



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

Review of YFA-RAP House

on 01/28/2015

## 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

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 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%

## 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

Mark Shearon, VP of Quality Assurance, Arnette House

Phil Whitby, Non-residential Manager, Orange County



## Quality Improvement Review

YFA-RAP House - 01/28/2015

Lead Reviewer: Ashley Davies

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Nicole Leslie, Program Director, Family Resources - St. Pete

Venus Highsmith, Program Director, AWC

**Persons Interviewed**

- |  |                          |                         |
|--|--------------------------|-------------------------|
| <input checked="" type="checkbox"/> Program Director | 3 Case Managers          | 0 Maintenance Personnel |
| <input checked="" type="checkbox"/> DJJ Monitor      | 2 Clinical Staff         | 1 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                         | 8 Health Records   |
| <input checked="" type="checkbox"/> Continuity of Operation Plan      | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 5 MH/SA Records  |
| <input type="checkbox"/> Contract Monitoring Reports                  | <input type="checkbox"/> PAR Reports                                 | 9 Personnel Records  |
| <input type="checkbox"/> Contract Scope of Services                   | <input checked="" type="checkbox"/> Precautionary Observation Logs   | 7 Training Records/CORE  |
| <input checked="" type="checkbox"/> Egress Plans                      | <input checked="" type="checkbox"/> Program Schedules                | 3 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**

- 4 Youth                      6 Direct Care Staff                      0 Other

**Observations During Review**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Admissions                           | <input checked="" type="checkbox"/> Posting of Abuse Hotline       | <input checked="" type="checkbox"/> Staff Supervision of Youth       |
| <input type="checkbox"/> Confinement                          | <input checked="" type="checkbox"/> Program Activities             | <input checked="" type="checkbox"/> Tool Inventory and Storage       |
| <input checked="" type="checkbox"/> Facility and Grounds      | <input 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"/> Transition/Exit Conferences                 |
| <input type="checkbox"/> Group                                | <input checked="" type="checkbox"/> Security Video Tapes           | <input type="checkbox"/> Treatment Team Meetings                     |
| <input checked="" type="checkbox"/> Meals                     | <input type="checkbox"/> Sick Call                                 | <input type="checkbox"/> Use of Mechanical Restraints                |
| <input 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

During the entrance conference, the reviewers were updated about administrative and operational changes that occurred since the last onsite QI and Contract Monitoring visit. Pasco County has been very supportive of the shelter. A door was recently added in the shelter to separate public and private space so the youth in the shelter have space away from visitors view. There was also a closet room in the shelter that was converted to a "chill out" room that is sensory oriented with plush carpet, lamps, seating, paintings, and a sound machine. An existing office was converted to a family counseling room, it was painted a soothing color, with a rug and comfortable seating. The intake room was also painted a more soothing color.

The community has been very supportive of the shelter and the 7th annual RAP River Run last June was very successful. RAP House was also the beneficiary of "Rock the Park" and is hoping to add a screened porch.

The agency has been training staff on DMST. The Residential Director went to Alabama in December and attended a conference on Human Trafficking and have invited them to do a training here. The agency is starting a training series with community based care and more adoption specific training to deal with the current need in the community.

Trinity College donated two computers and internet services for youth to complete school work.

The non-residential program has hired an additional counselor since the last review. The non-residential director reported that referrals are ahead of contract numbers.

## Standard 1: Management Accountability

### Overview

#### Narrative

Youth and Family Alternatives' organizational structure at the Executive Level includes George Magrill, President and Chief Executive Officer, Ken Conley, Senior Vice President for Administration and Andy Coble, Vice President of Prevention Services.

At the time of this onsite program review, the YFA Residential program employs a Residential Director, an Office Specialist, a Youth Development Specialist (YDS) Shift Leader, one Residential Counselor, and thirteen Youth Development Specialists, both full-time and part-time. The Non-Residential Program employs a Program Director, a Program Supervisor, three counselors, one Office Specialist, an Administrative Specialist, and a Data Entry Specialist. At the time of the onsite Quality Improvement program review, the position vacancies for the residential program included: two vacant YDS Part-time time positions, one vacant full-time YDS position, and one vacant counselor position. There were no non-residential vacancies reported by the agency. The agency operates a Risk Prevention and Management Team Meeting that reviews various issues that reviews incidents on the quarter. This team is comprised of various staff YFA staff members. Youth and Family Alternatives, Inc. is accredited by the Council on Accreditation (COA).

### 1.01 Background Screening

Satisfactory

Limited

Failed

#### Rating Narrative

The background screening process is completed prior to hiring an employee or utilizing the services of a volunteer, mentor, or intern. There were nine employees hired since the last QI review. All nine had background screening results documented prior to hiring. The agency had no volunteers that were working unsupervised with children or working more than twenty hours a week.

Employees and volunteers are re-screened every five years of employment. There was one employee who came due for a five year re-screening. The employee was the only one who came due for a re-screening in the prior twelve months and that screening had been completed within the proper time frame. The agency submitted the Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) on January 15, 2015 and has documentation on file.

### 1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

#### Rating Narrative

The program provides an environment in which both youth and staff feel safe, secure, and not threatened by any form of abuse or harassment. This is evidenced by information obtained in staff and youth surveys as well as observations during review.

The program's grievance binder was reviewed. A total of one grievance was reviewed and completed by staff with the necessary signatures. The evacuation route is posted for staff, youth, and visitors to view. The program has a total of sixteen video cameras for surveillance and all are functional and in good condition. The program provides a client handbook to youth in the program which details the responsibilities and expectations of youth while in the shelter.

There were four youth who completed surveys. Of these four youth, three reported that they know that the abuse hotline is available for them to report abuse at the shelter, one youth reported that they did not know about the availability of the abuse hotline. Two youth knew where the number was posted and could be located while two youth did not know where to find this number. None of the four youth reported any attempts to call the abuse hotline nor did they report anyone interfering with their attempts to make a call. All four youth reported that staff are respectful when talking with the youth and denied hearing staff use profanity or threats when speaking with youth. All four youth also reported feeling safe at the shelter.

There were six staff who completed the survey. Five staff reported very good working conditions and one staff reported the working conditions are good. All six staff were able to describe how the youth are allowed to call the Abuse Hotline or Central Communications Center and report suspected abuse (i.e. call themselves or have staff assist with the call if needed). All six staff denied ever hearing a co-worker use profanity, threats, intimidation or humiliation with the youth.

### 1.03 Incident Reporting

Satisfactory

Limited

Failed

#### Rating Narrative

The program has an internal incident report form that they utilize. This form is clear and documents all details of reported incidents.

A total of 42 incident reports were reviewed. The program had 11 incidents reported to the CCC within the last 6 months. All 11 incidents were reported to the CCC within the required 2 hour time frame of staff becoming aware of the incident. The other 31 reports were non reportable for CCC notification and received immediate assistance by staff. These non-reportable incidents ranged from physical aggression, clients receiving non-emergency first aid/medical treatment and clients running from the program.

There were three incident reports of cases where a youth received a medication outside of the two hour window. The reports stated that the pharmacist was called and reported no concerns and therefore all three youth received their medications. There was not evidence that these late medications were called into the CCC, as required. However, Program Director reports that they do call in late medications and that these incidents were not accepted as reportable by the CCC. Program Director reports that staff will do a better job of documenting calls to the CCC and stating on the incident report that the operator did not accept the incident(s) as reportable.

There were seven incident reports that did not specify what the type of incident was, as there is normally a checkmark or a checked box to indicate this. There were also three reports that indicated a youth was baker acted but the staff narrative did not include whether the youth was placed on sight & sound/one-to-one per program policy requirements. The Program Director reported that all youth are placed on one-to-one once a baker act is initiated and sometimes this information is not added to the incident report. The Program Director added that the staff will be sure to include this in the future, and that a newer form may be developed to assist with this, and other missed areas, at some point.

The program complies with the requirement and procedures outlined in the department policy and administrative codes.

### 1.04 Training Requirements

Satisfactory

Limited

Failed

#### Rating Narrative

The program maintains an individual training file for each staff, which includes an annual employee training hours tracking form and related documentation, such as certificates and occasionally sign-in sheets or agendas for trainings attended. Training is scheduled throughout the year and is provided by multiple sources, including the Florida Network, program staff, and the web-based program utilized by the program (Relias). Relias offers a variety of training for all program staff that helps to ensure staff learn essential and necessary skills required to provide CINS/FINS services and perform specific job functions.

A total of 7 program staff training files were reviewed (4 residential staff and 3 non-residential staff). Of the 7 training files reviewed, 4 staff (2 residential and 2 non-residential) were either in their first year of training or had recently completed their first year. All 4 first year staff had completed the following required trainings: program orientation, CINS/FINS core training, fire safety equipment, CPR/First Aid, and an in-service component.

The 2 residential staff had completed all required trainings for their first year with the exception of one staff who did not complete the PREA training. Program Director was aware of this and reports that all other staff complete this training in their first year.

One non-residential staff had not completed several required trainings but was just hired in September 2014 so she still has 8 months to complete all required trainings. This same staff member has completed some required trainings, such as CPR/First Aid, program orientation, CINS core training, Fire safety, and Prea training. The second non-residential staff had completed all the required trainings for the 2013-2014 training year.

Three staff training binders were reviewed for annual training. Two of these staff are residential program staff, both of which had all required trainings for the year. The non-residential staff member did not have fire safety training for the 2013-2014 training year, but had already taken it for the 2014-2015 training year in the Relias system. Program Director is going to provide proof of suicide prevention training for this staff member, as the staff took the training but did not file the certificate in her training file.

It should be noted that all 7 staff had far exceeded the required first year (80 hours) and annual (40) training hours, as all 4 first year training files reviewed had over 100 hours of training and all 3 annual training files reviewed had over 50 hours.

Overall the training binders were organized and easy to read. All trainings are clearly tracked and all required trainings are offered fairly quickly for all new hires.

### 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.

Incident reports are reviewed as they come in and data is compiled on a month to month basis. QI staff and management staff review the data monthly and the QI Council reviews it quarterly.

Customer satisfaction data is reviewed at least once a year as part of the strategic planning process.

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.

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

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

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

The committee's have identified two areas of concern within the shelter and developed CQI Worksheets to address the issues. The worksheets identify the issue and desired outcome. There were several issues identified during an audit of the residential charts. A CQI worksheet was put into place to correct issues found in the charts. Corrective action plans have been put into place and a follow-up will be scheduled to ensure recommendations are implemented. Supporting documentation from the file reviews was attached to the CQI Worksheet. The second CQI worksheet reviewed identified several issues found during the chart audit of the non-residential charts. Again all files were reviewed and issues were identified. Supporting documentation was attached to the CQI Worksheet and a follow-up review was scheduled.

## Standard 2: Intervention and Case Management

### Overview

#### Rating Narrative

The agency is contracted to provide residential and nonresidential CINS/FINS services to youth and families residing in mainly in Pasco and surrounding counties. The program consists of a Non-Residential Program Director, a Non-Residential Program Supervisor, and four Counselors. The program provides non-residential services that are provided at the agency's office, local schools, and other community based organizations. The non-residential staff has also been trained on Trauma Informed Care based Pillars of Character that focus on youth Development and Outcomes. The agency has also worked to provide non-residential staff members with various topics for staff to use to conduct various groups with youth. The agency has a number of innovative practices that are evident in the program. All psychosocial assessments contain a concise summary write-up that follows the psychosocial assessment form. The summary is easily read and very helpful. Evidence of a focus on youth development was seen throughout the facility and is clear in the case file documentation as well.

### 2.01 Screening and Intake

Satisfactory

Limited

Failed

#### Rating Narrative

YFA RAP House Residential program has written policies for this indicator. There were three residential client records reviewed for compliance (two open and one closed). Centralized Intake services are available 24 hours a day 7 days a week for the program. The initial screening for eligibility occurs within seven calendar days of the referral by a trained staff member. Two out of three residential client records were screened within seven days of the referral.

The youth and parent/guardian received written documentation for all available services, rights and responsibilities, and grievance procedures and is evident by the client and parent/guardian signature. The parent/guardian receives the Parent/Guardian Brochure and acknowledges in writing about any possible action occurring through involvement with CINS/FINS services. All forms were signed and dated by youth and parent/guardian. A YMCA exercise facility is available to residential program youth. The parent/guardian provides written permission at intake for the youth to utilize the facility.

There were three non-residential files reviewed. Two of Three files were screened within seven calendar days of referral. One file documented the referral was called in on 5/18/14 and the counselor documented making several attempts to schedule an intake with the parent and it was completed on 6/2/14. Information concerning the Case Staffing Committee is available but not provided in writing at intake.

### 2.02 Needs Assessment

Satisfactory

Limited

Failed

#### Rating Narrative

YFA RAP House Residential program has a written policy for a Psychosocial Assessment (Needs Assessment). Three (3) Residential client records were reviewed for compliance. (2 open and 1 closed). The Needs Assessments in the residential program were initiated and completed within one calendar day of admission and was signed by a Masters or Bachelors level counselor and supervisor. Two (2) out of three (3) residential cases were identified with an elevated risk of suicide. In both cases, an Assessment of Suicide Risk was conducted and reviewed by a licensed mental health professional the same day. Both cases were well documented with signatures by the counselor and licensed mental health professional, date and time.

In all three non-residential files reviewed the Psychosocial Assessments were completed within two to three face-to-face contacts following initial intake. All three Psychosocial Assessments with Psychosocial Summary were completed and signed off by a counselor and supervisor. The Psychosocial Assessment contained a Referral Problem Statement as seen by the youth and as seen by the significant other. The Psychosocial Summary tied in information obtained from all sources and was reviewed by the supervisor.

### 2.03 Case/Service Plan

Satisfactory

Limited

Failed

#### Rating Narrative

YFA RAP House Residential program has a written policy for the Case/Service Plan. There were three residential client records reviewed for compliance (2 open and 1 closed). In the residential program, all Case/Service Plans were developed and initiated within six and seven calendar days of the Needs Assessment. Prioritized goals were identified by prioritized needs in the Needs Assessment based on information gathered during screening, intake and assessment or in a subsequent individual counseling session conducted with the youth by the counselor. All three residential client records addressed the date of the plan, service type, frequency, location of services, person responsible, target date for completion, signatures by youth, counselor and supervisor. Two residential client records did not have the parent's signature on the Case/Service Plan; however, multiple attempts to contact and actual contacts with the parent were evident in all three client records. In one case, goals were discussed with the parent over the phone. In the other case an explanation of why the parent did not sign the Case/Service Plan was evident on the Case/Service Plans. There were no actual completion dates on any of the three residential client records reviewed; however, two cases were still open to residential services.

There were three non-residential files reviewed. All three files contained Treatment Plan Reviews supported by case notes and chart reviews. However, for one file, the 30, 60 and 90 day Treatment Plan Reviews were all done but listed late. The counselor does have documentation of chart supervision on 8/28/14 that addressed progress on the Treatment Plan and this is the 30 day review, done early. Therefore, credit is being given for having done it.

### 2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

#### Rating Narrative

YFA RAP House Residential program has written policy for the Case Management. There were three residential client records reviewed for compliance (2 open and 1 closed). Each youth in the residential program was assigned a counselor after admission. The counselor provided individual and family sessions and managed the case throughout the time the youth was provided residential services. The counselor established referral needs and coordinated referrals for services based upon the on-going assessment of the youth's/family's problems and needs. In two cases coordination of service plan implementation was evident. In the third case, service plan implementation was not able to be coordinated due to the brief stay in the residential program. The counselor monitored the youth and family's progress in services and provided support for families in all three cases reviewed. In one case reviewed, it was necessary for the counselor to monitor an out-of-home placement with a longer term residential facility. In one case, the youth was referred by the Case Staffing Committee (CSC). The client record showed clear evidence of case coordination between the non-residential counselor representing the CSC and the residential counselor to address the problems and needs of the youth and family. None of the cases reviewed had court hearings or related appointments. The closed residential case reviewed was provided case termination and follow-up.

There were three non-residential files reviewed. Case activity was documented in the Progress Notes in all three files. Family involvement was also documented. In two files, documentation in the Progress Notes was satisfactory but not very detailed as to coordination of services with outside agencies. In one file, the Progress Notes were very detailed and provided a picture of coordination with outside service agencies the child is involved with. This file also documented contact between the counselor and diversion program, as well as medication status. Additionally, the counselor sent a letter to the diversion program after discharge to advise that the youth had completed treatment goals and approved case for closure.

### 2.05 Counseling Services

Satisfactory

Limited

Failed

Rating Narrative

YFA RAP House Residential programs have written policy for the Counseling Services. There were three residential client records reviewed for compliance (2 open and 1 closed). The residential Program provides individual/family counseling and group counseling at least five days/week to address the youth and family's needs and is documented in the client record and a group log binder. The youth's presenting problems are addressed in the Needs Assessment and the Initial Case Service Plan. No youth in the client records reviewed were in the residential program longer than 30 days. Therefore, no Case/Service Plans indicated a 30 day review. Case notes were maintained for all counseling services provided and youth's progress was documented. The residential program client records are maintained on all youth, organized and are in chronological order. An ongoing internal process that ensures clinical reviews of case records and staff performance is evidenced by documentation in a peer review binder.

There were three non-residential files reviewed. There was documentation on counseling services in all three files. The supervisor meets with counselor every 30 days for a chart review meeting of each child's progress on treatment goals and counselor's performance. The supervisor signs off on all chart reviews.

**2.06 Adjudication/Petition Process**

Satisfactory

Limited

Failed

Rating Narrative

In all three files reviewed from West Pasco, all had documented phone calls and certified letters sent to parent of notification of the Case Staffing Committee, no less than five working days prior to the staffing. Local school district representative and CINS/FINS provider were present in all three case staffings. Additionally, youth, child and representatives from Law Enforcement and other agencies were present. Case Staffing Plans were developed for each youth and their treatment plan dates were revised accordingly. In two of three cases, the program brought the youth back for a second case staffing, as needed. There appears to be a concerted effort to ensure the youth's progress is assessed timely and treatment plan is revised, if needed.

**2.07 Youth Records**

Satisfactory

Limited

Failed

Rating Narrative

All residential client case files reviewed were all clearly marked "CONFIDENTIAL". Several staff interviews and on-site observations confirmed that client case files are stored in a locked file cabinet in a secure area of the facility in both residential and non-residential services.

All client case files reviewed revealed that all files are consistently organized with file section cover sheets designating which forms are located in each section of the client case file. All documentation reviewed in both residential and non-residential files matched the cover sheets for each section of the case file showing consistent organization.

## Standard 3: Shelter Care

### Overview

#### Rating Narrative

The RAP House is an eighteen (18) bed crisis shelter facility located on Plathe Road approximately 2 miles West of Little Road in Port Richey. The program is operated by Youth and Family Alternatives which also operates two other CINS/FINS shelter facilities in Florida (Brooksville, Bartow). The facility is well designed, nicely decorated, attractively landscaped, very clean 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. The agency has also provided new Youth Development training to staff members. At the time of this onsite Quality Improvement (QI) review, the RAP youth shelter had seven CINS/FINS youth in the shelter. Youth in the shelter at the time of this onsite review responded to an online survey. These residents reported that they feel safe and that they had not witnessed or experienced any adults threatening any residents. The shelter has a grievance process and grievance forms are available to the youth in common areas. The agency accepts grievances directly from residents and checks the grievance box on a routine basis to address resident concerns.

### 3.01 Shelter Environment

Satisfactory

Limited

Failed

#### Rating Narrative

Facility is a very clean, well kept place and it shows that the staff truly takes pride in their program. The grounds are very clean and set back in a wooded area. The facility appears free of graffiti and all furniture appears in operational order. Schedules are posted clearly in several places throughout the facility. The schedule does meet all contractual requirements for physical activities, faith-based, education and quiet time. All rooms are clean and bed linens are clean and functional. Facility has lots of natural light but also has adequate lighting to perform the required task.

There are no expectations in this area.

### 3.02 Program Orientation

Satisfactory

Limited

Failed

#### Rating Narrative

The facility has a very clear policy and procedure regarding Program Orientation and at Intake the youth and parent receives information regarding the program and signs forms stating they received that information. The facility has forms in the chart that clearly show the youth receive all the information.

There are no expectations

### 3.03 Youth Room Assignment

Satisfactory

Limited

Failed

#### Rating Narrative

The facility has clear documentation within the youth files that clearly capture all the youth's history (i.e. medical, mental or physical disabilities, sexual aggression, and suicide risk) that the staff use to determine where to place the youth to consider potential safety and security concerns. If a youth comes into the facility with special needs and risk such as risk for suicide, mental health, substance abuse, physical health or security risk factors an alert system is enacted and that alert is placed on the youth's file, in the program log book, and on the alert boards placed throughout the facility behind blinds to help maintain privacy for the youth.

There are no expectations in this area.

### 3.04 Log Books

Satisfactory

Limited

Failed

#### Rating Narrative

Facility logbooks were reviewed all the back to 10/23/14. Logbooks capture all contractual requirements and are clean and legible. Safety and security entries are highlighted. Correction are single lined through and initialed. Program Director reviews logbook at least once weekly and makes recommendations as needed. Oncoming supervisor does review the logbook at the being of the shift.

Best practice would be that every staff review the last two shifts of the logbook upon coming unto the shift or at least documentation from the shift supervisor that they have reviewed the log and passed the information down to the other staff. Also, if you are going to use a highlighting system within the logbook a key in the front of the logbook to show the color differences. A signature log in the front of the logbook would be good to distinguish everyones signatures.

### 3.05 Behavior Management Strategies

Satisfactory

Limited

Failed

#### Rating Narrative

The facility has a very clear policy and procedure when it comes to their behavior management system. There system consist of levels for the youth to achieve as there behaviors and participation in the program continues. Youth also have the opportunity to receive ninja bucks that they can redeem in the facility store to purchase items such as candy, soda, clothing items and shoes. Throughout the facility there are signs posted that remind the youth of the six pillars of character and the AYD 12 developmental outcomes. The Program Director and Team Leader review the Behavior Management plan regularly and discuss its progress with the staff at regular residential meetings. They also monitor the staff carrying out the program to ensure it is being followed according to the facilities plans. Seven staff training files were reviewed and of the seven, five had signs that the staff had been trained in the Behavior Management System and two did not but the Program Director is looking for clarification on that. The facility has good relationships with community partners to help with donations for the store and even special items such as shoes from pay-less.

There are know exceptions in this area.

### 3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

#### Rating Narrative

The facility has a very clear and percise policy and procedure on staff supervision. A very clear marked binder consist that is kept in the file room that all staff have access to. The binder has a phone list of all staff and emergency phone numbers. Staffing meets all contractual requirements according to Florida Administrative code and Florida Network contract. The facility has a sixteen camera video system that records for seven to nine days and then writes over itself. Logbooks were reviewed and showed that staff do fifteen minute bed checks during sleeping hours.

Best practice would be to have one male and one female on each staff but the facility is working on recruiting more male staff but it is hard in the community to get them. Best Practice is that bed checks are done every fifteen minutes but would recommend not the same time every time.

### 3.07 Special Populations

Satisfactory

Limited

Failed

#### Rating Narrative

Facility has a very clear and precise policy and procedure when it comes to working with youth in the Special Population Standard. Three youth files were reviewed and all youth had all contractual required documentation with in them or the DV respite binder. The facility does not handle Stadff Secured youth and Program Director reports that they have not served any Probation Respite youth this year. Program Director reports that they serve on the average of one Domestic Violence per month. All the Domestic Violence youth files are clean, and well organized. All the youth Case Plans reflect them getting Anger Management help and coping skills and other intervention skills are thought in groups held daily with the Direct Care staff and the Counselors. None of the youth files reviewed were transistioned over to CINS/FINS services before they were discharged. All youth stays were less than 14 days. All youth were screened by the JAC/Detention screening unit and met criteria to be admitted

under the Domestic Violence contract. The facility does not have fixed Domestic Violence beds so they have a process in place to get approval from the Florida Network for every youth that comes in under Domestic Violence.

There are no exceptions in this area.

## 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 health screening section that is required to be completed by staff members. The agency also utilized a Suicide Risk Assessment instrument that is conducted on youth that indicate a positive on the CINS Intake form. The agency's staff members consult directly with the Vice President for Prevention who holds is a licensed mental health counselor (LMHC). 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. At the time of this review, the VP of Prevention services was primarily responsible for reviewing and consulting on assessments completed to determine if these youth need to stay on this status or have this level of supervision reduced. The agency utilizes an effective color-coded general alert system that informs direct care staff of the youth's health, behavior or mental health status. The agency also documents any youth that has received onsite or offsite first aid or medical care. 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 Assessment Form and the Health Screening Form 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 youth files reviewed for Healthcare Admission Screening. In all five files the CINS/FINS Intake Assessment Form was completed at admission. One of the five youth documented a possible heart murmur, a hearing problem, and a possible head injury. The youth's mother was contacted and reported the youth had a follow-up doctor's visit during the week of the on-site review with a cardiologist but that the primary care physician did not think it was anything major and was due to stress. The youth's mother also stated the youth has not worn hearing aids in several years. The shelter arranged for the youth to use a pocket talker and was arranging for the youth to receive hearing aids. The CPI involved with the youth was contacted regarding the reported head injury and the CPI stated there was no evidence or reported abuse in the home. The remaining four youth did not document any chronic conditions requiring follow-up. Two of the five youth were on medications and they were listed as well as the reasons for the medications.

### 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 answer "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 was 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 three of the four files the youth was removed from suicide precautions and placed on standard supervision. One file documented the youth was to remain on constant sight and sound supervision and assessed again at a later date. There was documentation two days later that the counselor completed another suicide assessment and talked to the LMHC and the youth was 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 for Medication Control and Management last reviewed and updated on January 28, 2014 and then revised on May 29, 2014. The policy has detailed procedures for storage of medication, dispensing medication, over-the-counter medications, medication side effects, inventory, disposal, and training. This policy covers the requirements for medication distribution in accordance with the DJJ Health Services Manual.

The shelter provided a list of fourteen staff who are trained to supervise the self-administration of medications.

The shelter maintains a large supply of disposable razors. These razors are given to the youth to use and then disposed of. At the time of the review the shelter had 170 razors in inventory. These razors are inventoried once a week and when used. The inventory, when the razors are used, documents the starting number, the number used, and the end number. The shelter has a supply of ten scissors that are inventoried weekly. There are two clippers and two tweezers that are inventoried weekly. There is a sign in/out log that is completed anytime a youth uses any of the aforementioned sharps. The log documents the date, the staff initials, the youth's name, the item, the time out, the time in, and the staff initials again.

All medications are inventoried by maintaining a running perpetual balance and are also inventoried each shift. This process was observed during the review. Two staff members, one from the shift leaving and one from the on-coming shift inventory the medications. One staff member counts the number of pills and the other staff member records the number, with their initials next to it. Once the staff member has finished counting the pills they also initial the count on the Daily Medication Count Log so that each count has two staff signatures verifying the amount of pills. In addition, the board and tools used to count the medication on is sanitized between each use to avoid cross contamination for youth allergic to certain medications.

Observations on-site revealed that all medications are stored in a separate, secure area, which is inaccessible to youth. All prescription medications are locked in a cabinet behind two locks. Oral medications are stored on a separate shelf in the medical cabinet from topical medications, and clearly labeled. At the time of this review, there were two CINS/FINS youth that were on medication. The shelter maintains a Medication Distribution Binder for youth currently in the shelter on medications. The shelter only distributes non-aspirin over-the-counter pain relief medication. In addition, no youth on prescribed medications are permitted to take OTC's unless prescribed by a pharmacist.

There were no injectable medications on site, or identified as needed, for any youth during the time of the on-site review. The shelter has a system in place for refrigeration of medication if needed. At the time of this on-site review, there was no medication that required refrigeration.

At the time of the on-site review there were two CINS/FINS youth on medications, these two file, as well as, one additional closed file were reviewed to verify the medication administration process. All three files documented the Medication Verification Form was completed for all medications administered. A Prescription Medication Log Sheet was maintained for each medication that listed the youth's name, medication, instructions including dosage and time to be given, medication side effects and/or precautions, staff signature on the Prescription Medication Log, and youth signature. All three files also had original prescriptions that came from the doctor or hospital, with instructions, as well as, side information from the pharmacy. A cover sheet is also maintained for each youth which includes a picture of the youth, the youth's name, intake date, and date of birth. All medications in the three files reviewed were given as prescribed. The program also completes a Medication Intake/Discharge Form which list medications the youth is taking, the quantity, and is signed by the youth, parent, and staff member at intake and discharge.

There were three incidents reported to the CCC for medication errors. One incident was a missed dose of medication. The error was discovered the following morning by the next shift during medication counts. The incident was reported to the CCC and there was detailed follow-up by the Program Director regarding the incident. The pharmacist was notified and reported this would have no adverse effects on the youth and to continue with the next scheduled dose. The staff who missed giving the dose of medication was required to attend the medication training with Nurse Gurk on October 27, 2014 and received a written verbal coaching related to the incident. The second incident report related to medication involved a youth who was supposed to receive two pills and only received one. The error was discovered during medication counts on the next shift and reported immediately. All required notifications were made. The pharmacist was contacted and reported the error would cause no harm to the youth and to continue with regular doses at prescribed times. The third incident regarding a medication error involved a youth who did not receive his medication and 7am, the error was discovered at 8am during shift change. The CCC was notified, as well as, the pharmacist. The pharmacist reported the youth could be given the pill with no adverse side effects since the pill is to be given once a day and does not include a mandated time for administration. The staff member responsible for this error received an individual memo to their file as a reminder on the importance of the medications and ensuring the process is followed fully. The Program Director also scheduled two staff meetings on 9/17/2014 and 9/2/2014 to review the medication process with all staff.

It appears the program has processes in place to help prevent medication errors, including "cheat sheets" used at medication administration times, the logbook documenting youth receiving medication, two alert boards located in different areas of the shelter documenting youth on medications and times to be given, and medication counts between each shift change. The Program Director also conducts staff meetings with medication administration as a main topic of discussion, and training is also provided by both the agency and the nurse consultant for the Florida Network. The Program Director takes a proactive approach to ensuring medication administration is a top priority and any errors are handled accordingly.

**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 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 of staff to glance at the file and know what alerts each youth has. The shelter also has two alert boards, one is located in the hallway in the administrative area and the other one is located in the youth dorm area. Having two alert boards makes it easier for staff to quickly see what youth are on alerts when they are in different areas of the shelter.

There were six youth files reviewed to ensure all alerts were appropriately documented. All six 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 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 program keeps an episodic log that lists all emergencies/incidents that occur which required medical attention or follow up care, including but not limited to those incidents reported to the CCC.

All staff are trained on emergency medical procedures as evidenced by documentation in their training files.

The knife for life and two different types of wire cutters are located in the shelter, behind two locked doors (laundry room and storage closet).

First aid kit/supplies are located throughout the shelter and in the vans. These kits are inventoried weekly, as evidenced by review of the Facilitation Verification Checklist. Staff check the following weekly: first aid kits are fully stocked, sharps containers are not full, poison control information and emergency numbers are available, and biohazard disposal units and personal protective equipment is available.

The program utilizes Zee Medical Services to restock the first aid kits as needed. Program Director reports that a representative from Zee

Medical comes out at least 4-5 times each year to replenish all first aid kits.