



**QUALITY IMPROVEMENT
PROGRAM REPORT
FOR**



***Youth and Family Alternatives, Inc.*
Runaway Alternatives Project
RAP House Youth Shelter**

**7522 Plathe Road
New Port Richey, FL 34653
(Local Service Provider)**

***Review Date(s):
April 11-12, 2012***

CINS/FINS Rating Profile

Program Name: **Runaway Alternatives Project (RAP House)**
 Provider Name: **Youth and Family Alternatives, Inc.**
 Location: **Pasco / Circuit 6**
 Review Date(s): **April 11-12, 2012**

QA Program Code: **N/A**
 Contract Number: **V2021**
 Number of Beds: **09**
 Lead Reviewer : **K. Carr**

Indicator Ratings

1. Management Accountability		
1.01	Background Screening of Employees/Vol.	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	Limited
1.06	Disaster Planning	Satisfactory

% Indicators Rated Satisfactory Compliance: 50%
% Indicators Rated Limited Compliance: 50%
% Indicators Rated Failed Compliance: 0%

3. Shelter Care/Health Services		
3.01	Shelter Care Requirements	Satisfactory
3.02	Healthcare Admission Screening	Satisfactory
3.03	Suicide Prevention	Limited
3.04	Medications	Satisfactory
3.05	Medical/Mental Health Alert Process	Satisfactory
3.06	Episodic/Emergency Care	Satisfactory

% Indicators Rated Satisfactory Compliance: 83%
% Indicators Rated Limited Compliance: 17%
% Indicators Rated Failed Compliance: 0%

2. Intervention and Case Management		
2.01	Screening and Intake	Satisfactory
2.02	Psychosocial 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

% Indicators Rated Satisfactory Compliance: 100%
% Indicators Rated Limited Compliance: 0%
% Indicators Rated Failed Compliance: 0%

Overall Rating Summary

Satisfactory Compliance:	78%
Limited Compliance:	22%
Failed Compliance:	0%

Methodology

This review was conducted in accordance with FDJJ-1720 (Quality Assurance Policy and Procedures), and focused on the areas of (1) Management Accountability, (2) Intervention and Case Management, and (3) Shelter Care/Health Services, which are included in the Children/Families in Need of Services (CINS/FINS) Standards (July 2011).

Persons Interviewed

- | | | |
|--|--|--|
| <input checked="" type="checkbox"/> Program Director | <u> 2 </u> # Clinical Staff | <u> 3 </u> # Other (listed by title): <u>VP</u> |
| <input checked="" type="checkbox"/> DJJ Monitor | <u> </u> # Food Service Personnel | <u>Prevention, Non-Res PD, Offc</u> |
| <input type="checkbox"/> DHA or designee | <u> </u> # Healthcare Staff | <u>Specialist II</u> |
| <input type="checkbox"/> DMHA or designee | <u> </u> # Maintenance Personnel | |
| <u> 2 </u> # Case Managers | <u> 2 </u> # Program Supervisors | |

Documents Reviewed

- | | | |
|---|--|--|
| <input type="checkbox"/> Accreditation Reports | <input checked="" type="checkbox"/> Fire Prevention Plan | <input 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 | <u> 4 </u> # Health Records |
| <input checked="" type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | <u> 0 </u> # MH/SA Records |
| <input type="checkbox"/> Contract Monitoring Reports | <input type="checkbox"/> PAR Reports | <u> 18 </u> # Personnel Records |
| <input type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | <u> 14 </u> # Training Records/CORE |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | <u> 4 </u> # Youth Records (Closed) |
| <input type="checkbox"/> Escape Notification/Logs | <input type="checkbox"/> Sick Call Logs | <u> 21 </u> # Youth Records (Open) |
| <input type="checkbox"/> Exposure Control Plan | <input type="checkbox"/> Supplemental Contracts | <u> 2 </u> # Other: <u>Group & Case</u> |
| <input checked="" type="checkbox"/> Fire Drill Log | <input checked="" type="checkbox"/> Table of Organization | <u>Staffing Binders, 1 Grievance</u> |
| <input checked="" type="checkbox"/> Fire Inspection Report | <input type="checkbox"/> Telephone Logs | |

Surveys

- | | | |
|-----------|-----------------------|------------------|
| 3 # Youth | 3 # Direct Care Staff | 0 # Other: _____ |
|-----------|-----------------------|------------------|

Observations During Review

- | | | |
|---|--|--|
| <input checked="" 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 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 checked="" type="checkbox"/> Treatment Team Meetings |
| <input checked="" 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 checked="" 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 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

The Bureau of Quality Improvement wishes to thank the following review team members for their participation in this review, and for promoting continuous improvement and accountability in juvenile justice programs and services in Florida:

Keith D. Carr, Lead Reviewer, Principal Consultant, Forefront LLC
Kirstie Naoom, Quality Improvement Review Analyst, DJJ Bureau of Quality Improvement
Latrice Covington, Prevention Contract Manager, Office of Prevention and Victim Services
Nicole Hartsock, Program Director, Sarasota YMCA

Please note that this report refers to each indicator by number and title only. Please see the applicable standards for the full text of each indicator. The standards are available on the Bureau of Quality Improvement website, at <http://www.djj.state.fl.us>.

Strengths and Innovative Approaches

Youth and Family Alternatives (YFA), a private not-for-profit organization that has headquarters in New Port Richey, Florida. YFA provides a broad array of services to children, youth and families throughout Central Florida. YFA service offerings include Family Help, Youth and Family Crisis Shelters, Foster Care, Adoption Services, Family Intervention Team Services, CASA (Child Adolescent Substance Abuse), Youth Empowerment Services and Street Outreach services. The agency has multiple programs and services in several counties. These counties include Citrus, Hardee, Hernando, Highlands, Hillsborough, Lake, Manatee, Marion, Osceola and Pasco.

The agency as a whole is updating all of its shelters with major renovation plans to add update each facility with priming, new painting, flooring, as well as other cosmetic and physical changes. These updates have begun and will continue to occur over the next several months.

Youth and Family Alternatives is certified by the Council of Accreditation (COA). The Council on Accreditation (COA) partners with human service organizations worldwide to improve service delivery outcomes by developing, applying, and promoting accreditation standards.

The YFA-RAP House site has access to a licensed mental health counselor that provides consultation and expertise on all major mental health and suicide risk related issues that occur in its residential and non-residential program. Andy Coble, Vice President of Prevention is accessible to the agency's residential and non-residential CINS/FINS staff members. In addition, the agency has an additional Non-Residential staff member that is s LMFT.

The agency has also utilizes some training through web-based training services that offers an array of training options for staff members to complete through online learning systems.

The program is involved with the National Safe Place Program, and monitor mobile and stationary safe place sites throughout their catchment area. Additionally, the program has several other funding sources for program services that it provides to the community. YFA service offerings include Family Help, Youth and Family Crisis Shelters, Foster Care, Adoption Services, Family Intervention Team Services, CASA (Child Adolescent Substance Abuse), Youth Empowerment Services and Street Outreach services.

The agency has revised its Behavior Management System by utilizing components of Advancing Youth Development, Character Counts and the Boys Town BMS. The agency has been working the Florida Network's trainer on the development of this system and on conducting training sessions on the new system with all staff members and has also created new forms for the updated BMS system.

The agency has recently completed its annual RAP River Run fundraiser. The agency has been working with local partners to through its Cooks for Kids program, Wells Fargo, Bank of America and has recently partnered with the local Panera Bread Company. The agency also partners with several groups to work with their program including Prodigy Art.

The agency also conducts parenting courses for status offenders and youth in diversion programs.

Standard 1: Management Accountability

Overview

The Runaway Alternatives Program (RAP House) operates and provides CINS/FINS residential shelter and non-residential services for youth and their families in Pasco County. The RAP House program is under the leadership of Heath Numbers, Program Director. Ms. Heather Numbers who oversees the day-to-day operations of the Residential program. Carolyn Kehr, Non-Residential Program Director oversees the Non-Residential program. Both Ms. Numbers and Mrs. Kehr report to Andy Coble, Vice President of Prevention and the CINS/FINS Residential and Non-Residential Programs. Mr. Coble reports to George Magrill, President and CEO. Other positions include residential staff members that are assigned to the youth shelter and include 1 Residential Supervisor, 1 Youth Care Specialist IV, 1 Youth Care Specialist II, 1 Therapist I, 1 Therapist II, 1 Counselor II, 12 Youth Care Workers and 1 Office Specialist II. In addition to the residential program, the non-residential component has a Director, 1 Therapist, 1 Counselor II, 1 Court Liaison, 1 Office Specialist and 1 Office Specialist II. At the time of this program review, there are no official volunteers listed by this agency on the organization chart. At the time of the quality improvement review, there are four (4) vacancies listed on the agency's organizational chart. The residential shelter lists one (1) vacant full time Youth Care staff vacant position, 1 vacant part-time Youth Care position and vacant part time Youth Care staff position. The Non-Residential program lists 1 counseling position in Dade City service area this is vacant.

The agency operates a total of three (3) youth shelters and the company handles all personnel functions are executed through its Human Resources division located at its central office in New Port Richey Florida. This office processes all state and local background screenings. The provider agency conducts orientation training to all shelter personnel through its Residential Supervisor. The majority of core trainings are also provided by the Florida Network trainer. Each employee has a separate training file containing a training plan and copies of documentation for training received.

The shelter has been licensed by the Department of Children and Families to provide runaway and emergency shelter services, with the current license in effect until August 9, 2012. Youth and Family Alternatives, Inc. is Accredited by the Council on Accreditation (COA). The agency's current COA Accreditation is active through October 2012. The program's Continuity of Operations Plan (COOP) was approved by the Florida Network in May, 2011.

Annual training is tracked according to the employee's date of hire. An individual training file is maintained for each employee, which includes supporting documentation such as sign-in sheets and certificates. The program has a designated trainer on staff to assist in ensuring that all staff members are trained on an annual basis.

The agency utilizes an internal disciplinary procedures and actions policy. This policy uses a graduated process that contains various methods of progressive discipline.

1.01: Background Screening of Employees/Volunteers

Satisfactory Compliance

The agency has a policies and procedures manual that addresses background screening of employees and volunteers and five (5) year rescreening requirements. The current policy indicates that it was last updated in 2009. The agency has a separate Human Resources department that is responsible for all screening prior and during employment. All files were highly organized in a six-

section file folder.

A total of ten (10) employee personnel files were reviewed to determine the agency's adherence to DJJ Standard 1.01. Of these files, eight were new or recently hired staff members. Of these files, all 8 had background screenings that were completed prior to their hire date. The two (2) On-going staff member files reviewed both contained screening results that were received after their five (5) year anniversary dates. Both of these files had documentation that indicates that each staff member's screening results were submitted by the agency to the DJJ Background Screening Unit shortly before their 5 year anniversary dates.

Each employee personnel file contains evidence of local law enforcement and National Crime Information Center criminal background check and Hire Right background screening checks. The agency has also demonstrated and provided evidence that the Annual Affidavit of good moral character has been sent to the DJJ Background Unit prior to the January 31 deadline.

1.02: Provision of an Abuse Free Environment

Limited Compliance

The program has posted the Florida Abuse Hotline number at various locations throughout the facility and informs youth of these procedures during program orientation and in the Resident Handbook. Further, the agency's staff members receive a copy of the employee handbook that also includes the agency's Code of Conduct upon hire. A review of all internal incidents and internal disciplinary actions was conducted onsite.

This reviewer assessed all reported DJJ-Central Communications Center incidents reported and all documented internal incidents. The agency utilizes its internal disciplinary procedures and actions process. This policy uses a graduated process that contains various methods of progressive discipline. The agency's Progressive Discipline Process includes Verbal Correction, Written Disciplinary Counseling, Administrative Leave, Final Written Warning and Termination of Employment steps. This policy also includes a Performance Improvement Plan that focuses on Measurable/Tangible Improvement goals, Provision of Training or Special Direction, Interim performance Evaluation and Employee Assistance Program. The program also includes a Personal Improvement Plan that incorporates input and suggestions. The reports also specify the type of action that included a written either Verbal Correction, Written Disciplinary Counseling, Administrative Leave, Final Written Warning and Termination of Employment.

A total of eight (8) internal reports that addressed employee behavior related or work performance issues were reviewed. Of these reports, all were associated with employee work performance and included written summary documentation of the reason for the report and a formal response to the employee from the Program Director. Two (2) of these reports indicate the agency's decision to terminate employment. One case involved deficient supervision practices that led to an alleged sexually acting out incident between 2 residents. At the time of this review, this incident is under an open and on-going administrative review by the DJJ Office of the Inspector General and a program review by the DJJ Office of Prevention and Victim Services. The male youth in this case was taken into custody by Sheriff's Office and processed in the Juvenile Alternative Center. The other incident involved a staff member that was terminated for using confirmed harsh, inappropriate language that included cursing directed at youth. Other cases involve a staff member that was cited for deficient supervision practices on multiple occasions that could lead to an event that could potentially harm youth under the program's care.

A total of three (3) youth survey and three (3) staff member surveys were recorded during this onsite program review. Similarly, no incidence of youth being deprived of basic needs or abused by program staffs was reported during youth surveys conducted during the review or observed during the visit.

1.03: Incident Reporting

Satisfactory Compliance

The agency has a comprehensive incident reporting policy that addresses the agency procedures regarding all reportable incidents. The current policy requires that all eligible incidents to be reported to the Department's Central Communications Center (CCC) within two (2) hours of the incident.

A total of ten (10) incidents were recorded since the last onsite DJJ QA review. Of these nine (9) out of 10 were reported within the 2 hour time requirement. The incidents include a range of issues including court ordered absconds, medication errors and alleged consensual sexual contact between residents. Several incidents required the agency to implement disciplinary action. Two (2) out of 10 incidents are currently engaged in open and on-going administrative review by the DJJ Office of the Inspector General and a program review by the DJJ Office of Prevention and Victim Services.

Several other internal incidents that have occurred in the agency are documented. These incidents were also reviewed. None of these incidents reviewed onsite required further reporting to the DJJ CCC. The current incident reporting policy was last updated in 2009.

1.04: Training Requirements

Limited Compliance

The agency has a training policy (1.06 and 1.07) that addresses all major training requirements. The policy addresses requirements for first year and on-going staff members. The policy was last reviewed and updated 3 years ago in 2009. The policy requires agency staff members to achieve a total of eighty (80) hours for all new hires and complete a minimum of forty (40) hours for all On-going full-time, Part-time and On-call agency staff members. The agency utilizes a dedicated staff person to provide training to residential employees.

A total of eight (8) new/recently hired and four (4) On-going staff member files were reviewed to determine the agency's adherence to the DJJ QI training standard. Of the 8 new or recent hire training files reviewed, all 8 have evidence of some completed initial orientation and other required topics. Of the 4 On-going files, 1 of the four (4) files has the majority of training required to meet the annual training requirement. The remaining three (3) files lack clear records and documentation to indicate that these staff members have met the annual On-going staff member training requirement of 40 hours. While onsite, the review provided the agency with the names of the staff member training file under review to give the agency the opportunity to provided any other information to mitigate the initial findings. The agency provided an updated training log for all 4 On-going training files under review. Only 2 out of four (4) had evidence of training documentation to verify meeting the annual requirement (103 and 33 training hours respectively). The remaining 2) On-going training files did not meet the annual training requirement.

1.05: Interagency Agreements and Outreach

Limited Compliance

The agency's interagency agreements were presented for review of current agreements and

outreach efforts. The reviewer of this standard assessed all interagency agreements presented by the service provider.

The agency collaborates with the Pasco County Sheriff's Office to provide domestic violence counseling. The agency provides parenting classes to the community. However, at the time of this program review there no documentation to support evidence of these activities. The agency documents outreach activities in NETMIS. There was no documentation of interagency agreements for services for alcohol and other drugs use/abuse; adolescence/adolescent behavior; and youth educational issues. There were two (2) interagency agreements that appear to be old and had no dates.

1.06: Disaster Planning

Satisfactory Compliance

The program has a comprehensive Disaster and Emergency Plan/manual and the organization is in line with the all standards of 1.06 Disaster Planning. The program has a comprehensive Emergency Response Plan that was reviewed by the FNYFS on May 26, 2011.

The current Disaster and Emergency Plan includes: 1) all of the required types of emergency situations; 2) evacuation sites for the shelter; 3) meeting sites on the outside of the building in the event of evacuation; 4) evacuation routes to ensure safe and secure transportation; 5) checklist of all appropriate and necessary equipment; 6) staff contact list; and 7) notification procedures to the Florida Network and other funding sources/agencies.

The YFA-RAP House Disaster Preparedness Plan is posted at specific exit points throughout the youth shelter. The program participates in the Universal Agreement for Emergency Disaster Shelter with the Florida Network Member Agencies. Disaster storage practice and supplies were observed.

The plan has procedures related to various emergency disasters such as hurricane, tornado, flooding, rioting and others. The plan also has procedures regarding bringing food, medication, log books, cell phones, radios and other necessities. The emergency disasters supplies are checked and updated by the end of April each year.

Standard 2: Intervention and Case Management

Overview

Youth and Family Alternatives RAP House service region provides both shelter and non-residential services for youth and their families primarily in Pasco County. The YFA RAP House Non-Residential service region program component consists of 1 Director, 1 Therapist, 1 Counselor II, 1 Court Liaison, 1 Office Specialist and 1 Office Specialist II. The counselors are responsible for providing case management services and linking youth and families to community services. The YFA Non-Residential program coordinates the Case Staffing Committee, a statutorily-mandated committee that develops a treatment plan for habitual truancy, lockout, ungovernable, and runaway youth when all other services have been exhausted or upon request from the parents/guardians. The Case Staffing Committee can also recommend the filing of a CINS Petition with the court as needed. The Non-Residential program also conducts parent assistance sessions through the Why Try program to families receiving CINS/FINS services.

Residential counseling services, including individual youth, family and group services. A psycho-social assessment is conducted on all youth admitted to the program. Other mental health assessments are also conducted on an as needed basis. If needed youth are referral to local area mental and substance abuse agencies that parent with YFA. Case management and substance abuse prevention education are also offered to residential clients. Aftercare planning includes referring youth to community resources, on- going counseling and educational assistance. The youth shelter staff members include a Program Director, Residential Program Supervisor, Therapist (1), Counselor, Youth Care Specialist (2), Direct Care staff members (12) and an Office Specialist. The Direct Care workers are responsible for completing all applicable admission paperwork, orientating youth to the shelter, and providing necessary supervision and assistance throughout the duration of each resident's shelter stay.

2.01: Screening and Intake

Satisfactory Compliance

A review of the agency's policy and procedures for psychological assessment was conducted and was found to be inclusive of all components required by Standard 2.02. A total of six (6) residential and four (4) non-residential files were reviewed for adherence to this standard. Ten (10) out of 10 files documented that eligibility screenings were being completed within the seven (7) day requirement. The majority of these screenings were referrals to screenings to initiating contact were completed the same day. Ten (10) out of ten files document that youth and parents are receiving services options, rights and responsibilities and grievance procedures. Nine (9) out of 10 file document parents receive the parent brochure. The one (1) file that doesn't have documentation has the parents initial that it was received but not checked yes or no.

2.02: Psychosocial Assessment

Satisfactory Compliance

A review of the agency's policy and procedures for psychological assessment was conducted and was found to be inclusive of all components required by Standard 2.02. A total of six (6) residential and four (4) non-residential files were reviewed for adherence to this standard.

Eight (8) out of 10 files documented the psycho-social assessment was completed within 72 hours or 2 to 3 face-to-face visits. The two files without the psycho-social assessments entered the shelter within the past two days.

All the psycho-social assessments were completed by master's level staff and has supervisor signature. Two of 10 files documented an elevated risk of suicide on the psycho-social assessment and an assessment of suicide risk was conducted under the supervision of a licensed mental health professional.

2.03: Case/Service Plan

Satisfactory Compliance

A review of the agency's policy and procedures for case/service planning was conducted and was found to be inclusive of all components required by Standard 2.03. A total of six (6) residential files were reviewed for adherence to this standard. All were developed within the

required seven (7) working days of completion of the assessment. All of the case/service plans identified goals, including frequency, persons responsible, target dates, and date plan was initiated.

All required signatures were found on all case/service plans. Due to all the files being open and on-going cases, there were no completion dates found. However, they were properly marked as %continued+and %revised.+ There was one exception found in this standard. One (1) of the six (6) files did not have any documentation of 30, 60, 90 day reviews. The date of the case plan was initiated on 11/21/2011 and target date set for 12/21/2011, however no evidence in file of the 33, 60, 90 day review being completed.

2.04: Case Management and Service Delivery

Satisfactory Compliance

A review of the agency's policy and procedures for case management and service delivery was conducted and was found to be inclusive of all components required by Standard 2.04. In accordance with this standard all the files indicated a counselor was assigned to ensure delivery of services for each youth. The files were well organized and maintained. A total of four (4) client files were reviewed. All files contained documentation of referrals being given as needed for mental health conditions and case staffings. Documentation was included to show that the liaison attend court with youth and parent. When youth were placed out of home in the shelter, the documentation showed constant communication from the counselor. Three (3) of the four (4) files had documentation to show the family was being provided support and progress was being monitored.

There was one exception found in this standard. One (1) file shows no documentation of support or progress of the youth and family since 03/09/2012. Prior to this date there was consistent documentation of attempts at or contract made. This includes attending counseling sessions and case staff.

2.05: Counseling Services

Satisfactory Compliance

A review of the agency's policy and procedures for counseling services was conducted and was found to be inclusive of all components required by Standard 2.05. A total of six (6) client files were reviewed for adherence to this standard. Of these files, 4 were non-residential and 2 residential. All files reviewed demonstrate that counseling services are being provided in accordance with youth's case/service plan. Individual and family counseling is provided through the shelter and non-residential programs. The agency's group log was received and group counseling sessions are occurring five (5) days a week. All case files reflect coordination between presenting problems, psycho-social assessments and case/service planning. The youth's progress is maintained in chronological case notes in all files reviewed. All files indicate that the agency has a process in place to maintain confidentiality as required.

One (1) out of two (2) files reviewed did not have 30 or 60 day reviews of case/service plans. The agency has a new counselor in place and an updated case/service plan with completed on 04/10/2012. The reviewer verified that the documentation demonstrates an on-going process where program supervisors are reviewing the case records and youth management.

A review of the agency's policy and procedures for the adjudication/petition process was conducted and was found to be inclusive of all components required by Standard 2.06. A total of three (3) Case Staffing files were reviewed. The agency has a designated case staffing binder. All files and the Case Staffing binder were well organized and all required documents were easy. Upon the initiation of the Case Staffing the families and committee are notified within the required timeframe. All files reviewed contained a review summaries completed prior to the court hearing.

Evidence of documentation showed that the youth and family were provided with updated revised plan following Case Staffing. The documentation demonstrated consistent attendance of mental health, school district, law enforcement, and DJJ representation.

Standard 3: Shelter Care/Health Services

Overview

The YFA Rap House youth shelter is licensed by the Department of Children and Families (DCF) for eighteen (18) beds and it primarily serves youth from Citrus, Hernando and Sumter Counties. The shelter also provides services to youth referred to them from the Department of Children and Families. The shelter building includes a large day room, dormitory, dining room, kitchen, laundry, staff offices, and conference rooms. During the quality assurance review, the shelter was found to be in good condition and the furnishings in good repair, and the rooms and common areas were clean. The dormitory is divided into two separate areas, one for the boys and one for the girls. There are 2 bathrooms on each dorm wing. The sleeping rooms house two youth each; each youth has an individual bed, bed coverings and pillows. In addition, the youth have access to a recreational games, volley ball court and basketball. This youth shelter is not designated by the Florida Network of Youth and Family Services to provide staff secure services.

The youth care workers are responsible for processing new admissions, and providing orientation of youth to the shelter; the supervision of youth; and for maintaining inventories on all sharps and medications. Youth care workers also assist in the self-administration of prescribed and over-the-counter medications, and administer first aid when needed. Disaster plans, knife-for-life, wire cutters, and first aid kits are located in multiple locations throughout the facility, to include the staff station, medication room, and kitchen. All medications are stored in a locked cabinet in a dedicated medication room. The program's behavior management system consists of four (4) levels (Orientation level, Level C, B and A (Honor Level)). Youth start on the orientation level and advance up or down the levels depending on the total number of points accumulated each day; and privileges are based on the youth's level.

Oversight of mental health services are provided by the Vice President of Prevention, who is a Licensed Mental Health Clinician (LMHC), one Masters level Program Director and one Master's level therapist and one Bachelor's level counselor. The RAP House shelter also has access to a Master's level Licensed Family Therapist. Youth admitted to the program are screened using the CINS/FINS Intake Form. If a youth answers "yes" to any of the six questions pertaining to suicide risk on the CINS/FINS Intake form, an Assessment of Suicide Risk is completed. A medical and mental health alert system is in place.

Groups are scheduled to be conducted on a minimum of 5 days a week. The RAP House Shelter has also partnered with several local businesses and community partners that donate baked goods and prepared hot meals onsite in the shelter kitchen to the CINS/FINS program participants.

3.01: Shelter Care Requirements

Satisfactory Compliance

A review of the agency's policy and procedures for screening and intake was conducted and was found to be inclusive of all components required by Standard 3.01. The agency is not a staff secure program per their contract with the Florida Network of Youth and Family Services.

A total of four (4) open CINS/FINS residential client files were reviewed to assess this indicator. Of these files, all client files have evidence of each resident receiving a comprehensive orientation with the 24 hours time requirement following admission. All case files reviewed have evidence that residents received Youth Rights information, Grievance Procedure and a cross section of process information. Specifically, the youth receive a handbook that outlines their rights and responsibilities and formal grievance process, which are also posted on a bulletin board in the common area, as well as program rules and expectations. The grievance box is full with blank forms and posted in common areas and accessible to all shelter residents.

The agency has an overnight bed check policy. The current policy requires that all resident bedrooms and residents be admitted to the youth shelter be checked via visual observation and documentation no more than 15 minutes. The agency requires that all overnight staff members conduct bed checks thorough the overnight work shift. A review of agency documentation for nineteen (19) randomly selected overnight work shifts was selected. Each individual bed check is conducted by the Youth Care Worker on duty. The monitor reviewing this indicator reviewed bed check shift logs from August 2011 through February 2012. At the time of this onsite review, all bed check documentation reflects a consistent accounting of count on average less than 13 minutes on the overnight shift. Bed checks are not written in real-time. Bed check entries are documented between 10-15 minute intervals such as 12:00 am, 12:15am and 12:30am. In addition, the schedule reflects compliance with at least one male and one female staff member is scheduled to work on each overnight shift.

3.02: Healthcare Admission Screening

Satisfactory Compliance

The program has a health screening form that is used at the time of admission to the shelter. Non-Health Care staff complete the health screening form. The health screening form includes: Client Information, Child Abuse Screening, Mental Health Screening, Substance Abuse Screening, Medical Needs, Staff Observation of Client at Intake, and Parent Notification. The program has written procedures identifying health care screenings and referral. The program utilizes an alert list and alert board to identify youth's health concencers to include: medications, allergies, and medical issues.

A review of six (6) youth files for admission healthcare screenings indicated that all six files contained a healthcare screening. Healthcare screening forms contained all required elements; however the form did not include a place for the name of the youth. One youth's screening form indicated youth sustained a burn to his arm two weeks from admission date. There is no documentation on the screening form that indicates that a medical referral was not needed and/or that follow-up was or wasn't needed with medical provider and coordination with parent.

The program has a suicide risk screening operating procedure that indicates staff are to utilize the CINS/FINS Intake Form and Health Screening Form to screen for any potential suicide risk/ideation. Screenings are conducted during the intake process. Suicide screening results are to be reviewed and signed by the supervisor and documented in the youth's case file. Youth are to be placed on sight and sound supervision until assessed by a licensed professional or non-licensed under the direct supervision of the licensed professional.

A review of five files for suicide prevention indicated that four of the five files contained a suicide risk screening. Suicide screening for one youth indicated that youth was placed on sight and sound supervision on 3/23 for a hit to question #5 (didn't care if you lived or died) no explanation was provided on the form as required. Sight and Sound logs contained write overs on dates 03/23/2012 and 03/24/2012. Progress notes do not indicate that youth was placed on sight and sound until 03/26/2012 when the youth was assessed by the counselor. Another youth's intake screenings (2 screenings completed on same date by same staff, however had conflicting documentation) indicated that the youth was Baker Acted 2 months ago and had recently burned his arm on a dare, is on psychotropic medications, and diagnosed as bipolar. Suicide Risk Screening indicated no to all seven questions, however based on the intake screening information, the youth was to be placed on sight and sound supervision immediately, youth was not placed on S&S until 04/10/2012 at 11:35 am, which was several hours following intake (12:55am on 4/9). One youth's suicide screening results were not reviewed and signed by the supervisor as required and/or documented in the case notes. The youth indicated yes to extremely sad, hopeless or depressed and yes to extremely worried, there was no explanation to support the indication of yes as required on the form. Another youth's suicide screening results indicated a yes for questions 5-7, aside from one of the affirmative responses, no others were explained further. Youth's sight and sound supervision logs indicated missed checks from the times of 12:00am-12:35am on 03/21/2012 and 11:55pm on 03/27/2012 to 12:35am on 03/28/2012. Youth Brittany was placed on sight and sound supervision at intake and an initial assessment for suicide was completed by the counselor on 03/20/12, the results indicated the youth was to remain on the elevated level of supervision of sight and sound. The youth was re-assessed by the counselor on 03/23/2012 and a voice mail message was left for the LMHC to confer with follow-up recommendation to continue youth on sight and sound supervision. There was no documentation to support that the LMHC, returned the call and/or to provided instructions or conferred with the unlicensed counselor until a follow-up assessment was completed on 03/29/2012, 6 days later. Based on incident findings and review of video recordings on 03/28/2012 @ 9:28pm to 9:31pm sight and sound supervision checks and location of youth were not accurately documented, as youth was not in the dining area as indicated on the supervision log, during the incident.

Sight and sound supervision logs are not completed in real time not to exceed five minutes. One (1) youth's sight and sound supervision log on 3/29/2012 indicated that times are pre-populated and checks are not completed in real time, as the youth was removed from the facility by law enforcement at 6:35pm and times were written in on the log until the youth returned at 7:00pm.

3.04: Medications

Satisfactory Compliance

The program had a list delineated in writing of staff that are designated to have access to secured medications, and limited access to controlled substances. All medications in the shelter are stored in a separate, secure area, which is inaccessible to youth. Oral medications are stored separately from topical medications. There were no injectable medications on site, or identified as needed for any youth during the time of the review. The shelter has a system in place for refrigeration of medication if needed, however there was no medication that required refrigeration

during the time of review. Controlled medications are locked in a cabinet behind two locks. Shift-to-shift counts, and a perpetual inventory is maintained, and documented for controlled and prescribed medications. Sharps are maintained in a locked cabinet. Scissors are maintained in the Residential Supervisor's office. The program utilizes the DJJ Medication Administration Record (MAR). The MAR contained all the necessary information to include: youth's name (printed and signed), date of birth, allergies, side effects, picture of youth, staff and youth initials on MAR when medication is dispensed and received. Shift to Shift count for psychotropic medication for one youth's Seroquel 100mg medication count was off for the 04/12/2012 shift to shift inventory. Staff counted medication prior to 8-4 shift therefore count was off by one pill. Over the counter medications that are accessed regularly are inventoried weekly on a perpetual inventory. Inventory log for acetaminophen from February and March 2012 indicated that two tablets were administered and not documented as required. A CCC incident dated 09/30/2011 indicated a staff member gave a youth the incorrect psychotropic medication, which was supposed to be discontinued.

3.05: Medical/Mental Health Alert Process

Satisfactory Compliance

The program has a medical, mental health alert system in place to ensure information concerning the youth's medical condition, allergies, common side effects of prescribed medications, and other pertinent mental health treatment information, is communicated to staff. The program utilizes an alert form that is in the youth's file; an alert board that is located near the administration hallway, and the facility logbook to document any new or updated alert notifications. All six (6) youth files reviewed for medical and mental health alert process indicated that youth were placed appropriately on alert if needed.

3.06: Episodic/Emergency Care

Satisfactory Compliance

The program has a facility operating procedure to facilitate the provisions of emergency medical and dental care to include obtaining off-site emergency services, parental notification and implantation of a daily log. The policy indicates that all staff is trained in emergency procedures to include First Aid and CPR. Two (2) of the four (4) staff files reviewed for on-going training requirements did not have documentation to support that staff were re-certified in First Aid and CPR as required. Knife, for-life and wire cutters were located in the laundry room. First aid kits are maintained throughout the facility and maintained by Zee Medical Supplies at least one time quarterly. Seven incidents were reviewed within the previous six months for Episodic Emergency

Care. Six of the seven incidents required off-site emergency medical care. One youth was provided first aid care at the facility by staff. Three (3) incidents contained documentation to support that staff notified the parent as required. Four (4) incidents did not (snorting controlled substance and 02/26/2012; first aid to groin area; pain in stomach-ER; and swallowing needle). All seven (7) incidents were documented and maintained in a log as required. One (1) incident indicated that the youth was taken to the hospital on 01/21/12 and supporting emergency care medical review documentation also indicated the youth received first aid on-site and sent to the ER on 01/21/2012, however CCC report confirmed that youth was taken to the hospital on 01/24/12.

Overall Rating Summary	
Satisfactory Compliance:	78%
Limited Compliance:	22%
Failed Compliance:	0%