



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of YFA-New Beginnings

on 11/11/2015

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Standard 2: Intervention and Case Management

2.01 Screening and Intake	Satisfactory
2.02 Needs Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management and Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/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 3: Shelter Care

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

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

Standard 4: Mental Health/Health Services

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

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

Overall Rating Summary

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

Rating Definitions

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

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

Review Team

Members

Ashley Davies, Lead Reviewer and Consultant, Forefront LLC

Linda Sessions, Program Manager, Tampa Housing Authority

James Myles, Executive Director, Bethel Community Foundation

Nicole Hartsock, Residential Supervisor, Family Resources



Persons Interviewed

- | | | |
|--|--------------------------|-------------------------|
| <input checked="" type="checkbox"/> Program Director | 2 Case Managers | 0 Maintenance Personnel |
| <input type="checkbox"/> DJJ Monitor | 1 Clinical Staff | 2 Program Supervisors |
| <input type="checkbox"/> DHA or designee | 0 Food Service Personnel | 0 Other |
| <input type="checkbox"/> DMHA or designee | 0 Health Care Staff | |

Documents Reviewed

- | | | |
|---|--|--|
| <input type="checkbox"/> Accreditation Reports | <input checked="" type="checkbox"/> Fire Prevention Plan | <input checked="" type="checkbox"/> Vehicle Inspection Reports |
| <input checked="" type="checkbox"/> Affidavit of Good Moral Character | <input checked="" type="checkbox"/> Grievance Process/Records | <input type="checkbox"/> Visitation Logs |
| <input checked="" type="checkbox"/> CCC Reports | <input type="checkbox"/> Key Control Log | <input checked="" type="checkbox"/> Youth Handbook |
| <input type="checkbox"/> Confinement Reports | <input checked="" type="checkbox"/> Logbooks | 3 Health Records |
| <input checked="" type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 5 MH/SA Records |
| <input type="checkbox"/> Contract Monitoring Reports | <input type="checkbox"/> PAR Reports | 6 Personnel Records |
| <input type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 5 Training Records/CORE |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 4 Youth Records (Closed) |
| <input type="checkbox"/> Escape Notification/Logs | <input type="checkbox"/> Sick Call Logs | 3 Youth Records (Open) |
| <input checked="" type="checkbox"/> Exposure Control Plan | <input type="checkbox"/> Supplemental Contracts | 0 Other |
| <input checked="" type="checkbox"/> Fire Drill Log | <input checked="" type="checkbox"/> Table of Organization | |
| <input checked="" type="checkbox"/> Fire Inspection Report | <input type="checkbox"/> Telephone Logs | |

Surveys

- | | | |
|---------|---------------------|---------|
| 6 Youth | 6 Direct Care Staff | 0 Other |
|---------|---------------------|---------|

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

Comments

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

[Rating Narrative](#)

Strengths and Innovative Approaches

Rating Narrative

The shelter has fully implemented the Pyxis Med-Station 4000 and has hired a Registered Nurse (RN) who is on-site three days a week approximately 20-24 hours. The RN has extensive knowledge of the Pyxis Med-Station and also works with the same machine in a hospital setting. The RN has proven to be a great asset to the shelter in implementing the Pyxis Med-Station, as she is able to fix most errors and discrepancies and also does extensive training with all staff.

The shelter works closely with the local library and staff regularly take youth from the shelter to check out books or work on school work. The library also keeps a bookshelf at the shelter fully stocked with young adult books that the youth can take home with them when they leave the shelter.

In the past three months the shelter has had two self-identified transgender youth. The Program Director reported staff handled it very well and the youth did really well in the shelter and found a foster family in town.

The shelter had their annual fundraiser race the week before the review. The Program Director reported it was very accepted and well known throughout the community. They did not have the final total of money raised yet.

The non-residential program reported there have been no changes since the last review with the exception of one counselor being promoted to a senior counselor. The non-residential program has been receiving lots of referrals.

Standard 1: Management Accountability

Overview

Narrative

Youth and Family Alternatives' organizational structure at the Executive Level includes George Magrill, President and Chief Executive Officer, Ken Conley, Senior Vice President for Administration and Andy Coble, Vice President of Prevention Services. At the time of this on-site program review, the program employed a Residential Director, one Office Specialist, three Youth Development Specialist (YDS) Shift Leaders, one YDS Team Leader, two Residential Counselors, and nine Youth Development Specialists. The non-residential program employs a Program Director, a Program Supervisor, and four counselors. The agency operates a Risk Prevention and Management Team Meeting that evaluates various issues and reviews incidents 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

There were six staff members hired since the last on-site review. All six employee files were reviewed to ensure a background was completed prior to the employee being hired. All six staff members had an eligible background screening completed prior to their hire date. There were no members requiring a 5-year re-screening during this review period.

The Annual Affidavit of Compliance was completed and submitted on January 15, 2015.

1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

Rating Narrative

YFA's policy and practice is consistent with QI 1.02 including written grievance policies that are shared with both non-residential and residential clients/families at intake. A Grievance Notebook is maintained that demonstrates a consistent pattern of timely review of client complaints by staff (other than Direct Care). Resolution of grievances and feedback to clients are timely. Review of grievances indicated complaints primarily, client-to-client, but several complaints involved staff language/communication. Several grievances were without resolutions. The grievance policy is contained in the Shelter Orientation handbook. For non-residential clients, grievance procedures are contained in the YFA Rights & Responsibilities brochure. Grievance box and forms are available to youth in the common area. YFA Abuse Hotline policy contained in the Agency Incident Reporting policy provides expressed freedom for clients to report abuse and mandatory requirement for staff to report.

All six staff surveyed knew the procedures to allow a youth to call the abuse hotline. All staff also reported they have never heard another staff member deny a youth access to the abuse hotline. All six staff also reported they have never heard a co-worker use inappropriate language when speaking with the youth or use threats, humiliation, or intimidation.

All six youth surveyed reported they know about the abuse hotline but have never called. All six youth reported they have not been denied access to call the abuse hotline if wanted. Four of the youth surveyed reported staff are respectful when speaking with the youth and two youth reported they are not. Four youth reported they have not heard staff use inappropriate language when speaking with the youth and two youth reported they have. All five youth responding to the survey question reported they feel safe in the shelter.

1.03 Incident Reporting

Satisfactory

Limited

Failed

Rating Narrative

There is a written policy in place. There were six Central Communication Center (CCC) reports in the last six months. All were reported within the required two-hour time-frame. There was documentation that all six CCC reports were closed and follow-up communication and tasks were completed as required by the CCC.

1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

There were two staff training files reviewed for the first year training requirements. Both staff documented more than the required number of training hours with 141.5 and 146 hours. Both staff documented that all required trainings, as well as, additional trainings were covered.

There were three staff training files reviewed for annual training requirements. One staff had completed a full year of annual training and documented 67.5 hours. Most of the required trainings were covered with the exception of Fire Safety and Crisis Intervention. The remaining two staff still had time remaining in their current training cycle to complete all trainings. One of the staff documented 20 hours so far with five months left to receive the additional hours and trainings. The other staff documented 59.5 hours so far with one month left to receive additional hours and trainings.

1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

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

Quarterly review of incidents, accidents and grievances are reviewed as they come in and data is compiled on a month to month basis. Quality improvement staff and management staff review the data monthly and the quality improvement (QI) council reviews it quarterly.

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

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

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

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

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

The peer reviews have identified areas of concern within the shelter and developed CQI Worksheets to address the issues. The worksheets identify the issue and desired outcome. The issues identified for residential were relating to the youth files and ensuring certain documentation was consistently completed, such as alerts documented, service plans signed, group notes completed, etc. A new team was formed as a result of the peer review findings. This team meets every Wednesday to perform internal chart reviews. Supporting documentation from the file reviews, as well as, meeting minutes were attached to the CQI Worksheet. The issues identified for non-residential were aftercare plans being signed and progress notes relating back to the service/treatment plan goals. Again all files were reviewed and issues were identified. Supporting documentation was attached to the CQI Worksheet and a follow-up review was scheduled.

1.06 Client Transportation

Satisfactory

Limited

Failed

Rating Narrative

YFA's transportation policy remains in draft status, awaiting review and sign-off by agency administrator. However, the draft policy does include all elements required including approved Florida license, insurance, administration sign-off when no third party is available and notification to the Office regarding client passenger drop-offs. Review of vehicle logs and shelter logbook have records of client vehicle transportation.

1.07 Outreach Services

Satisfactory

Limited

Failed

Rating Narrative

YFA's community outreach policy seeks broad-based community engagement to educate, communicate and promote both the missions of YFA and CINS/FINS, as well as involvement as policy advocates with other community family/youth serving agencies. The Agency is represented on the Juvenile Justice Circuit 5 Advisory Board by one of their Non-Residential Counselors and is evidenced by review of Board agendas and minutes. Review of NETMIS outreach printout for YFA agency show New Beginnings Shelter and Non-Residential staff community involvement/contact with the following: Children's Alliance Breakfast; Community Alliance; Oxford Outreach Afterschool Program; Dependency @ the Centers-Lecanto; DJJ Circuit 5 Training event; Mega Sports Camp-Sumter; Sumter County Flag Meeting; Sumter County School Board; Wildwood Middle/High School; Bushnell Elementary School; Sumter Middle/High School; Sumter County Children Alliance; Wildwood Family Resource Center; Refuge of Jumper Creek-Sumter; and Citrus High School.

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 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 component consists of a Non-Residential Master level Program Director and Program Supervisor.

The program has assigned four full-time Counselors, one Counselor in Citrus County, one Counselor in Hernando County, and two Counselors in the Sumter County service region.

2.01 Screening and Intake

Satisfactory Limited Failed

Rating Narrative

A review of the agency's policy and procedures for screening and intake was conducted and was found to be inclusive of all components required by Standard 2.01. A total of three residential client files were reviewed to determine the agency's adherence to this standard (2-open and 1-closed). In addition, six non-residential files were reviewed (two of the six were case staffing files). All nine files reviewed met the requirements for this standard and met the 72-hour eligibility screening requirement upon being referred. Each resident (shelter & non-residential) receives a Client Handbook that informs the recipient of the orientation process, client rights, grievance procedures, 24-hour access to service, admission release criteria, intake and assessment process, services offered, client responsibilities release of information and voluntary placement agreement information.

A recommendation given to the agency to is provide Florida Network CINS/FINS (blue) pamphlets to all families.

2.02 Needs Assessment

Satisfactory Limited Failed

Rating Narrative

A review of the agency's policy was conducted by the peer reviewer. This review indicates that the agency has a satisfactory policy that addresses the major components required for meeting the standards of this indicator. The written policy in place indicates that the Needs Assessment (NA) is initiated within 72 hours of a youth's intake for residential files and within 2-3 visits for non-residential files. The NA is considered initiated when the program Intake & Assessment Form has been completed. A total of four randomly selected non-residential and three residential files were used to assess this indicator. All seven files reviewed met the required time-frame. Additionally, in all but one of the three residential files reviewed, the full NA was completed and signed by counselor and supervisor. The NA is thorough and the summary comprehensive, including input from youth, parent, DJJ and referral source. When applicable the youth are referred for an Assessment of Suicide Risk conducted by or under the direct supervision of a licensed mental health professional. In addition, all files reviewed were neat, organized and well written. It is clearly the practice of the program to coordinate with the families to identify youth needs and plan services accordingly.

One of the four non-residential files reviewed indicated suicide risk, the client was assessed and the file was reviewed and signed off on by a licensed professional in a timely manner. Note: It is beneficial if the supervisor/program director review and sign in a timely manner, as this ensures that the process is being followed correctly by staff.

Florida Network requires that we title the former "Psychosocial Assessment" as a "Needs Assessment".

In one of the four non-residential files, the Needs Assessment signature page does not include credentials of the counselor or supervisor.

Exception:

In one of the residential files the counselor states NA was incomplete due to d/c before 7-days, however, the NA should have been completed in 72 hours, as this client was admitted in August 2015.

2.03 Case/Service Plan

Satisfactory
 Limited
 Failed

Rating Narrative

A review of the agency's policy and procedures for case plans and reviews was conducted and was found to be inclusive of all components required by Standard 2.03. A total of four non-residential and three residential files were reviewed to determine the agency's adherence to this standard. The case plans in all seven of the files met all indicator requirements for this standard. The needs and goals were identified in accordance with the psycho-social assessment and screening tools, date of plan, type, frequency and location of service, person responsible, target dates, actual completion dates and required signatures were documented. Goals for both residential and non-residential are comprehensive and they address issues revealed in the screening and assessment phases.

Exception: One of the three residential files reviewed did not have a supervisor signature. Three of the four non-residential files were missing the location for services.

2.04 Case Management and Service Delivery

Satisfactory
 Limited
 Failed

Rating Narrative

A review of the agency's policy and procedures for case plans and reviews was assessed and was found to be inclusive of all components required by Standard 2.04. A total of seven files (residential & non-residential) were reviewed for the completion of case management and service delivery requirements. Of these files, all contained documentation to satisfy the performance standards. Each file possessed evidence of the referral being issued based on need. All case files contain documentation that supports service plan implementation; progress reports and updates; general support to families; documented referrals to case staffing committee when applicable; evidence of recommending appropriate additional services; case monitoring reviews and termination with the required 180-day follow up, where applicable.

A recommendation given to the agency is to utilize case management tabs to include paper referral forms, fax cover sheets or some documentation showing the exchange between agencies.

2.05 Counseling Services

Satisfactory
 Limited
 Failed

Rating Narrative

A review of the agency's policy was conducted and indicates that the agency has a satisfactory policy that addresses the major components required for meeting the standards of this indicator. The written policy and procedures indicates that individual, group, and family counseling services are employed by the designated program. Agency documentation of presenting problems included addressing psychosocial Assessment, initial Case/Service Plan, and case/Service Plan reviews. All seven files reviewed held documentation, including chronological entries and progress notes to support the practice. The agency also captures case notes maintained for individual counseling services provided and documents youth's progress. Review of the Group Log showed documentation to support youth attendance in group on a daily basis. In all seven files reviewed, the youth's presenting problems were addressed in the assessment, the plan of service and in the case notes. Additionally, all of the files supported the practice of regular supervision. The reviewer of this indicator found that youth and families receive counseling services in accordance with the Case/Service Plan; the program provides individual/family counseling (shelter care); and group counseling is provided at least five days/week (shelter care).

2.06 Adjudication/Petition Process

Satisfactory
 Limited
 Failed

Rating Narrative

A review of the agency's policy was conducted by a peer reviewer. This review indicates that the agency has a satisfactory policy that addresses the major components required for meeting the standards of this indicator. Two files were reviewed for the Adjudication/Petition Process. Both files met the required time-frames for notification of the Case Staffing Meeting. Both the parent and committee were notified in the specified timeframe, as evident by letters and emails included in the clients file. Additionally, all of the required representatives were present for the meetings, with the exception of a DCF and State Attorney's office representative, however they had been invited. At each of the meetings, a copy of the revised plan of service was provided to the families, surpassing the seven day requirement. The non-residential Clinical Supervisor explained the Case Staffing procedure in accordance with DJJ Standard.

2.07 Youth Records

Satisfactory
 Limited
 Failed

Rating Narrative

A review of the agency's policy was conducted and indicates that the agency has a satisfactory policy that addresses the major components required for meeting the standards of this indicator. A total of seven files were reviewed for this indicator. This reviewer observed the location where files are kept in a locked file cabinet marked confidential in the staff area. All records reviewed were all marked confidential. All were in order according to the file check sheet with the exception of the residential files. The Needs Assessment is listed on the right side of the file but is actually found behind the psychological testing tab.

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 six 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

YFA's shelter environment policy and procedures are comprehensive, including requirements for external and internal inspections, both grounds, building facility and vehicles. Review of YFA's internal control documents show completion of Daily Shift inspections, including beds/bedrooms, clothing, laundry area, food/kitchen, bathrooms/showers, walls/furnishings, classrooms and common areas. Additionally, monthly maintenance inspections are completed of all facility building and equipment, including lighting, cameras, air-conditioning, kitchen appliances, as well as grounds. Annual inspections were reviewed and all were current. It included Disaster Plans; facility fire & equipment inspections; Residential Group Care inspection; food service inspection; and DCF Child Care License. Fire drills and mock fire drills are conducted at minimum monthly. And a review of the Fire Prevention notebook captured a comprehensive fire prevention plan with facility egress plans and the same is posted throughout the facility. YFA's New Beginnings facility is clean and well maintained. There is a daily structure that provides a constructive and healthy engagement for staff and clients.

3.02 Program Orientation

Satisfactory Limited Failed

Rating Narrative

There were five youth files reviewed and all contained the required components for orientation. Documentation demonstrates that youth are signing the orientation checklist that covers such topics as contraband, program rules, and grievances. Staff reviews the program rules and expectations during orientation with the youth. This is also covered in Life Skills group.

The youth and parent handbook was reviewed and it covers all required orientation topics. All files contained documentation that both parent and youth signed and received handbook.

Staff are trained in proper orientation procedures and monitored by the Program Director.

3.03 Youth Room Assignment

Satisfactory Limited Failed

Rating Narrative

There were five youth files reviewed and all contained the necessary documentation. The program has a youth room assignment form that is completed at intake. This form covers all the required classification topics. The room assignments are based on age, history, if there is a safety plan, and temperament of youth at the time of intake.

The program has an alert system in place to notify of any youth with special needs. Each youth file has documentation that explains what the program's alerts stand for.

3.04 Log Books

Satisfactory Limited Failed

Rating Narrative

The program log book was reviewed and contained documentation of resident counts, safety and security issues, and home visits. When errors were made staff properly crossed out the mistake with a single line and initialed.

Upon starting their shift staff are required to document that they have reviewed the two previous shifts; however, this is not being done consistently.

Highlighting of safety and security issues was present in the log; however, it did not appear to be consistent. On some shifts a certain incident would be highlighted and then on another occasion that same type of incident would not be highlighted.

There was no documentation showing that the Program Director or designee are reviewing the log weekly to provide recommendations or positive feedback regarding log book documentation.

3.05 Behavior Management Strategies

Satisfactory

Limited

Failed

Rating Narrative

The programs behavior management system was reviewed. During the intake process documentation is given to the youth that explains the system. Information includes what the levels are, how to move up levels, and what happens when a rule is broken. The program provides positive incentives for the youth. The Collegiate room allows youth to have space/time to themselves to read, play video games, or hangout. Kudos are posted in the common area and when youth get kudos they get to pick out a fun prize. The behavior system contains some exercises that the youth completes on their own requiring them to come up with their own goals and definitions for words such as respect and caring. Information about the behavior system is also posted around the shelter for youth to view.

A review of the training files indicate that staff are trained on behavior management.

The Program Director observes staff interacting with the youth and meets with them quarterly and annually to recognize the positive and discuss any concerns.

3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

Rating Narrative

The Team Leader is in charge of scheduling. Schedules are kept in a binder for staff to easily access. The schedule shows that staff ratios are being met. Due to a low number of male staff some shifts have been covered by two females. The Team Leader and Program Director have continued to work on hiring males and as of today have gained more male staff.

There is a staff phone list and the Team Leader will call staff if coverage is needed and staff will holdover if next shift is late.

The log book was reviewed and documentation shows that staff are completing fifteen minute bed checks as required.

3.07 Special Populations

Satisfactory

Limited

Failed

Rating Narrative

The staff secure program policy was reviewed; however, the program has had no staff secure youth in the last six months.

There is currently no policy in place for Probation Respite and Domestic Minor Sex Trafficking; however, the program has had no youth that fall under either criteria in the last six months.

Three Domestic Violence Respite files were reviewed and documentation showed the youth had pending DV charges and they were screened by JAC/Detention/JPO. None of the youth stays exceeded fourteen days.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

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

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

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

4.01 Healthcare Admission Screening

Satisfactory Limited Failed

Rating Narrative

The agency has a policy for Health Care Admission Screening and Ongoing Monitoring last reviewed and updated on September 13, 2013. Upon admission to the shelter, Youth Development Staff (YDS) use the CINS/FINS Intake Screening Form, the Health Screening Form, and Tuberculosis Symptom Assessment Questionnaire to screen youth for medical, mental health, and substance abuse concerns. Staff will evaluate the youth's acute needs to determine whether the youth is suffering from a condition or contagious disease/illness that may create a risk to shelter youth/staff. Whenever possible, the youth's parent/guardian or caseworker will be actively involved in the condition and scheduling of follow-up medical appointments or care. However, if the youth's guardian or caseworker is unable or unwilling to provide for the youth's medical appointments, the shelter will ensure the youth's needs are met.

There were five open residential files reviewed. Each file had evidence that the staff completed the health screening section of the CINS/FINS Intake Screening form, the Health Screening Form, and the Tuberculosis Symptom Assessment Questionnaire. Out of the five youth, three were on medications. The medications were listed, as well as, the reasons for the medications. Three of the youth also documented different types of allergies. The allergies were documented on the alert form in the front of the file and the youth were appropriately entered into the shelter's medical/mental health alert system. None of the youth documented any chronic conditions requiring follow-up medical care; however, the agency has procedures in place if needed.

4.02 Suicide Prevention

Satisfactory Limited Failed

Rating Narrative

The agency has a policy for Suicide Prevention in place that was last reviewed and updated on September 13, 2013. A suicide screening is completed during the initial intake and screening process using the six questions on the CINS/FINS Intake Form Risk Screening section. If the youth answers "yes" to any of the six questions the staff will then complete the Evaluation of Suicide Risk Among Adolescents (EIDS). A suicide assessment is then completed by a qualified professional within twenty-four hours. Youth awaiting an assessment are placed on constant sight and sound supervision. If at any time during the screening or at any time during the youth's stay at the shelter any staff observes or believes a youth presents as an immediate threat to themselves or others, the youth will be placed on one-to-one supervision and staff will immediately call 911 and/or follow Baker Act procedures.

The shelter uses two different levels of supervision, 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 four youth files reviewed and all four files documented the CINS/FINS Intake Assessment form as completed during the initial intake and screening process. All CINS/FINS Intake Assessment forms were signed by a supervisor. All four 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 four files documented an assessment of suicide risk was completed by a qualified professional within twenty-four hours. All assessments were completed by a master's level counselor and a telephone conversation was documented with a Licensed Mental Health Counselor (LMHC) on each assessment and signed the next time the LMHC was on-site. In two of the four files the youth was removed from suicide precautions and placed on standard supervision. Two files documented the youth were to remain on constant sight and sound supervision and assessed again at a later date. There was documentation two days later (in both files) that the counselor completed another suicide assessment and talked to the LMHC and the youth were removed from suicide precautions. All four files documented five minute observations of the youth were maintained the entire time the youth was on precautions. There was documentation in the log book each time a youth was placed on and removed from suicide precautions. There was also documentation observed in the log book between each shift change of all youth on suicide precautions.

4.03 Medications

Satisfactory Limited Failed

Rating Narrative

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

4000 Medication Cabinet.

The shelter has hired a Registered Nurse (RN) who has been employed at the shelter for approximately three months. The RN came in with extensive knowledge on the Pyxis Med-Station 4000 Medication Cabinet due to working with the system in a hospital. The RN is on-site approximately 20-24 hours a week, split up between three days and works at a hospital one day a week. She has made herself very accessible to the shelter staff, she is on-call 24/7 to help staff through any issues they run into when she is not there. She also comes on-site at any time, if needed, for an emergency situation. Due to her extensive knowledge with the Pyxis machine she is able to fix most problems and discrepancies encountered. She completes trainings with staff on using the Pyxis machine and anytime a discrepancy is found, she re-trains the staff to ensure they fully understand where the error was so that it does not happen again. All staff must complete a thorough training with the RN before they are allowed to access the Pyxis machine on their own. The RN will give the staff a test subject with a medication and the staff must demonstrate the ability to accurately enter all information into the system prior to the RN signing off of the certificate of completion. Everyone working in the shelter has received this training with the RN, with the exception of one staff who was on maternity leave. The RN has a vast amount of resources available to her in case of an emergency situation. She has a family member who installs and calibrates the Pyxis machines in hospitals so she is able to call that person if she comes across a situation she cannot fix herself. The shelter has two Super Users assigned to the Pyxis Med-Station, the RN and a Team Leader.

All youth medication is stored in the Pyxis Med-Station and refills, not currently being used, are stored in the locked medication cabinet. After the youth's information is entered into the Pyxis Med-Station, a bin within the machine is assigned to the youth. The youth's medication is placed in that bin and once it is closed it can only be opened during assigned medication times or for inventory purposes. Staff using the Pyxis Med-Station have to enter a password as well as their finger print to gain access. All topical medications are stored in a separate drawer in the Medication Cabinet. All over-the-counter medication is stored in a separate locked medical cabinet in the same room as the Pyxis Med-Station.

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

All medications in the shelter are counted three times per week by the RN. All medications are also inventoried when given by maintaining a perpetual inventory with running balances when given. Staff are required to count the medication and enter the beginning amount into the Pyxis machine each time they give a medication. The shelter has not had any controlled medications in the last three months requiring a shift-to-shift inventory but the RN and lead staff members reported those medications would be counted each shift when they have them. The RN maintains all inventory sheets in a binder. The inventory sheets are actual print-outs from the Pyxis computer and lists every medication in the Pyxis Med-Station and the count. The RN then inventories each medication and documents the physical count on the inventory sheet next to the applicable medication and ensures the two counts match.

The only over-the-counter (OTC) medication given at the shelter is Tylenol. Only youth in the shelter who are not on any type of prescription medication at all are allowed to have an OTC. Youth on prescription medications cannot receive Tylenol unless it is prescribed by a doctor. The RN reported this is for safety purposes as some types of prescription medications may have adverse effects if mixed with other OTC medications. Sharps are maintained in a box, in a locked cabinet and are inventoried weekly and when used.

There were three youth currently in the shelter on medication. The agency still maintains hard copies of all documents relating to the medication process, as well as, enters all information into the Pyxis Med-Station. The youth's prescription medication log sheets reviewed documented the youth's name, side effects of the medication, dosage, instructions, Doctor, prescription number, and times to be given. Each log sheet documented when a medication was given, staff signature, youth signature, and perpetual inventory with running balance. A cover sheet was located for the youth that included a picture of the youth. The RN verifies all medications herself with the pharmacist. If she has any questions regarding the medications she will actually take the medication to the local pharmacy to have them verified in person. All prescription medication log sheets reviewed for the youth documented that all medication was given at prescribed times.

The RN has set up a flag in the Pyxis Med-Station that staff must acknowledge every time a pill count goes below 14. Staff then have to fill out the Low Medication Alert Form and give to the RN. The form documents the youths name, date, medication, pharmacy, number of refills remaining, number of pills remaining, date the medication will run out, and comments. The RN will contact the parent/guardian to get the medication refilled. The RN will also pick up medications at the local pharmacy for families that live out of county or further from the shelter and cannot bring the medication. The parent/guardian must call the pharmacy to have the medication refilled and then have it transferred to the local pharmacy so the RN can pick it up. This helps to ensure the medications arrive in a timely manner and there are no lapses in the medication administration. The refills are locked in the medication cabinet and documented on the inventory form for inventory purposes. They are not placed into the Pyxis Med-Station until the original bottle in the machine is empty. The RN reported this process is used to reduce staff confusion and help with discrepancies in inventories.

The RN reported that there are no medication errors relating to youth not receiving a medication, a youth receiving the wrong medication, missing medications, or the youth receiving a medication late have happened since the Pyxis Med-Station was installed. It was reported most discrepancies were just staff not paying attention and pressing the wrong button when entering beginning counts for medications when they were given. The RN was able to show print-outs from the Pyxis Med-Station for each discrepancy she fixed. The print-out showed what the problem was and how it was fixed.

The RN has posted detailed, step-by-step instructions next to the Pyxis Med-Station for staff to follow when inputting a medication into the machine and also when giving a medication.

4.04 Medical/Mental Health Alert Process

Satisfactory Limited Failed

Rating Narrative

The agency has a policy in place for the Medical and Mental Health Alert System (last reviewed and updated on September 13, 2013). There are two alert boards located in the shelter for staff to review. One alert board is located in the hallway in the administrative area and the other board is located in the dorm area. 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. All applicable alerts were also documented on the two alert boards. All alerts were also documented next to each youth's name in the logbook at each shift change. All dietary alerts and restrictions were documented on the alert form located in the kitchen and on the front of the youth's file.

4.05 Episodic/Emergency Care

Satisfactory Limited Failed

Rating Narrative

The agency has a policy and procedures on episodic/emergency care. The current policy is documented as having an effective date on September 13, 2013.

All staff have current training in CPR/First Aid and the use of emergency equipment (knife-for-life, wire cutters, first aid kit). The shelter's first aid kits are maintained by ZEE Medical. ZEE Medical is a private company that provides fully stocked first aid kits and also restocks all contents as needed. First aid kits are located throughout the shelter and in the vehicles. The knife-for-life and wire cutters are located in the medication room.

The shelter only had one instance of episodic care, in which a youth had to be taken off-site to the hospital, over the past six months. The incident was documented as required and required parties were notified. Follow-up instructions/care were also documented.

The shelter maintains a binder of mock emergency drills. The shelter has completed two mock drills in the last six months, one was a seizure and the other was a panic attack.