



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

Review of YFA-RAP House

on 01/30/2013

## CINS/FINS Rating Profile

### Standard 1: Management Accountability

1.01 Background Screening	Satisfactory
1.02 Provision of an Abuse Free Environment	Limited
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Limited
1.05 Interagency Agreements and Outreach	Satisfactory
1.06 Disaster Planning	Satisfactory
1.07 Analyzing and Reporting Information	Limited

Percent of indicators rated Satisfactory: 57.14%  
 Percent of indicators rated Limited: 42.86%  
 Percent of indicators rated Failed: 0.00%

### Standard 2: Intervention and Case Management

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

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

### Standard 3: Shelter Care

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

Percent of indicators rated Satisfactory: 77.78%  
 Percent of indicators rated Limited: 11.11%  
 Percent of indicators rated Failed: 0.00%

### Standard 4: Mental Health/Health Services

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

Percent of indicators rated Satisfactory: 60.00%  
 Percent of indicators rated Limited: 40.00%  
 Percent of indicators rated Failed: 0.00%

## Overall Rating Summary

Percent of indicators rated Satisfactory: 67.86%  
 Percent of indicators rated Limited: 28.57%  
 Percent of indicators rated Failed: 0.00%

### Rating Definitions

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

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

### Review Team

#### Members

Keith Carr, Lead Reviewer, Forefront LLC/Florida Network of Youth and Family Services

Pat Gerard, Chief Operating Officer, Family Resources, Inc.

Danielle Husband, Manager III, Hillsborough County Government



## Quality Improvement Review

YFA-RAP House - 01/30/2013

Lead Reviewer: Keith Carr

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

Shelia Woods, Specialist, Florida Department of Juvenile Justice

**Persons Interviewed**

- |  |                          |                         |
|--|--------------------------|-------------------------|
| <input checked="" type="checkbox"/> Program Director | 4 Case Managers          | 0 Maintenance Personnel |
| <input type="checkbox"/> DJJ Monitor                 | 1 Clinical Staff         | 3 Program Supervisors   |
| <input type="checkbox"/> DHA or designee             | 0 Food Service Personnel | 9 Other                 |
| <input type="checkbox"/> DMHA or designee            | 0 Health Care Staff      |                         |

**Documents Reviewed**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Accreditation Reports                        | <input type="checkbox"/> Fire Prevention Plan             | <input type="checkbox"/> Vehicle Inspection Reports |
| <input checked="" type="checkbox"/> Affidavit of Good Moral Character | <input type="checkbox"/> Grievance Process/Records        | <input type="checkbox"/> Visitation Logs            |
| <input type="checkbox"/> CCC Reports                                  | <input type="checkbox"/> Key Control Log                  | <input type="checkbox"/> Youth Handbook             |
| <input type="checkbox"/> Confinement Reports                          | <input type="checkbox"/> Logbooks                         | 0 Health Records                                    |
| <input type="checkbox"/> Continuity of Operation Plan                 | <input type="checkbox"/> Medical and Mental Health Alerts | 6 MH/SA Records                                     |
| <input type="checkbox"/> Contract Monitoring Reports                  | <input type="checkbox"/> PAR Reports                      | 22 Personnel Records                                |
| <input type="checkbox"/> Contract Scope of Services                   | <input type="checkbox"/> Precautionary Observation Logs   | 0 Training Records/CORE                             |
| <input type="checkbox"/> Egress Plans                                 | <input type="checkbox"/> Program Schedules                | Youth Records (Closed)                              |
| <input type="checkbox"/> Escape Notification/Logs                     | <input type="checkbox"/> Sick Call Logs                   | Youth Records (Open)                                |
| <input type="checkbox"/> Exposure Control Plan                        | <input type="checkbox"/> Supplemental Contracts           | Other   |
| <input type="checkbox"/> Fire Drill Log                               | <input type="checkbox"/> Table of Organization            |   |
| <input type="checkbox"/> Fire Inspection Report                       | <input type="checkbox"/> Telephone Logs                   |   |

**Surveys**

- 5 Youth                      7 Direct Care Staff                      0 Other

**Observations During Review**

- |  |   |   |
|--|---|---|
| <input checked="" type="checkbox"/> Admissions     | <input type="checkbox"/> Posting of Abuse Hotline       | <input type="checkbox"/> Staff Supervision of Youth       |
| <input type="checkbox"/> Confinement               | <input type="checkbox"/> Program Activities             | <input type="checkbox"/> Tool Inventory and Storage       |
| <input type="checkbox"/> Facility and Grounds      | <input type="checkbox"/> Recreation                     | <input type="checkbox"/> Toxic Item Inventory and Storage |
| <input type="checkbox"/> First Aid Kit(s)          | <input type="checkbox"/> Searches                       | <input type="checkbox"/> Transition/Exit Conferences      |
| <input type="checkbox"/> Group                     | <input type="checkbox"/> Security Video Tapes           | <input type="checkbox"/> Treatment Team Meetings          |
| <input type="checkbox"/> Meals                     | <input type="checkbox"/> Sick Call                      | <input type="checkbox"/> Use of Mechanical Restraints     |
| <input type="checkbox"/> Medical Clinic            | <input type="checkbox"/> Social Skill Modeling by Staff | <input type="checkbox"/> Youth Movement and Counts        |
| <input type="checkbox"/> Medication Administration | <input 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 Florida Department of Juvenile Justice (DJJ) is the State of Florida's agency responsible for providing programming and services to reduce juvenile crime and increase public safety. According to Florida Chapter 984 the State must provide a continuum of services to prevent Status Offenders from entering the Juvenile Justice system. These services are typically referred to as Children in Need of Services and Families in Need of Services (CINS/FINS). The Lead Agency for CINS/FINS Services for the State of Florida is the Florida Network of Youth and Family Services (FNYFS). Youth and Family Alternatives, Inc. (YFA) is a local service provider and delivers CINS/FINS service through a contract with the Florida Network of Youth and Family Services, Inc., (FNYFS) on behalf of the Department of Juvenile Justice. The agency provides residential and non-residential services for youth and their families in Citrus, Hernando and Sumter Counties. Prior to the QI Team's on-site visit on January 30-31, 2013, the agency's personnel were notified of the monitoring visit and all documents for the agency to prepare in advance of the onsite Quality Improvement review. All of the staff members were cooperative with the monitoring team throughout the onsite review.

Youth and Family Alternatives, Inc. (YFA) promotes a broad range of service offerings to youth and families in need in this region. The agency has a total of three (3) residential youth shelters that provide CINS/FINS services. The Runaway Alternatives Project (RAP House) youth shelter is located in New Port Richey, Florida. The agency has multiple interagency agreements with local community stakeholders and partners in this service region. The agency places a high degree of importance on creating opportunities and that promote getting the word out through its street outreach and community partnership programs. A large part of these efforts go to promoting its residential and non-residential CINS/FINS services. The agency has community partners in key areas that include local schools, law enforcement, local mental health and receiving facilities, local area businesses, faith-based organizations and various other community-based organizations. Youth and Family Alternatives in partnership with these community partners provide an array of services that help youth and their family to resolve family issues and increase family stabilization and unification.

The agency has an agency-wide Street Outreach component that markets all of the agency's service offerings all 3 of its major service regions. The agency also has an active eighteen (18) member Board of Directors that provides leadership, support and promotes the agency's services throughout the service region. The Outreach staff members conduct presentations to various entities, organizations, human service agencies. Agency information is also presented to interested persons and/or groups, community provider meetings and at community events. The agency also distributes information cards and brochures. Youth and Family Alternatives promote the National Safe Place Program and secures numerous safe place sites throughout their service area. The program has grant funds the Department of Health and Human Services to conduct street outreach activities to support these efforts. Through this grant, materials such as hygiene products, blankets, tee-shirts, snacks and bottled water, as well as information about the services provided at the shelter, are provided to at-risk youth.

The agency was recently awarded a Civil Citation Contract to provided additional diversion services. In addition, the agency has recently completed a 5 Kilometer fund raising event on an annual basis called the RAP House Run. The agency has staff members that participate in local prevention organizations and partnerships that include participation in Mid-Florida Homeless Coalition, local county schools – McKinney Vento Transportation Assistance program, Pasco County Sheriff's Office and other organizations.

The agency-wide outreach efforts include the use of the online media. The agency has posted an informative video featuring its services on the YouTube internet website. Further, the agency has invested in producing professional full color marketing materials that include tri-fold brochure, booklets and seasonal newsletters. The agency also reports that they have partnerships with local community organizations such as Trinity and Hudson Rotary Clubs, Prodigy Art And Dance, local community churches and yoga and wellness instructors.

## 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 Program Director, an Assistant Director, a Team Leader, two (2) Youth Development Specialist (YDS) Shift Leader, two (2) Residential Counselors, ten (10) Youth Development Specialists, and an Office Specialist. The Non-Residential Program is lead by Carolyn Kehr, Non-Residential Program Director and the Residential Program is lead by Heather Numbers. At the time of the onsite Quality Improvement program review, the agency position vacancies include 1 vacant YDS Part-time time position. There were no non-residential vacancies reported by the agency. In addition, the agency added an Assistant Residential Director position to increase the agency's ability to support daily operations and programming needs.

The agency operates a Risk Prevention and Management Team Meeting that reviews various issues that reviews incidents on the quarter and focuses specifically on Medication Related, Service Modalities involving Risk/Limit of Freedom of Choice, Facility safety issues, Danger to Self/Others, Serious illness/Injuries/Death, General Trends or Patterns, Elopements/Injuries/Illnesses. This team is comprised of various staff YFA staff members. Youth and Family Alternatives, Inc. is accredited by the Council on Accreditation (COA). In addition, the program's Continuity of Operations Plan (COOP) was approved by the Florida Network in May, 2012.

### 1.01 Background Screening

Satisfactory
  Limited
  Failed

#### Rating Narrative

The Program has a comprehensive Background Screening policy in place that addresses the requirements of this indicator. Of the ten (10) personnel files reviewed, all 10 documented background screenings were completed prior to hire. One of the ten personnel files selected was due for a five (5) year rescreening. This file was reviewed and was found to contain a 5 year re-screening requirement that was not completed as required. The employee was re-hired on January, 7, 2008. According to the Program policy, all 5 year re-screenings will be completed 30 days prior to 5 year employment anniversary.

The Annual Affidavit of Compliance with Good Moral Character requirement was completed by the agency and sent to the DJJ Background Screening Unit on January 25, 2013.

One employee that was due a 5 year re-screening was not re-screened. The agency was informed of this outstanding item. The agency's Human Resource department initially reported that this re-screen will be submitted onsite today during this onsite program review.

On day two (2) of the program, the Human Resource department located the outstanding re-screening document from day one of the program review. The agency reported that the re-screening was conducted in October 2012 prior the employee's anniversary date. This document had been misfile and was initially not placed in the staff member's personnel file.

### 1.02 Provision of an Abuse Free Environment

Satisfactory
  Limited
  Failed

#### Rating Narrative

The agency has a policy that requires that staff members report all incidents that involve abuse. This policy is called 1.03-1 Abuse and Neglect Reporting. The policy was documented as being last reviewed on March 6, 2009. In addition, the agency has an Environment and Code of Conduct policy that requires that all staff members adhere to a code of conduct that forbids physical abuse, profanity, threats and intimidation. The agency's staff members receive a copy of the employee handbook that also includes the agency's Code of Conduct at the time that they are hired.

The agency posts general information about the Florida Abuse Hotline in common areas throughout the youth shelter. Specifically the number is posted in the day room and other general locations. The Abuse Hotline information is also contained in the residential client handbook. This book is provided to the resident during the admission process.

The reviewer assessed grievances, incidents and youth and staff member surveys to determine if the agency maintains a shelter and work environment that promotes youth, staff and others feeling safe, secure, and not threatened by any form of abuse or harassment. This reviewer assessed all RAP House related DJJ-Central Communications Center (CCC) incidents reported and all documented internal agency incidents. A total of six (6) grievances were reviewed to assess issues and incidents of physical and psychological abuse, verbal intimidation, use of profanity and other related matters. Of these grievances, none contain content that residents report related to profanity or physical harm. However, five (5) of the 6 grievances indicate that youth report feeling uncomfortable or disrespected regarding how staff members communicate with them. Of these six (6), one was not responded to within 3 days as outlined in the agency's youth handbook. One of the 6

grievances did not have signatures of the parties involved to officially acknowledge that the grievance was adequately addressed with the 3-day administrative follow up. These cases indicate staff and youth communication issues related to when they have disagreements. A review of administrative actions did not indicate that any of these grievance cases required a formal administrative corrective action to address these documented grievances.

The review team also reviewed current DJJ CCC incidents with the last six (6) months, internal non-reportable agency Incidents, internal agency disciplinary action reviews and four (4) staff member surveys and five (5) client surveys.

Information reviewed in the DJJ CCC reports indicate incidents related to contraband being discovered in resident sleeping areas. Other incidents include absconding from the youth shelter, program disruption, youth behavior, and complaints against staff members. There are at least six (6) incidents related to lacking or inconsistent practice for conducting searches for contraband when youth return to the residential shelter. The reviewer assessed DJJ CCC Incidents and found that five (5) incidents were related to medication errors and other incidents were related to a broad range of other issues. One incident indicates that a staff member Other CCC incidents involved absconding, program disruptions and miscellaneous events are documented.

Information reviewed regarding disciplinary action revealed that a total of two (2) staff members were disciplined due to violating agency code of conduct and not meeting agency workplace performance requirements. The agency produced 2 individual Performance Correction Notices on 2 staff persons involved in this contraband incident.

One (1) staff person was terminated for allowing youth to use their personal mobile phone. Two (2) staff members were disciplined due to not using proper judgment to secure unsafe contraband, and failure to report contraband to the DJJ CCC in a timely manner. Another employee is currently suspended and under on open investigation for inappropriate contact with a resident. In this case three (3) out of four (4) investigating authorities have closed this case due to unsubstantiated information. The local State Attorney's investigation is still pending.

There were four (4) cases submitted by the agency with administrative documentations reports that were initially reviewed onsite. Of these cases, there were two (2) employees that received written disciplinary documentation for not following proper search of youth, identification of contraband and supervision. A male staff member was suspended for having inappropriate contact with a female resident. Another staff member was fired for allowing residents to use their personal mobile telephone. The 2 staff involved in not following proper search practices had scheduled re-training dates that were not fully completed by the Team Leader. The staff involved in the alleged inappropriate touching incident was still on suspension and the case is still pending with the States Attorneys' office. The staff involved in the permitting youth to use their personal mobile telephone was terminated.

At the time of this review, five (5) out of 5 onsite resident surveys indicated that residents are being not deprived of basic needs, or are being threatened or abused by program staff members. Five (5) out of 5 report not hearing in profanity. Four (4) out of 5 report feeling safe and having knowledge of the Grievance process.

The agency has a general practice that requires follow up on staff members that commit violations to agency policy and staff members that do not meet general work performance requirements. The agency provided administrative documentation called Performance Corrective Action reports that document the agency's formal response to an employee work issue. The types of agency responses include Verbal Correction, Written Disciplinary Counseling, Administrative Leave, Final Warning and Termination of Employment.

The Training Request forms used to verify the re-training for the 2 employees did not fully document the training materials covered or actual date that the re-training was completed. The Vice President, Prevention Services reported that the Program Director and Lead Team Member are both on Medical Leave and therefore the required follow up training for the staff involved improper search techniques did not take place as originally planned.

Four (4) out of seven (7) onsite staff member site surveys conducted onsite report that staff reports no use of profanity, threats, intimidation and hu in the work place.

### 1.03 Incident Reporting

Satisfactory

Limited

Failed

#### Rating Narrative

The Program has a policy in place that meets the requirement of this indicator and notifies the DJJ CCC when reportable incidents occur. The reviewer examined a total of (21) reported incidents during the last 6 months. Of the 21 incidents, four (4) were not reported within the 2 hour required time frame, leaving the Agency with a 19% non compliance rate. Of these incidents, 17 that were reported within the 2 hour time frame and the remaining were reported immediately.

### 1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy in place related to first year training requirements and an additional policy related to on-going training requirements. A total of nine (9) staff member training files were reviewed to assess the agency's adherence to the requirements of this indicator. Four (4) of the training files were first year training files and five (5) were on-going training files. All 4 of the first year training files met or exceeded the minimum training requirements of 80 hours.

Youth and Family Alternatives has a comprehensive initial New Employee Orientation training schedule that is completed within the first weeks of employment. Youth and Family Alternatives demonstrated offering employees a variety of training opportunities at a variety of locations throughout the course of the calendar year. Youth and Family Alternatives demonstrated an on-going commitment to crisis intervention techniques by offering employees both YDS and AYDS during the course of the calendar year.

The policies provided by Youth and Family Alternatives related to first year training requirements and on-going training requirements were both last reviewed in March of 2009 and the agency is encouraged to review and update the policies as needed to match current QI Standard requirements (Standard 1.04). The policy addressing On-going training requirements does not match the current QI Standard, which requires Direct Care Staff in residential programs that are licensed by DCF to have forty (40) hours of training on an annual basis. The current Youth and Family Alternatives policy requires twenty-four (24) hours of on-going training.

One of the 4 first year employee files did not include documentation of Suicide Prevention Training, however, it was reported by Youth and Family Alternatives that this employee is currently out on leave from the organization. One of the 4 first year employee files did not include documentation of receiving Suicide Prevention Training within the employee's first year of employment. The employee's training year was from April 2011 through April 2012 and this employee received 2 hours of Suicide Prevention Training in December 2012, which was outside the first year training requirement time frame.

None of the nine (9) employee training files contained documentation of the employee receiving any training on Cultural Competency, which is a recommended training in The Florida Network of Youth and Family Services Policy and Procedure Manuel 2012.

Three of the five (5) on-going training files did not contain documentation of the employees meeting the minimum on-going annual training requirement. One of the 5 on-going training files did not have documentation of current CPR and First Aid as required. None of the 5 on-going training files contained documentation of the employees receiving training on Suicide Prevention, Signs/symptoms of Mental Health and Substance Abuse or Universal Precautions, which are recommended trainings listed in The Florida Network of Youth and Family Services Policy and Procedure Manuel 2012.

One of the three (3) on-going residential employee training files did not contain documentation of the employee receiving the annual required training in Fire Safety.

### 1.05 Interagency Agreements and Outreach

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy in place. The program demonstrates strong community outreach and involvement. Agreements ensure that families receive medical, educational, therapeutic and other supports. Community partnerships are varied, and example of this are the following: volunteers such as Lowes who donated the time, building materials, and shelving for a Shelter Store in which the youth can earn "shelter bucks" to buy community donated items from the store. Volunteers are also preparing to create a garden along with their lawn and landscaping volunteer work.

### 1.06 Disaster Planning

Satisfactory

Limited

Failed

Rating Narrative

The Program has a policy in place for the standard. The program has a written disaster preparedness plan.

The reviewer examined documentation in the Emergency and Disaster logs and the Vehicle Inspection Log. The written disaster preparedness plan includes an emergency evacuation procedure. The program exercises fire drills with very detailed instructions accompanied by photographs for all shifts. The Agency vehicle log books identify two eight passenger vans to be used in case of emergency evacuation. The



vehicles are maintenance checked monthly as documented in the vehicle maintenance and inspection book. The fire drill log lists all emergency numbers such as fire departments, poison center, mental health, juvenile assessment center, etc. The log includes annual inspection reports for fire and sprinkler systems, fire extinguisher and the Pasco fire service report. The log includes a map of facility and facility evacuation procedure. The Agency has a color coded ready reference guide plan that lists by code color plans and actions to be taken by staff members.

An example of this is code red, fire protocol is the plan, evacuate is the action, 911 is the notification and documentation. These ready reference codes are located throughout the facility. Emergency supplies are in a locked room, however supplies are very limited. Mainly batteries and paper products. No food or water. No personal hygiene products.

No food or water in the emergency supplies room on the first day of the review.

On the second day of the review, there was a supply of food and water in locked rooms.

### 1.07 Analyzing and Reporting Information

Satisfactory

Limited

Failed

#### Rating Narrative

The program has a written policy in place that requires efforts to focus on the process of gathering data, analyzing and looking for trends and patterns in data and making recommendations based on trends and patterns.

As evidenced in the documents reviewed, when incidents, accidents or grievances occur there are reviews done on the Management team level, as well all facility level. Meeting agendas and meeting minutes report show that issues are discussed and analyzed on a quarterly basis.

The reviewer examined Performance Correction Notice, Program Issue/Outcome form (which is being newly implemented), CINS/FINS Management Team meetings agenda, Risk Prevention Management Team Meeting minutes, and RAP training request forms. The reviewer requested specific evidence of the agency identifying program issues that demonstrate the agency's ability to identify and then fully address program, operations, risk management issue. The agency provided documentation in the form of meeting agendas from July 2012 and October 2012 meetings of the agency's Risk Prevention and Management Team. Meeting agendas show that issues are such as medication, facility issues, injuries and trends. The agency did provide minutes for the July 2012 Risk Prevention and Management Team Meeting. No minutes were provided for the October 2012 meeting.

The Performance Correction Notice form is a document used by management to address issues due to deficient work performance or violations of employee conduct or behavior requirements. The document reviewed onsite contained a follow up plan for corrective action with specific follow up dates for YFA management to address follow up issues for each employee. Of these cases, there were two (2) employees that received written disciplinary documentation for not following proper search of youth, identification of contraband and supervision. The 2 staff involved in not following proper search practices had re-training dates that were not fully completed by the Team Leader.

The program has a written policy in place that requires efforts to focus on the process of gathering data, analyzing and looking for trends and patterns in data and making recommendations based on trends and patterns. The reviewer examined Performance Correction Notice, Program Issue/Outcome form (which is being newly implemented), CINS/FINS Management Team meetings agenda, Risk Prevention Management Team Meeting minutes, and RAP training request forms.

As evidenced in the documents I reviewed, when incidents, accidents or grievances occur there are reviews done on the Management team level, as well all facility level. Meeting agendas and minutes show that issues are discussed and analyzed on a weekly basis. The Stakeholder Committee reviews parent/youth satisfaction surveys quarterly.

The Training Request forms used to verify the re-training for the 2 employees did not fully document the training materials covered or actual date that the re-training was completed. The Vice President, Prevention Services reported that the Program Director and Lead Team Member are both on Medical Leave and therefore the required follow up training for the staff involved improper search techniques did not take place as originally planned.

Youth and Family Alternatives has an oversight process that assesses resident grievances, internal and DJJ CCC incidents. Examples provided by the agency indicate that the agency has reporting process. However, the agency internal review and response systems indicate proof limited follow up documentation related to these current incidents or trends in the last six months related to medication, contraband and proper search practices. These are clearly reported in DJJ CCC reports, but there is limited documented follow up to address these issues.

The agency did not make reference to the percentage or its effort to reduce certain risks related to addressing a certain outcome. For example, the agency could develop a plan to address the problem and set a target goal to address the identified problem. At the time of this onsite

review, the internal oversight process used by the agency demonstrates general awareness of issues. The agency should utilize focus on increasing its efforts to document the various intervention and strategies it uses to address a problem in more detail.

The agency had six (6) incidents related to contraband issues listed in the YFA RAP House DJJ CCC report. The agency had no recent documentation confirming that identification of contraband and searches were serious internal deficiencies/issues being addressed by their internal quality improvement department or Risk Management Team.

Lack of agency wide training for proper searches and orientation are lacking as evidenced by DJJ CCC incidents reported and onsite interviews. Interviews with staff onsite indicated that staff report potentially half of their peers are following proper search and orientation practices on a consistent basis.

Onsite interviews with staff members revealed that staff members signed documents indicating that they had completed program orientation and personal record inventory tasks on a certain date and they had not. This was called into the DJJ CCC onsite as a Falsification of Records during the onsite QI review. This incident is related to a youth that reported having found a large knife under her bed in the residential youth shelter.

The Performance Correction Notice is a tool used to address issues. The document I examined had a very extensive plan for correction with a follow up date of a month out, however there was never any follow up to this issue. The Vice President, Prevention Services says the program director is on FMLA and therefore this action may have fallen through the cracks.

## 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 non-residential program consists of Carolyn Kehr, Non-Residential Program Director and three (3) full-time Counselors in the New Port Richey and Dade City service regions. The non-residential component of the program staff also includes a staff member that is a Licensed Marriage and Family Therapist. All counselors have a minimum of a Bachelors' or Masters' level degree.

The program provides non-residential services that are provided at the agency's office, local schools, and other community based organizations. The agency was recently awarded a Reinvest in Children Grant. These funds will help expand its current non-residential family-based programs. The non-residential staff members use the "Why Try" program at the Sumter Youth Center that is used to address family issues with both youth and parents. The program works on issues ranging from anger management, communications, removing negative labels and the duration of this program is four (4) weeks. The non-residential program will now be able to provide more programming to other surrounding counties. 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. Further the non-residential program has been working with the new Youth Character Development programming that helps families develop and use very strong character/behavior focused treatment plans.

The non-residential program has re-structured the Court-Liaison position into a traditional counseling position. The agency has also hired a new staff person in the Dade City service region with a staff person with previous sheriff's office's School Resource Officer. At the time of the Quality Improvement review, the program has provided non-residential services to sixty-five (65) families since the beginning of the 2012-2013 fiscal year.

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. A new service plan format based on youth development philosophies of developmental outcomes and character development has been initiated recently, and further training on the new process should result in more goal oriented plans targeted at skills development. Evidence of a focus on youth development was seen throughout the facility and is clear in the case file documentation as well.

Clinical supervision in non-residential services is well-documented and interactive. Residential services do not have a documentation process for clinical treatment team meetings at this time.

This reviewer gained input from several staff members in determining systems and processes in place to facilitate meeting program standards. The Vice President of Prevention Services Andy Coble, Non-Residential Program Director Carolyn Kehr and various Youth Development Staff members were very helpful in answering questions, explaining processes, and locating documentation.

### 2.01 Screening and Intake

Satisfactory                       Limited                       Failed

#### Rating Narrative

A written policy is in place which closely tracks the CINS standard and includes all elements. Centralized intake is available 24 hours a day and documentation shows that screenings, crisis counseling, referrals, and intakes are conducted at all hours.

Nine (9) case files were reviewed for this key indicator; four (4) non-residential and five (5) shelter files. Screening forms were present in each file documenting eligibility for services and all screenings were performed within seven calendar days of referral with the exception of one case where the youth was in a hospital when originally screened and was released directly to the shelter.

Documentation of youth and family receiving, in writing, information regarding rights and responsibilities, service options, and parent/guardian brochure were observed in all files.

### 2.02 Psychosocial Assessment

Satisfactory                       Limited                       Failed

#### Rating Narrative

A written policy is in place which closely tracks the CINS standard and includes all elements. Detailed psychosocial assessments are completed on all youth and contain all elements required by the Florida Network Policy and Procedure Manual.

Nine case files were reviewed for this key indicator; four (4) non-residential and five (5) shelter. Assessments were completed within acceptable time limits on all youth who had been in services for more than 3 days. All were completed by a Masters level counselor, and signed by a supervisor.

One youth was only in the shelter for 2 days and had no assessment completed.

In one other residential case file, a youth was admitted to the shelter after being discharged from an inpatient psychiatric hospitalization, however the psychosocial assessment made no mention of the reason for the Baker Act. Recommendation: Part of intake paperwork and psychosocial assessment should be an explanation of the reasons for a recent Baker Act as well as a related assessment of current functioning.

Recommendation: All staff should use their credentials when signing official case file documents. This was not present in several residential files.

### 2.03 Case/Service Plan

Satisfactory

Limited

Failed

#### Rating Narrative

A written policy is in place which closely tracks the CINS indicator and includes all elements. Service plans are completed on all youth who have a psychosocial assessment completed and contain all elements required by the Florida Network Policy and Procedure Manual.

Nine case files were reviewed for this key indicator; four (4) non-residential and five (5) shelter. Service plans were generally completed within acceptable time limits. All were completed by a Masters level counselor, and signed by a supervisor.

In one residential file, the youth left within 24 hours of admission and did not have a service plan completed. In another residential file, a youth was in residence for 6 days and did not have a service plan. The file indicated that the plan was not completed because the counselor was on leave. In a third residential file, documentation in the progress notes indicates that repeated efforts to engage the youth to work on a service plan were fruitless, and the plan was not completed for 32 days. Several residential and non-residential files have no type, frequency, or location for the service to be delivered and indicate only the youth as the "responsible party".

### 2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

#### Rating Narrative

A written policy is in place which closely tracks the CINS indicator and includes all elements required by the Florida Network Policy and Procedure Manual. Each youth or family is assigned a counselor/case manager immediately.

Nine (9) case files were reviewed for this key indicator; four (4) non-residential and five (5) shelter. Progress notes indicate coordination of referrals and services from outside agencies and interaction and coordination with families.

Service plans do not generally identify referral needs, however progress notes do document case coordination with outside agencies and individualized referrals as needed. Aftercare plans frequently contain referrals to outside agencies.

### 2.05 Counseling Services

Satisfactory

Limited

Failed

#### Rating Narrative

A written policy is in place which closely tracks the CINS indicator and includes all elements required by the Florida Network Policy and Procedure Manual.

Each youth or family is assigned a counselor/case manager immediately and each case has an individual case file. Services documented show a good flow between presenting problems, psychosocial assessment, service plan and progress notes.

Nine case files were reviewed for this key indicator; four (4) non-residential and five (5) shelter. Case file documentation shows that youth and families receive individual and family counseling to address needs identified in the intake process presenting problems and psychosocial assessment. Residential group counseling occurs an average of five (5) times a week in shelter.

Non-residential services are offered in office and as well as in the school setting when appropriate and are apparently effective in keeping families intact, minimizing out of home placements and providing aftercare to youth discharged from shelter.

The residential program does not have a formal process of clinical case review of case records, youth management and staff performance at this time.

Non-residential counseling services are well documented and focused on presenting problems. The program manager has a system of reviewing cases with staff that is on-line and interactive to effectively track counselors assigned to outlying areas across several counties.

Chronological progress notes in files occasionally contain notes that are out of sequence or not properly signed.

## 2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

### Rating Narrative

Policy and procedure was reviewed and met all requirements of the indicator. Two (2) client files were reviewed that involved the case staffing process and documentation was complete and detailed. The Case Staffing process is active and meetings are held at least monthly. Most cases are truancy related.

No written requests for a case staffing hearing from a parent or guardian was noted in the files. All notices to parent/guardians and committee members were given at least one week prior to the meeting.

Case staffing committee membership reflects the required members as well as other service providers who regularly attend the meetings.

Parents and guardians are given a copy of the revised service plan at the meeting. The program works closely with the school system and the judicial system to track the youth's behavior following the committee hearing.

## 2.07 Youth Records

Satisfactory

Limited

Failed

### Rating Narrative

The program has all records secured in a locked room in a locking file cabinet. All files are marked confidential and have no client-identifying information on the outside of the file. The files are generally organized in the same sections in residential and non-residential services.

It is recommended that staff should review files to ensure consistency of organization, particularly so that important information can be accessed quickly by staff. Residential files in which a youth has had more than one admission to shelter can be quite confusing because there is often paperwork from other admissions mixed in with current paperwork.

The non-residential files are generally well organized and documentation is timely.

Residential files should be reviewed by agency supervisors and management to ensure that major sections are accurate, organized and completed as required.

## Standard 3: Shelter Care

### Overview

#### Rating Narrative

The Youth and Family Alternatives – RAP House youth shelter is located in New Port Richey, Florida. This residential shelter operates 24 hours a day, 365 days a year and is licensed to serve up to twenty-four (24) residents for runaway and emergency shelter services. The youth shelter is contracted to serve both CINS/FINS youth and children placed by the Department of Children and Families (DCF). The youth shelter utilizes effective documentation practices in the agency's program logbook.

The agency recently completed physical plant renovations and improvements. Specifically the agency installed new flooring and the interior walls and exterior repainted in the last four months. The agency has also provided new Youth Development training to staff members. The training focuses on six (6) pillars that are aimed at increasing positive youth behavior, communication and decision-making skills.

The CINS/FINS residential program includes Heather Numbers, Program Director, Eileen Copple, Assistant Director, Lisa O'Reilly, Youth Development Specialist (YDS) Team Leader, Marlene Trentacosta and Pamela McNett, YDS Shift Leaders, ten (10) YDS direct care staff members, Brittany Fairfield and Arleen Spenceley, Residential Counselors, and an Office Specialist.

At the time of this onsite Quality Improvement (QI) review, the RAP youth shelter served eight (8) residents on day one and seven (7) residents on day two. 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.

The agency has recently completed facility renovations to the youth shelter that include repainting the exterior and interior walls throughout the youth shelter. Additionally, the agency has added a bulletin board called the Accolade Board that is used to promote positive observations and attributes of the residents and staff members.

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 (2) 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.

Due to the fact that there were several safety and security issues at the facility involving contraband, we conducted a facility room search for contraband along with a shift leader and the Assistant Program Manager. Facility safety and security issues were reviewed and highlighted with all staff contacted during this site review.

### 3.01 Youth Room Assignment

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has a written policy that addresses the key indicators in this QI standard. All youth are assessed at intake for various issues related to room assignment. These issues are documented on page 2 of the CINS Intake Form that is located in each client's case file. This information is also documented on the agency's Admission Sleeping Assignment Form. Interviews with staff and youth did confirm that there is a room and bed assignment process in place as part of the initial intake process.

A review of six (6) client case files revealed that there was documentation in each file about what criteria are utilized for this process. All files had this information documented on the appropriate forms in each client case file. However, there was some inconsistency in how and where this information was actually documented in client case files in practice.

One file did document the criteria assessed for room assignment but no formal room and/or bed was assigned. One other file had the room/bed assignment on one form but not the other. Two (2) of the five (5) files did not have the room or bed assignment documented on the CINS Intake Form.

There is a duplicate form that is unnecessary and may be causing some confusion in terms of documentation

### 3.02 Program Orientation

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy that addresses all of the key indicators in the Quality Improvement (QI) indicator.

The youth orientation process was documented in each case on the orientation checklist. All key areas are covered during the orientation process including the behavior management, tour of facility, fire drill and emergency procedures, daily schedule and many other areas essential to daily activities and services offered to youth.

All youth are provided a copy of the client handbook at intake. Interviews with staff and youth confirmed this process.

The agency practice in the area of Program Orientation is inconsistent. The practice of conducting routine admission searches and documenting personal belongings are not being completed consistently by all staff members. The agency had six (6) incidents related to contraband issues listed in the YFA RAP House DJJ CCC reports. Interviews with random staff members onsite revealed that staff reported that half of their peers are conducting proper room searches and program orientation practices.

The agency had no recent documentation confirming that identification of contraband and searches were internal issues being addressed by their internal Quality Improvement department or Risk Management Team.

A case involving a large knife that was found in a female youth's bed room in January was reviewed onsite during the QI review contained signatures documenting that a staff member completed program orientation and a completed personal belonging inventory. However, further investigation and interviews with staff members resulted in staff admitting that they could not confirm or verify that these tasks were not completed by the actual persons signing the program orientation and personal belongings record on the documented dates on each form. While onsite a complaint against staff incident report was called in to the DJJ Central Communications Center (CCC) by the Lead Reviewer.

One exception was noted. One orientation form was not signed by the youth, only by the staff. In addition, there is a security flaw in the intake process related to the initial property possession inventory and security screening (metal detector wand) that has been acknowledged by the agency. During this QI site review several recommendations were made in terms of corrective actions:

- Training for staff on the intake inventory and security screening process.
- Revision of agency policy and reviewing this at staff meeting.
- Training for staff on conducting room searches.
- Conducting room searches on a regular basis.
- Reminding staff to be more safety/security conscious in general.

**3.03 Shelter Environment**

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy that addresses all of the key indicators in the QI indicator.

A comprehensive tour of the facility was conducted by this reviewer along with the Assistant Program Director. Facility cleanliness, maintenance and safety and security issues were identified assessed and evaluated. The facility was clean, well maintained, appropriately furnished and attractively landscaped.

The DCF Certificate of License #100021724 for the 20 bed facility is valid March 22, 2013 is posted in the lobby of the facility.

The annual Fire Inspection was conducted by Pasco County on July 25, 2012. No corrective actions were required and the facility was approved. That program's fire safety and evacuation plan was also approved by the Fire Marshall in 2009 and no changes have been made to that policy since that time. Fire drills are being conducted according to CQI requirements. Evacuation plans are posted in the facility at several locations along with emergency procedure manuals.

The annual group care and food service inspection is conducted jointly and annually by the Florida DOH. The most recent inspection was conducted on 4/24/12 and the rating was satisfactory. One violation was noted regarding dust on exhaust vents in restrooms.

Pest control services are provided by Orkin. An invoice was provided for the most recent service on January 2, 2013. There was no visible signs of any insect or rodent infestation at time of this review.

### 3.04 Log Books

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has a written policy that addresses all of the key indicators in the CQI indicator.

The facility maintains a log book that documents the daily programmatic activities at the facility. New intakes and discharges are documented as well as keys exchanged from shift to shift.

Major program incidents are documented by staff and suicide watch is highlighted in yellow.

A shift summary is reported at the end of each shift documenting the activities, number of youth at the facility and their current status.

Staff are not signing into the log individually at the beginning of their shifts.

Staff are not documenting their review of the previous two (2) shifts or time since last on duty.

#### Rating Narrative

The agency has a written policy that addresses all of the key indicators in the CQI indicator.

The facility has a daily program schedule that is posted in the day room of the facility. The schedule includes educational, recreational and treatment services. Sleeping hours, meal time, group counseling and on/off site recreational activities are also part of the weekly and daily plan.

Observations during this CQI site visit revealed that the staff were following the daily schedule on a consistent basis. Several interviews were conducted with youth and staff that also confirmed this.

### 3.06 Behavior Management Strategies

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has a written policy that addresses all of the key indicators in the QI indicator.

The agency has a new behavior management system that was implemented this past year. It is based on the nationally recognized curricula: Advancing Youth Development and Character Counts.

There are 12 developmental outcomes and 6 pillars of character that are utilized as the foundation for the behavior management system. Staff received training in the new system and the curriculums it is based over the past year.

The system has three levels: Orientation, Education and Graduation. Youth earn the opportunity to advance from level to level by demonstrating appropriate behaviors and earning points and privileges associated with each level.

Youth also earn the ability to purchase items from the "RAP Store" by earning RAP bucks for going above and beyond the standard requirements of the program and demonstrating leadership skills.

No exceptions.

### 3.07 Behavior Interventions

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has a written policy that addresses all of the key indicators in the QI indicator.

The agency has a policy on behavioral interventions and youth rights that all staff review during orientation training. Staff receive training in Techniques for Aggression Management and use of force protocols and policies.

Interviews with two staff (one counselor / one youth care staff) did confirm that staff are aware of the QI indicator requirements regarding the



restrictions around what type of consequences may be applied. Both staff stated that they use a "no touch" policy unless youth are actively attempting to hurt self or others and then would use minimal force necessary to prevent serious injury or harm.

There were no incidents involving excessive use of force. Youth interviews confirmed that staff

None noted at time of review.

### 3.08 Staffing and Youth Supervision

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has a written policy that addresses all of the key indicators in the QI indicator.

A review of staff schedules for the past three months indicated that there are at least two (2) staff on duty on each shift. There are three (3) shifts that cover the 24 hour daily work period: 8 AM to 4 PM, 4 PM to 12 PM and 12 AM to 8 AM.

A male and a female youth care staff member is assigned to work each shift in accordance with the CQI and licensing requirements.

A staff schedule binder is maintained in the secure, locked file room of the facility. Staff are able to review the weekly schedules that are developed by the Assistant Director on a weekly basis.

Interviews with the Assistant Program Director and several youth care staff confirmed the current active schedule.

### 3.09 Staff Secure Shelter

Satisfactory

Limited

Failed

#### Rating Narrative

This QI indicator is not applicable to this site review.

The agency is NOT contracted to provide Staff Secure shelter services.

N/A

## 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. Further, the agency's Vice President of Prevention Services is a Licensed Mental Health Counselor and is consulted regarding this sight's suicide risk screening and assessment process. At the time of this review, the VP of Prevention services is primarily responsible for 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

Youth and Family Alternatives has a written policy related to Health Care Screenings and On-Going Monitoring, dated 3/2009.

A total of six files were reviewed for this standard. All six of the files reviewed contained documentation of a healthcare screening completed on the youth at the time of admission.

Youth and Family Alternatives utilizes both the CINS/FINS Intake Assessment form to screen and document medical issues and an internal form, Health Screening Form to further screen for medical issues and concerns.

Youth and Family Alternatives also uses a separate internal TB Screening form to assist in the identification of TB.

Youth and Family Alternatives demonstrated regular documentation of the presence of scars, tattoos and other identifying markings.

One of the six health screenings reviewed did not include a date as to when it was completed.

Two of the six files reviewed had inconsistent documentation within the file on the various medical screening forms used. In one file, the YFA screening noted there were no known allergies, however, the outside of the file and the centralized intake form noted the youth has an allergy to Sulfa. In another file, it was noted the youth did not have any medical issues on one screening form, including mental health issues, however, in a separate medical screening form, it was documented the youth had a mental health diagnosis.

Three of the files reviewed contained incomplete documentation on the screening forms, leaving "yes" answers blank, not completing the names of the medications the youth takes, missing follow up information, etc. One of the files included statements related to medications such as:

"on all needed" and "logged in on med. sheet" instead of detailing the medications and reasons for the medications.

### 4.02 Suicide Prevention

Satisfactory
  Limited
  Failed

#### Rating Narrative

Youth and Family Alternatives has a written policy related to Suicide Prevention, titled "Mental Health, Substance Abuse, and Suicide Risk Screening" dated 5/2009.

Youth and Family Alternatives as a Florida Network approved suicide risk assessment, with an approval date of 8/22/2011.

Youth and Family Alternatives also shared a policy revision is in process, with a new policy titled "Suicide Prevention" in development. The new policy is being generated through the Risk Management department. The new policy in development includes utilization of the Florida Network approved suicide risk assessment tool.

A total of five files were reviewed for this standard, with each of the youth reviewed being placed on "Watch" due to risk of suicide.

All five of the files did include an initial screening for suicide risk during the screening and intake process, by using the 6 questions on the CINS/FINS Intake form.

Of the five files reviewed, four of the youth were not seen by a mental health professional within the 24/72 hour requirement, as outlined in QI Standard 4.02 and Florida Network Policy 3.02, Identification of Suicide Risk in Shelter.

One of the five files did not contain documentation of the approved suicide risk assessment documents being completed. During a verbal interview with the counselor on 1/31/13, it was confirmed the approved suicide risk assessment forms were not completed at intake and the full suicide risk screening process was not completed. Due to the paperwork not being completed as required, the youth was not placed on watch and the shift documentation of the youth being on Constant Sight and Sound was not completed as required.

Two of the five files reviewed did not include a supervisory signature on the risk assessment.

Two of the five files reviewed were missing the documentation of the youth being on Constant Sight and Sound "Watch". One file was missing 5 watch sheets and one file was missing 24 watch sheets.

#### 4.03 Medications

Satisfactory

Limited

Failed

##### Rating Narrative

The agency had a written policy called Risk Management (RM) 785 Medication Control and Management procedures that addressed the safe and secure storage, access, inventory, disposal and administration of medication in accordance with the DJJ Health Services Manual. The agency had a posted list of staff members that are permitted to assist in the delivery of medications and limited access to controlled substances (narcotics). This list was provided and posted on the outside of the metal medication cabinet.

Observations found all medication was stored in a separate room behind two (2) locks not including the lock to the medication room. The actual location of where medications are stored included a double locked metal cabinet that was affixed to the back wall. This room is co-located with metal cabinets that house agency client files. This room is inaccessible to residents. Youth are provided medication through a half-door with a service tray. Oral medications were not stored with topical medications. The shelter had a secured refrigerator designated for medication only. The refrigerator was empty at the time of the review. The agency provides a total of twenty-two (22) over-the counter medications. A perpetual inventory with running balances was maintained for all medications. All prescribed medications are counted three times per day. At the time of the review, there were no CINS/FINS youth taking narcotic or controlled medications. One youth was taking an over the counter sleep aid prescribed by a doctor and a multivitamin. One is taken in the morning and the sleep is taken prior to be time. The second youth in the shelter was taking an antibiotic three (3) times per day for 10 days. Sharps are required to be maintained at the shelter consists of scissors and razors. The shelter had an inconsistent record of documenting sharps at each shift change for the last six (6) months.

Shift-to-shift counts of all prescribed medications are conducted three (3) times per day on each shift. A perpetual inventory is maintained, and documented for controlled and prescribed medications. Sharps are maintained in a locked cabinet in a cabinet in the office adjacent Assistant Program Director Office. Scissors are maintained in the separate room with shelter supplies. The program utilizes the YFA Prescription Medication Log (PML) Sheet. The PML contained all the necessary information to include: youth's name (printed and signed), date of birth, allergies, side effects, picture of youth, staff members and youth initials on PML when medication is disbursed and received.

The agency had a posted list of staff members that are permitted to assist in the delivery of medications and limited access to controlled substances (narcotics). The list provided did not provide all the training dates of staff listed and was not signed by the Program Director of another designated individual.

A review of the DJJ Central Communication Center (CCC) reports indicate medication incidents that include a total of five (5) medication errors in the last 6 months. A request was made for any documented evidence of follow up by the agency as a result of medication errors. Agency management provided follow up for staff with deficiencies regarding other program issues, but no documented follow up or corrective action that specifically addressed medication exceptions. Written corrective action was documented and reviewed for search, contraband and supervision.

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

The agency provided documentation for sharps counts for the months of August 2012, one week in September 2012, three (3) weeks in October and no counts for November 2012, December 2012 and one (1) week of counts in January 2013.

A review of agency practice revealed that the agency is accepting outside over the counter medications from residents without a doctor's order.

#### 4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

##### Rating Narrative

The program has a written policy and procedure for medical and mental health alerts that contains all the required elements but it needs to be updated to current practice.

When a youth is admitted to the shelter, information gleaned from the intake process concerning medication, medical or mental health conditions is recorded in the log book coded with a letter, the guide to which is in the front of the log book. The letter codes are also used on the census board in the shelter for an easy reference point for incoming staff. Alerts are repeated in the log book at the beginning of each shift. When a youth is taken off a mental health alert, it is recorded in the log book.

Relevant alerts were observed in the case file, log books and on the client boards.

Recommendation: Colored alert pages should be dated and should contain more information about the specific threat identified in the alert. Generally, the alert contains the general topic area (ie "mental health", "substance abuse", etc) but contains no other information that would help staff to recognize and respond to the need for emergency care and treatment. In addition, the case file alert system utilized is to indicate the alert on a colored piece of paper on the top sheet of the file, however it was noted that this paper frequently tears loose from the file and could be easily lost particularly when the file becomes thick.

#### 4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

##### Rating Narrative

A written policy and procedure for episodic and emergency care is in place and is complete and detailed.

The program maintains a first aid and emergency care log in which all instances of administering first aid, calling 911 for medical care, or transporting a youth to an emergency room.

None.