating in special outings, going to the reward store and completing reflection time with a counselor. Reflection time is a minimum time away from the rest of the group. There was no indication group punishment was used. A review of staff training files supported staff are trained on the behavior management program. A review of the Managing Aggressive Behavior curriculum is also discussed during staff meetings.

All five (5) youth files contained the behavior management program acknowledgement form signed by the youth's parent/guardian during the intake process.

There were no exceptions to this indicator.

3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

Rating Narrative

The program maintains policy and procedures number SH3.01 to address shelter environment. The policy was made effective on 9/13/13 and was last reviewed on 2/15/17.

The program strives to maintain one male and one female member on duty at all times. The staff to client ratio 1:6 is maintained and the program provides 24-hour awake supervision of the youth. The actual staffing patterns are documented in the logbook. The residential supervisor prepares the projected youth care staff schedule for each shift. In the event of a youth care staff shortage, it is expected other staff remain on duty until relieved by another youth care worker.

Youth care staff are to always have direct visual contact with all youth during awake hours. Staff shall observe youth every fifteen minutes while they are in the bedroom. This documentation will be made in the logbook. Youth care staff are to avoid being alone with any youth for an extended period of time.

The logbook documentation supports staff to youth ratio was met throughout the review period. Overnight shift consistently had at least two (2) staff present at the shelter. Logbook documentation and staff

schedules supported at least one male and one female or two female staff were providing supervision to the youth at all times. Fifteen (15) minute checks were consistently documented in the logbook while youth were in their bedrooms. The shelter has sixteen working cameras located throughout the facility with thirty-day recording capability.

There were no exceptions to this indicator.

3.07 Special Populations

Satisfactory

Limited

Failed

Rating Narrative

There is a written policy that states shelters shall provide services to special populations which is defined as Domestic Violence Respite (DV), Domestic Minor Sex Trafficking (DMST), Probation Respite, and Staff Secure for youth ages 10-17 who have been charged with an offense of domestic violence (including youth who have been previously adjudicated for other issues) specifically designed to provide a safe alternative to secure detention for youth with pending or adjudicated charges for domestic violence. These services will be provided primarily to youth who reside in Citrus, Hernando, Sumter, Hardee, Highlands and Polk Counties Youth from counties other than those listed may be served with the prior approval of the Network.

Procedures for each special population includes a general description of services, youth eligibility, youth referral/determination, limits on youth to be served, and services to be provided. Each section details criteria and processes.

Agency has no cases of Staff Secure, Probation Respite, or DMST in the past six months. Three files were reviewed for DV Respite (all closed). All DV respite files were admitted to the placement and had a pending DV charge and have evidence of being screened by JAC detention but did not meet criteria for secure detention. No youth stays exceeded twenty-one days. No youth transitioned to CINS/FINS or Probation Respite. Only one of the three files reviewed has a case plan and goals were related to focusing on managing behaviors, family coping skills or other interventions designed to reduce the occurrence of incidences that resulted in the placement. The remaining two files were for youth that discontinued services before a service plan could be completed.

There were no exceptions to this indicator.

3.08 Video Surveillance System

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedures that addresses the key elements of the QI Indicator. The policy was last revised on 4/7/2017 and signed by the President/CEO and Board Chair. Agency policy will utilize video surveillance technology in all common areas to meet guidelines and not violate a reasonable expectation of privacy.

The agency's policy for video surveillance is to record all general work areas. Access is limited to supervisory staff, those with a need to know, or law enforcement. Supervisor reviews recordings at least every fourteen days. All surveillance is kept for a minimum of thirty days and has date, time, and location stamp on footage.

Agency has posted notice of recording on the front door of the facility. They have sixteen (16) cameras

interior and exterior general locations of the shelter, all are visible. There are no cameras located in bedrooms or bathrooms. System can capture and retain video photographic images including facial recognition. Recordings include date, time, and location on them and can be stored for a minimum of thirty days. System is backed up by generator in case of a power outage. A list is provided of which staff is allowed access to the system. Supervisor reviews the footage at least every fourteen days or when there is an incident, and enters into a log book. Agency has a process where a third party requesting to view a copy of footage must go through the Program Director. The video surveillance system is located in the Regional Director's office.

There were no exceptions for this indicator.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

Youth and Family Alternatives (YFA) has screening systems and processes to detect general health and mental health risks presented by prospective residents. This process requires that each resident that meets CINS/FINS eligibility requirements be screened by staff members for the severity of potential health and mental health issues. Designated trained YFA residential and non-residential staff members utilize agency screening forms that include the general screening form, CINS Intake form, Psycho-Social Assessment and the Evaluation of Imminent Danger for Suicide (EIDS). The CINS intake form includes a health screening section that is required to be completed by staff members.

The agency also utilizes a Suicide Risk Assessment instrument that is conducted on youth that can indicate a positive “hit” on the CINS Intake form. The agency does not have a licensed staff member that works primarily at the New Beginnings youth shelter location. The shelter has access to the Vice President of Prevention Services, who is a Licensed Mental Health Counselor (LMHC), who reviews all suicide risk assessments and consults and reviews with staff regarding youth placed on elevated or sight and sound supervision status. All YDS staff members at the youth shelter are trained on the suicide risk screening process and utilize the CINS Intake form to screen for potential risks prior to placing all youth on sight and sound supervision status.

The agency utilizes an effective color-coded general alert system that informs direct care staff of the youth’s health, behavior or mental health status. The agency also documents any youth that has received on-site or off-site first aid or medical care. Staff members are trained on safety and first aid training topics as confirmed by documentation in training files.

4.01 Healthcare Admission Screening

Satisfactory

 Limited

 Failed

Rating Narrative

The agency has a policy for Health Care Admission Screening last reviewed and updated on February 28, 2017.

At the time of intake/admission, Youth Care Staff are to utilize the CINS/FINS Intake Assessment form and the Health Screening Form to screen for medical, mental health, and substance abuse concerns. Staff also evaluate the youth’s acute needs to determine whether the youth is suffering from a condition or contagious disease/illness that may create a risk to shelter youth/staff.

Whenever possible, the parent/guardian or caseworker is to be actively involved in the coordination and scheduling of follow-up medical appointments or care. However, if the youth’s guardian or caseworker is unable or unwilling to provide for the youth’s medical appointments, the shelter program will ensure the youth’s needs are met. Follow-up appointments and/or emergency care are to be documented in the youth’s case record and the communication log book.

There were five youth files reviewed for Healthcare Admission Screening. In all five files the CINS/FINS Intake Assessment Form, the Health Screening Form, and the Tuberculosis Symptom Assessment Questionnaire were completed at admission. In two of the files reviewed, the youth were taking medication and the medication as well as the reasons for taking it were documented. Two of the youth had allergies documented. None of the youth had any type of chronic health condition that required monitoring or follow-up care but there are procedures in place if it is needed. All five of the Health Screening Forms were reviewed and signed by the RN within 72 hours.

There were no exceptions to this indicator.

4.02 Suicide Prevention

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy for Suicide Prevention in place that was last reviewed and updated on March 31, 2017.

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

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

There were five open youth files reviewed and all five files documented the CINS/FINS Intake Assessment form was completed during the initial intake and screening process. All CINS/FINS Intake Assessment forms were signed by a supervisor. Three of the five files documented "hits" on the form requiring the youth to be placed on suicide precautions. The remaining two files did not document "hits" on the form but did document a previous baker act so these two youth were placed on suicide precautions to be further assessed. All five files also documented the EIDS was completed during the intake process and the youth were placed on constant sight and sound supervision until assessed by a qualified professional.

All five files documented an assessment of suicide risk was completed by a qualified professional within twenty-four hours or first thing Monday morning for the two youth admitted over a weekend. All assessments were completed by a bachelor or master's level counselor and a telephone conversation was documented with a Licensed Mental Health Counselor (LMHC) on each assessment and signed the next time the LMHC was on-site. There was also a note in the progress notes documenting the telephone conversation with the LMHC. In all five files the youth were removed from suicide precautions and placed on standard supervision. All five files documented five minute observations of the youth were maintained the entire time the youth was on precautions. All changes in supervision levels were documented in the shelter log book.

There were no exceptions to this indicator.

4.03 Medications

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy for Medication Control and Management last reviewed and updated on March 29, 2017. Agency ensures safe, uniform medication control and management.

Intake: Youth and parents are interviewed about youth's current medications by RN if available. If not an

authorized staff will be able to conduct the interview. Medication must be accepted with a current, patient specific label intact on the original medication container only and the medication label must identify the medication, child for whom it is prescribed, dosage and frequency requirements, prescribing physician, and expiration date. Med must be stored in Pyxis after information is confirmed to be correct. Allergy and medication alerts are placed on youth files in addition to on the medication board in the med room.

Verification: Verification of medication will be conducted by RN when on premises. In the absence of an RN a staff or counselor can verify medications.

Storage: All medications should be stored in the Pyxis that is located in the medication room.

Assisting in the Self Administration of Medication: RN will be responsible for assisting in self administration when on premises. When RN is not on site authorized staff will assist in self administration of medication. Time, dose, frequency, medication and youth must be verified before assisting with medication distribution.

Over the Counter Medication (OTC): agency does not have OTC medication on site other than an OTC med that is prescribed for a youth by a physician.

Inventory: Syringes and sharps are to be counted on a weekly basis. A perpetual inventory with running balances is maintained on all medications in the youth's individual Medication Log Sheet. Shift to shift inventories will occur with controlled medications only.

Disposal: In the event of an unauthorized discharge the parent/guardian shall be contacted and arrangements be made to pick up medication which has been left at the shelter. If medications are not picked up within 14 days, nurse will be contacted to determine best method of disposal of medication and recommendation will be followed. If RN is not available, disposal will follow the Food and Drug Administration and the Office of National Drug Control Policy guidelines for disposal.

Training: All staff that received the "Administering Medication" training will be allowed to assist in the self-administration of medication.

All medications are stored in the Pyxis 4000 located in the medication room. Agency has a minimum of two super users (RN and Program Director). Oral and inject-able medications are stored separately from other medications by use of separate cubies per medication. Shift to shift counts are conducted daily for controlled substances. Monthly, the agency has meetings to review Knowledge Portal reports. Agency Nurse, Program Director, and President of Prevention are all present at monthly meetings.

Agency typically uses the RN to verify medications. In the event the RN is not on site staff contacts the pharmacy to verify medications. Nurse assists with safe administration of medications when on site. When RN is not at the program, youth development staff assist in the safe administration of medication. It is also agency practice for medication discrepancies to be cleared each shift by staff that created the discrepancy. Agency also has a fridge designated for medications only located in the medication room and is set at the recommended temperature.

There were no exceptions to this indicator.

4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place for Medical and Mental Health Alert System last reviewed and updated on March 20, 2017.

Medical, mental health conditions, and allergies are documented on the CINS/FINS Intake Assessment. A "Medical Alert" sticker on the outside of the youth's file indicates the youth has a medical or mental health condition. If the youth has any allergies they will be documented on the "Allergies" sticker on the front of

the youth's file. Any special dietary needs and/or food allergies are documented on the CINS/FINS Intake Assessment and also on the Special Dietary Needs/Allergy Board in the kitchen. There are two alert boards located in the hallway in the administrative area and the other board is located in the dorm area. These alert boards list all alerts the youth have.

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

There were five youth files reviewed to ensure all alerts were appropriately documented. All five files documented all the youth's alerts on the form inside the front cover of the file coincided with the alerts documented on the outside front cover of the file. These alerts also coincided with information documented on screening and assessment forms located inside the file. All applicable alerts were also documented on the two alert boards. All dietary alerts and restrictions were documented on the alert form located in the kitchen and on the front of the youth's file. A "Youth Roster" is documented in the logbook each shift change. This documents all youth in the shelter and any alerts the youth are currently on.

There were no exceptions to this indicator.

4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy on Episodic/Emergency Care that was last reviewed and updated on March 20, 2017.

If a youth is in need of emergency care, 911 is called and the incident is reported. If the youth is transferred to an off-site facility for emergency treatment, the shift leader or designee is to record in the youth's monitoring note the hospital to which the youth is to be taken prior to the youth leaving the property. After discussion with the Program Director or Residential Supervisor, the shift leader or designee on duty is to contact the youth's parent/guardian. Upon a youth's return to the shelter from an emergency medical facility, the shelter will keep in the file a verification of receipt of medical clearance, any discharge instructions, and follow-up care that may be required.

The shelter keeps a Monthly Incident and Accident Review log that lists all emergencies/incidents that occurred which required medical attention or follow-up care, including but not limited to those incidents reported to the CCC. There have been two instances in the last six months of youth being transported off-site for emergency medical. Both incidents were reported to the CCC and also documented on the Incident and Accident Review log. The log documented a brief description of the incident, the episodic care required, and if any follow-up care was needed. The CCC reports documented all notifications to the youth's parent and to program management. The CCC reports also documented a more detailed description of the incident and care received. Both incidents were also documented in the shelter log book.

All staff are trained on First Aid and CPR. The knife for life and wire cutters were located in the shelter. First aid kits/supplies are located in the medication room, kitchen, and both vans. These kits are inventoried weekly by the RN. The RN uses a First Aid Kit Checklist that lists each item in the first aid kits and the location of the kits. During the review of the kits the RN will check off each item and document if it had to be replaced due to expiring or if it was replenished due to being used. These checklists were completed weekly for the last six months. The information from the checklist is then transferred over to the First Aid Kit Inspection Log. This log documents the date, checks off each first aid kit inventoried, and then documents notes.

There were no exceptions to this indicator.