



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of YFA-New Beginnings

on 04/04/2018

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

Percent of indicators rated Satisfactory: 85.71%
Percent of indicators rated Limited: 14.29%
Percent of indicators rated Failed: 0.00%

Standard 3: Shelter Care

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

Percent of indicators rated Satisfactory: 87.50%
Percent of indicators rated Limited: 12.50%
Percent of indicators rated Failed: 0.00%

Standard 2: Intervention and Case Management

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

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

Standard 4: Mental Health/Health Services

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

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

Percent of indicators rated Satisfactory: 85.19%
Percent of indicators rated Limited: 14.81%
Percent of indicators rated Failed: 0.00%

Rating Definitions

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

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

Review Team

Members

- Ashley Davies, Lead Reviewer/Consultant, Forefront LLC
- Tiffany Martin, Project Manager, Florida Network of Youth and Family Services
- Felicia Wells, Program Director, Youth Advocate Program
- Susan Yang, Shelter Supervisor, Boys Town of Central Florida
- Jason Kasten, Direct Care Supervisor, Arnette House

Persons Interviewed

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

Documents Reviewed

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

Surveys

5 Youth 5 Direct Care Staff

Observations During Review

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

Comments

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

Rating Narrative

Strengths and Innovative Approaches

Rating Narrative

YFA has restructured leadership in each region for all CBC and shelter programs in that designated region. YFA North consist of the Case Management contract with Kids Central Inc and the New Beginnings Youth Shelter (NBYS). Vice President of North Programs is Melissa Atkinson.

YFA has designated a Program Manager for NBYS and RAP House. The Residential Supervisor of RAP House was promoted to Program Manager for NBYS in March of 2018.

NBYS held an Open House for the public on March 1, 2018. It was very successful with close to thirty attendees coming out to tour the facility and learn about services provided by the shelter to the community. Attendees included the local Guardian ad litem program, Hernando County Sherriff's Office, DCF's Children's Legal Services, foster parents, parents, high school volunteers, members of local churches, and a guest from Representative Blaise Inglogia's office. Seventeen of the guests indicated they would like volunteer at the shelter and have the opportunity to support the agency's mission.

Standard 1: Management Accountability

Overview

Narrative

At the time of this onsite program review, the Youth and Family Alternatives (YFA) New Beginnings residential program employs a Shelter Manager, a Residential Supervisor, an Office Specialist, three Youth Development Specialist (YDS) Shift Leaders, one Residential Counselor, a Registered Nurse, and eight Youth Development Specialists that are both full-time and part-time. There was one counselor position vacant, the Residential Supervisor position was vacant, one Shift Lead position was vacant, and there were seven YDS positions vacant. The agency operates a Risk Prevention and Management Team Meeting that reviews various issues quarterly. This team is comprised of various YFA staff members. Youth and Family Alternatives, Inc. is accredited by the Council on Accreditation (COA).

1.01 Background Screening

Satisfactory

Limited

Failed

Rating Narrative

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

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

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

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

There were fourteen staff hired since the last on-site Quality Improvement Review. All fourteen staff received a background screening with a rating of "eligible" prior to being hired. At the time of the review, four of those staff no longer worked for the agency. There were no staff who required a five-year re-screening during this review period. The Annual Affidavit of Compliance with Level 2 Screening Standards was submitted on January 29, 2018.

There were no exceptions to this indicator.

1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

Rating Narrative

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

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

Clients are informed by staff that they have the right to have unimpeded access to the telephone in order to report if they have been mistreated.

Any allegations against staff are reported to Abuse Registry, CCC, and Program Director/Manager immediately. The Program Manager/Director takes all necessary measures to ensure safety of the youth. Procedure closes by stating failure to follow the above procedure will result in disciplinary action.

The program has a grievance process that is explained to the youth during the intake process. The grievance procedures given to the youth in the orientation packet direct the youth to give the completed grievance to a staff member to turn in. However, in practice the completed grievances are to be placed in the locked grievance box located in the dayroom or the one located outside the Program Manager's office. The grievance box being used had been recently replaced just prior to the on-site Quality Improvement review. The box that was being used was not locked and youth were complaining grievances that had been placed in the box were missing. This was box was replaced with a box that has a lock on it. The box is checked by the Program Manager.

There have been eleven grievances filed in the last six months. The program's policy is to address the grievances within twenty-four hours. Out of the eleven grievances, six were addressed by the Program Director within twenty-four hours. All six documented the resolution, if the youth agreed, the youth signature, the staff signature, and the date. One of the remaining five grievances was not addressed due to the youth being discharged the following day. Another grievance was addressed three days later due to the supervisor being out of the office. One grievance documented a resolution by the Program Director; however, did not document the date of the resolution, if the youth agreed, or the youth's signature. The remaining two grievances were filed on March 15, 2018 and still had not been addressed. The current Program Manager began at the program March 17, 2018 and reported both of these youth had already been discharged.

The program reported there have been no calls to the abuse hotline in the last six months relating to inappropriate treatment of the youth while in the shelter.

All youth surveyed reported appropriate procedures for access to the abuse hotline. The youth also reported being treated professionally and feeling safe in the shelter. All staff surveyed reported appropriate procedures for allowing the youth unimpeded access to the abuse hotline.

Exceptions:

One grievance was addressed three days later due to the supervisor being out of the office.

One grievance documented a resolution by the Program Director; however, did not document the date of the resolution, if the youth agreed, or the youth's signature.

Two grievances were filed on March 15, 2018 and still had not been addressed. The current Program Manager began at the program March 17, 2018 and reported both of these youth had already been discharged.

1.03 Incident Reporting

Satisfactory

Limited

Failed

Rating Narrative

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

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

There were nine CCC reports in the last six months. All were reported within the two-hour time frame. Out of the nine reports, eight required follow-up communication with the CCC and documentation the reports were completed and closed out. One report was regarding a missing key fob which was found the following day so no further documentation was needed for that report.

There was documentation that seven of the eight reports were closed and follow-up communication and tasks were completed as required by the CCC. The agency was unable to find any follow-up communication or documentation for one report. This report was completed under different leadership and the documentation could not be found. Seven of the nine incidents had a corresponding incident report completed and placed in a binder. All nine incidents were documented in the program's log book.

Exceptions:

Two CCC reports did not have a corresponding incident report.

For one CCC report, the program was not able to provide follow-communication with the CCC on completing and closing the case.

1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

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

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

There were three staff training files reviewed for training completed in the first year of employment. Only one staff met the 80-hour training requirement for the first year, with 169 hours. The other staff documented 65.5 and 29 hours, respectively. None of the three staff completed all required trainings in the first 120 days of employment. The staff were missing between one and seven required trainings in the first 120 days. In addition, two of the staff were also missing other trainings required to be completed during the first year of employment. These two staff were missing one and three trainings that were required. An additional training file was reviewed only for the first 120-day training requirement. This staff had only completed 6.5 hours of training during the first three months of employment. This staff had only completed one training, Confidentiality, required during the first 120 days and only has three weeks left to receive the additional eleven required trainings.

There was only one training file applicable for the annual training requirements. This staff documented more than the required 40 hours with 41.25 hours. All required trainings were documented.

The agency uses an on-line trainings system called Relias to track and maintain all trainings. Instructor led trainings only include the MAB training, medication training, and the CPR and First Aid training. Documentation of these trainings is maintained in the staff's personnel files located at the agencies Human Resources office.

Exceptions:

There were three staff training files reviewed for training completed in the first year of employment. Only one staff met the 80-hour training requirement for the first year, with 169 hours. The other staff documented 65.5 and 29 hours, respectively. None of the three staff completed all required trainings in the first 120 days of employment. The staff were missing between one and seven required trainings in the first 120 days. In addition, two of the staff were also missing other trainings required to be completed during the first year of employment. These two staff were missing one and three trainings that were required. An additional training file was reviewed only for the first 120-day training requirement. This staff had only completed 6.5 hours of training during the first three months of employment. This staff had only completed one training, Confidentiality, required during the first 120 days and only has three weeks left to receive the additional eleven required trainings.

1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

The program has multiple policies and procedures that outline its Continuous Quality Improvement (CQI) process (QI 275, dated 1/13/15), CQI Teams (QI 280, 9/1/16), and Data Collection and Evaluation (QI 350, 12/1/15). In addition, the agency has a comprehensive CQI Plan for FY 2017-2018 that describes the agency's CQI structure, committees, stake holders, CQI cycles, data collection and analysis, reporting, and corrective actions.

YFA appoints staff at various levels to participate on in the CQI process on seven CQI teams in addition to the CQI Council. The teams are as follows: Peer Review, Outcomes Measurement, Risk Prevention and Management, Training, Safety Committee, Employee Retention, and Stakeholder Involvement. Each team has an appointed team leader who is responsible for coordinating team meetings and attending the CQI Council meetings. The CQI council and CQI teams meets quarterly. The Director of QI and Risk Prevention maintains a calendar and a log of all team meetings. Agendas for all team meetings are maintained respectively along with meeting minutes. The CQI teams are responsible for

providing updates and recommendation to the CQI Council on a quarterly basis regarding areas outlined in the purpose and goals for each team. Quarterly reports are to be written for each team. Annual reports are also required from each CQI Team and are due by July 31 for the FY activities.

The agency does quarterly reviews of case records through peer review groups. The reviewer completes a Review Tool for each case. Upon completion of case record reviews, the results are aggregated and a report is submitted to the VP of QI to be presented at the CQI Council meeting. Quarterly case reviews were last completed in November 2017 and February 2018 for the program.

Incidents, accidents, and grievances are reviewed quarterly by the Risk Prevention Committee and Safety Committee. The committees are responsible for reviewing incidents, accidents, and grievances for each program and report to the CQI council. A review of the quarterly meetings held by the Risk Prevention Committee and Safety Committee was conducted onsite to support evidence of practice. Both committees meet on a quarterly basis and provide evidence of agendas and minutes to supporting their meetings. The Incident Report Rollup was reviewed for the current FY to date containing the aggregated monthly report of incidents, accidents, and grievances (if applicable) for the agency's programs. Evidence of shelter staff meeting agendas showing discussion of Florida Network/QA, incidents, grievances, and safety during the staff meeting.

Customer Satisfaction Data is reviewed by the Stakeholder Involvement Team. The team met quarterly 10/10/17 and 1/9/18. Copies of the agendas and minutes for these dates were reviewed. The survey results for the YFA New Beginnings CINS/FINS program indicate 100% satisfaction for the shelter for the period October through December 2017. There was no data available for the non-residential program.

Outcome data is reviewed quarterly by the Outcome Measurement Committee. The team met quarterly on 1/17/18, 9/27/17, and 6/14/17. Copies of the agendas and minutes for these dates were reviewed. The team collects outcomes data for the CINS/FINS program separately and aggregates the data in a spreadsheet monthly. The data for the current FY July-December 2017 was reviewed on site.

CQI Council meetings were held 10/20/2017, 2/23/2018, and the next one scheduled for 4/20/2018. Evidence of meetings held is maintained in a binder. The meeting minutes and agendas were reviewed and include attendees and reports from the CQI teams.

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

There were no exceptions to this indicator.

1.06 Client Transportation

Satisfactory

Limited

Failed

Rating Narrative

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

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

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

The agency has a list of approved drivers that is sent out monthly from the agency's Human Resources (HR) Office. The list includes all drivers for all programs operated by the agency. At the time of the review all staff at the shelter were on the list and were approved drivers. The HR Department uses a system called Checkr that randomly runs driver's license checks on employs and flags the employ if the license comes up invalid. All drivers are covered under the company insurance policy.

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

There were sixty-three single client transports documented in the log in the last six months. Three of those sixty-three transports did not document supervisor approval. There were also four instances of single client transports documented in the log book that were not documented on the Single Youth Transport Log, so those four instances also did not have supervisor approval.

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

Exception:

There were sixty-three single client transports documented in the log in the last six months. Three of those sixty-three transports did not document supervisor approval. There were also four instances of single client transports documented in the log book that were not documented on the Single Youth Transport Log, so those four instances also did not have supervisor approval.

1.07 Outreach Services

Satisfactory

Limited

Failed

Rating Narrative

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

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

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

Agency provided print-outs of attended events in the community from NetMIS. There were twenty-two events attended between October and December 2017. There was no documentation to support any outreach events were conducted/attended from January 2018 to the time of the review, April 2018, in NetMIS. The current Program Manager did provide copies of agendas and sign-in sheets of meetings attended in February 2018 with the Mid-Florida Homeless Coalition's Hernando County Provider's Meeting and the Hernando County Criminal Justice Mental Health Substance Abuse Reinvestment Grant meeting. A sign-in sheet was also provided of an Open House held at the shelter in March 2018.

There was documentation of staff attending the DJJ circuit meetings. Copies of agendas and minutes from the last two meetings were provided.

Agency has outreach agreements with Baycare, Bene's Career Academy, Pasco Kids First, United Way of Hernando County, Lighthouse for the Visually Impaired and Blind, Pasco Sheriff's Office Special Victims Unit, Sumter County School Board, and Saint Leo University. All outreach agreements are up-to-date.

Exception:

There was no documentation to support any outreach events were conducted/attended from January 2018 to the time of the review, April 2018, in NetMIS.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

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

The program screens and assesses each youth and family referred for intervention services to determine what, if any, services are needed. Services include screening, intake, and assessment of the youth and family, case management services, determination of needed services, development of case service plans, referrals to services identified in the service plan, crisis intervention services, and follow-up contact at 180 days after the termination of the agency services.

2.01 Screening and Intake

Satisfactory Limited Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of the CQI indicator. The policy manual was last reviewed on 02/14/17 and signed by the VP of Prevention Services and the Chief Operating Officer.

The provider's procedure requires the requires the Program Supervisor/Director will ensure a counselor contracts the family to conduct the initial screening no later than seven working days.

An eligibility screening is completed upon request for services and is available to families 24 hours a day.

- If a counselor is not available, the Centralized Intake Screening Form will be completed by a Youth Development Staff or Support Staff.
- If it is determined the youth is in need of crisis, mental health or substance abuse services, the on-call supervisor will be contacted to assist with the family's immediate needs.
- For non-emergencies, the referral form and Centralized Intake Form may be given to the Program Director to determine if an intake will be scheduled or if youth will be placed on the waiting list.

Upon intake youth and family will receive available services options, rights and responsibilities, possible actions occurring through the involvement of CINS/FINS, Shelter Handbook (for sheltered youth) and a description of the grievance process.

There were a total of ten files reviewed for this indicator, five residential files (three closed and two open) and five non-residential files (three closed and two open).

Of the five residential files reviewed, all the files had a Centralized Intake Screening Form completed within seven calendar days of referral. Four files had a signed Acknowledgement of Receipt of Rights and Responsibilities and Receipt of Notice of Information Practices, by the parent and youth.

Of the five non-residential files reviewed, all files had documentation showing youth were screened within seven days of the referral. For all files reviewed, there were parent and youth signatures on the Rights and Responsibilities form.

Exception:

One residential file did not have the youth's signature on the Acknowledgement of Receipt of Rights and Responsibilities and Receipt of Notice of Information Practices. The only document this youth signed in the file was the YFA Handbook Agreement.

2.02 Needs Assessment

Satisfactory Limited Failed

Rating Narrative

The agency has written policy and procedures that addresses the key elements of the QI Indicator. The policy was last Revised on 04/01/2017 by the Chief Operating Officer and VP of Prevention Services.

CINS/FINS Programs will conduct a full Needs Assessment, to be initiated in a timely manner, for each youth and family participating in services. This assessment evaluates a variety of issues faced by the family, not just the presenting problem represented by the youth.

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

There were a total of ten files reviewed for this indicator, five residential files (three closed and two open) and five non-residential files (three closed and two open).

Of the five residential files reviewed, four Needs Assessments were initiated within 72 hours of the youth being admitted into the program. These Needs Assessments were located in the Intake Section of the file and were initiated by a Youth Development Staff (YDS). A counselor then completed a separate Needs Assessment, located in the Clinical Section of the file, in these four files. These four Needs Assessments were all signed by a supervisor. None of the files demonstrated an elevated risk of suicide as a result of the Needs Assessment.

Of the five non-residential files reviewed, all contained documentation of completion of the Needs Assessments within two to three face-to-face visits. All Needs Assessments reviewed were completed by a Bachelors or Masters level counselor and signed by a supervisor.

Exceptions:

One residential file had a blank Needs Assessment in the Clinical Section. The Needs Assessment the YDS initiates at intake, located in Intake Section, only had one page and there was no date, no time, and no signature/name for the YDS initiating the assessment.

Three residential files had incomplete Needs Assessments. These incomplete Assessments had numerous sections not completed (i.e. Present for interview, Developmental History, Childhood Socialization, Adolescent Socialization, Family History, Family Social-Economic Background, Family dynamics, Suicidal Lethality Assessment, Legal History, Drug/Alcohol History, Mental Status, etc.).

2.03 Case/Service Plan

Satisfactory Limited Failed

Rating Narrative

The agency has written policy and procedures that addresses the key elements of the QI Indicator for Service Plan Development and Service Monitoring. The policy was last reviewed on 2/14/17 by the Chief Operating Officer and VP of Prevention Services.

All client case records shall contain a service plan.

- The service plan is a statement of goals, proposed actions and objectives developed in partnership with the youth and family.
- Service plans will be individualized and will include specific strategies for interventions, services and resources with a timeline for service delivery.
- An extension of the Service Plan is the Aftercare Plan and will be developed similarly to the development of the Service Plan.
- Service plans will not focus solely on the youth.

- If the CINS/FINS program is unable to provide needed services, a written referral will be made by the counselor.
- For mental health or substance abuse referrals, the counselor will refer to either licensed or certified substance abuse mental health provider or to the local community mental health center.
- The service plan and the After-Care plan will be developed with the youth and, if possible, the parent/guardian at the time of the Needs Assessment and no later than seven working days following completion of the Needs Assessment.
- If service plan cannot be signed by the youth or the parent the counselor will document the reason for unavailability and will make efforts to review and obtain a signature as soon as possible.
- Service plan will be reviewed every thirty days at a minimum for the first three months by counselor/parent or guardian and every three months thereafter. These reviews shall be documented, and highlighted in yellow in the youth's file on the Chronological Contact Sheet and Progress Notes.
- At the end of 90 days or at any time there are significant changes in the youth's progress and goals, a new Service Plan must be developed with the youth and family.
- The Service Plan and aftercare plan are reviewed and signed by the program director.

There were a total of ten files reviewed for this indicator, five residential files (three closed and two open) and five non-residential files (three closed and two open).

Of the five residential files reviewed, four files had Service Plans that were developed within seven working days of Needs Assessment. Four files had Individualized and prioritized needs and goals identified by the Needs Assessment. Four files did not have actual completion dates; however, it was noted the youths were discharged prior to target completion dates. One file had the parent/guardian signature on the service plan. Four files were not reviewed for progress/revised by counselor and parent every thirty days, it was documented these youths were discharged prior to their thirty day review. All Service Plans had: service type, frequency, location, persons responsible, target dates for completion, signature of youth, signature of counselor, signature of supervisor, and date plan was initiated.

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

Exceptions:

One residential file did not have a completed Needs Assessment with a date so it is unable to be determined if the Service Plan was developed within seven working days of the Needs Assessment.

One residential file had "Alternative Education" identified in the Needs Assessment and Summary; however, this was not addressed in the Service Plan.

Four residential files did not have the parent/guardian signature on the Service Plan or any documented attempts to review the Service Plan and obtain the signature.

2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

Rating Narrative

The agency has written policy and procedure that addresses the key elements of the QI Indicator for Case Management and Service Delivery as well as Family Involvement. The Case Management and Service Delivery policy was last reviewed on 2/14/17 by the Chief Operating Office and VP of Prevention Services.

All clients shall be assigned a counselor to assist in the provision of needed or assigned services. Youth and Family Alternatives, Inc. believes families should be engaged in assessment, planning, implementation, monitoring and follow-up care. Both residential and non-residential counselors and staff will encourage family input and involvement in decision making for the youth and family.

Each youth is assigned a counselor who will ensure the delivery of services through provision or referral.

Case management process includes:

- establishing referral needs and coordinating referrals

- coordinating service plan implementation
- monitoring youths/family's progress
- providing support for families
- monitoring out of home placement
- referrals to the case staffing committee
- recommending and pursuing judicial intervention
- accompanying youth and parent/guardian to court hearings
- referral to additional services
- continued case monitoring
- case termination with follow-up.

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

There were a total of ten files reviewed for this indicator, five residential files (three closed and two open) and five non-residential files (three closed and two open).

All five residential files had counselors assigned and provided case monitoring. No files had out-of-home placement or referrals to case staffing. Also, no families were accompanied for court hearings. Only one of the five residential files documented referrals were made based upon the on-going assessment of the youth's/family's problems and needs.

There were five non-residential files reviewed. Four of the five files documented the youth's/family's progress in services was monitored. Four the five files documented support was provided for the families. Three of the four files documented referrals are were made as necessary.

Exceptions:

Of the five residential files reviewed four did not establish referral needs and coordinate referrals to services based upon the on-going assessment of the youth's/family's problems and needs. Of those four files, all documented a clear need for various referrals, including: anger management, alternative education, family counseling, counseling for healthy relationships/attachments, Job Corps, and individual counseling.

- One non-residential file did not make referral to case staffing addressing the problems and needs of the youth/family. The Case Manager made a referral to the shelter and the father did not follow through. The Case Manager documented she informed him that "parental prosecution will be next step." The next step should have been a referral to case staffing.
- One non-residential file did not document any progress in services and did not document any support was provided for the family. The youth was enrolled on 12/4/17 and the Service Plan was developed on the same day. The next contact attempt was made on 12/15/17 by the Case Manager at the school. Then one more contact was documented on 1/10/18 with the mother informing her the case would be closed. In the Discharge Summary there was not additional services offered to the youth and family or any referrals made.

The three closed residential files and two of the closed non-residential files had no documentation of thirty and sixty day follow-ups.

2.05 Counseling Services

Satisfactory

Limited

Failed

Rating Narrative

The agency has written policy and procedures that addresses the key elements of the QI Indicator for CINS/FINS Counseling Services and Family Involvement. The policy was last reviewed on 2/14/17 by the Chief Operating Officer and VP of Prevention Services.

An array of services shall be provided to youth and their families. Services are based on the needs of the family, for preserving the unity and integrity of each family, and to prevent the youth from entering the juvenile justice system.

Youth and families receive counseling services, in accordance with the youth's case/service plan to address needs identified during the assessment process. YFA counseling services reflect all case files for:

- coordination between presenting problem(s)

- needs assessment
- case/service plan
- case/service plan reviews
- case management and follow-up
- maintain individual case files on all youth and adhere to all laws requiring confidentiality
- maintain chronological case notes on the youth's progress

YFA also maintains an ongoing internal process that ensures:

- clinical review of case records
- youth management
- staff performance regarding CINS/FINS services.

There were a total of ten files reviewed for this indicator, five residential files (three closed and two open) and five non-residential files (three closed and two open).

All five residential files reviewed documented counseling services in accordance with the Case/Service Plan. Each youth received individual and family counseling. Group counseling was documented at least five days per week. Group counseling was at least thirty minutes in length and documented a clear leader and topic. Presenting problems were addressed in the Case Plan and Needs Assessment. Case notes were maintained for all counseling services provided.

All five non-residential files reviewed demonstrated that presenting problems are addressed in the Needs Assessment, case plan, and notes. Two of the three files documented that individual/family counseling was being provided in accordance with the Case/Service Plan.

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

Exception:

Three non-residential files did not document the youth and families received counseling services in accordance with the Case/Service Plan.

2.06 Adjudication/Petition Process

Satisfactory Limited Failed

Rating Narrative

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

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

1. The family or youth is not in agreement with the services or treatment offered,
2. The family or youth will not participate in the services or treatment offered,
3. The agency counselor needs additional assistance in developing a case plan,
4. The family or youth have not demonstrated substantial progress in achieving goals specified in the service plan,
5. The services or treatment selected have not addressed the problems and needs of the Family or youth or

6. The parent/guardian requests, in writing, that a case staffing committee meeting be convened.

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

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

There were no exceptions to this indicator.

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

The agency has written policy and procedures that addresses the key elements of the QI Indicator for Youth Records. The policy was effective on 06/26/14 and revised on 10/01/15 and signed by the President/CEO and Board Chair.

The program maintains confidential records for each youth that contains pertinent information involving the youth and his/her treatment at the program. All records are marked "confidential" and kept in a secure room or locked in a file cabinet that is marked confidential, which is accessible to program staff. All records that are transported are locked in an opaque container that is marked confidential. Youth records are maintained in a neat and orderly manner so that staff can quickly and easily access information.

There were fourteen youth files reviewed for this indicator. Ten files were marked "confidential". The residential files are kept in a locked file room within locked cabinets marked "confidential". For the transportation of the non-residential files the agency has a solid black, locking bag.

Exception:

Four files were not marked confidential; three residential and one non-residential.

Standard 3: Shelter Care

Overview

Rating Narrative

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

3.01 Shelter Environment

Satisfactory

Limited

Failed

Rating Narrative

Agency policy SH 3.01 (effective 9/13/13 and last updated 2/15/17), SH 430 Daily Program, and SH 480 address indicator 3.01 Shelter Environment.

Shelter programs will conduct weekly safety inspections of all internal and external areas and equipment which includes emergency generators, communication equipment or any other safety related equipment or supplies needed in an emergency. Weekly inspections are to be documented in a weekly inspection log and are designed to ensure that the program remains safe, clean and in good repair. Any required corrective action will be communicated to the program director and initiated on a Maintenance Request Form.

Random facility checks will be conducted by the Program Director, Residential Supervisor or Team Lead to ensure that all buildings are in presentable condition at all times. The Shift Lead or designee will conduct a formal daily inspection of the wings at least three times a day. Room checks include ensuring: beds are made and free of clothing; clothing is properly stored; furniture is in good repair; program is free of infestation; bathroom and showers are clean and functional; there is no graffiti on walls, doors or windows.

Policy and procedures are in place outlining responsibilities of daily and weekly chores for both staff and youth. Agency policy specifically addresses cleanliness responsibilities for the office areas, bedrooms, living areas, kitchen and dining areas, laundry room, outside grounds, and all public areas.

Daily programming will follow an on-going "master" schedule outlining specific times and schedules for: wake up and bedtime; meals; housekeeping/chores; organized recreational activities; leisure time; group counseling/therapy; educational activities; personal hygiene; visitation and phone time; homework and reading time; and faith-based activities or alternatives for those youth who do not wish to participate.

Facility grounds appeared clean and well maintained throughout the review. The property included a paved basketball court, beach volleyball court, and ample outdoor space. The agency utilizes both staff and youth involvement to ensure chores are completed in a timely manner and on schedule. The agency also uses in-house staff for their lawn care needs. Pest control is handled by an outside agency (Orkin) and was last completed on 3/26/18. There was no visible signs of bugs or bug infestation noted during the visit.

Youth and facility safety is a team effort handled by both in-house staff and external organizations. First aid kits are inspected weekly, refilled/replaced when necessary, and tracked in the First Aid Kit Inspection Log. Drills are completed multiple times a month and tracked on various forms (fire drill, tornado, episodic care) and maintained in the safety drills log. Chemicals are stored properly and counts from weekly inventory audits are maintained in the MSDS binder. Inspection of agency vehicles found all vehicles were locked and contained required safety equipment.

Youth bedrooms were clean and well maintained. Each youth had their own individual bed with clean covered mattress, pillow, sufficient linens and a blanket. Youth wishing to lock up personal items can place them in the Matrix System. Youth are also given the opportunity to personalize and decorate their rooms within a set of guidelines.

Youth have opportunities to engage in meaningful and structured activities both on and off site. There are three "master" plans (weekday, weekend, and summer) outlining specific times and schedules for: wake up and bedtime; meals; housekeeping/chores; organized recreational activities; leisure time; group counseling/therapy; educational activities; personal hygiene; visitation and phone time; homework and reading time; and faith-based activities or alternatives for those youth who do not wish to participate. Schedules are posted throughout the facility and accessible to both staff and youth. Also posted throughout the facility are Egress plans, abuse hotline numbers, poison control numbers, grievance procedures, rules, and the "6 pillars of character" outline.

DCF License was current and valid until August 2018.

Last health inspection was satisfactory and completed 12/27/17.

Fire safety inspection was last completed 1/1/2018.

There were no exceptions to this indicator.

3.02 Program Orientation

Satisfactory

Limited

Failed

Rating Narrative

Agency policy SH 3.02 (effective 9/13/13 and last updated 2/28/17) addresses indicator 3.02 Program Orientation.

Client orientation shall begin at time of admission and should be completed within twenty-four hours. Staff working the overnight (12am to 8am) shift have the discretion to provide a brief orientation at time of admission and postpone a more comprehensive orientation until the following morning. Shift leaders are responsible for assigning orientation responsibilities.

Youth Development Staff participating in the orientation process with newly admitted youth complete a "Client Orientation Checklist" indicating review of the following areas has been completed with the youth. The Client Orientation Checklist includes:

- . * Identification of key staff and their roles
- . * A review of emergency building evacuation procedures and a tour of the program
- . * A review of the suicide prevention process and alerting staff to any suicidal thoughts
- . * Room assignment
- . * A review of the daily program schedule
- . * A review of "Youth Rights", "Grievance Procedures", and how to contact the Florida Abuse Hotline
- . * A review of program goals and the services available
- . * A review of the behavior contracting process and its impact on eligibility
- . * A review of the visitation schedule, telephone procedures and mail procedures
- . * A review of the religious activities
- . * A review of program rules governing conduct and consequences if rules are violated
- . * A review of medical treatment procedures and how to access medical care services
- . * A review of how to access mental health services
- . * Review of policies on contraband, dress code, and expectations related to hygiene
- . * Review of linen exchange

In addition to the client orientation process, new admits are provided a comprehensive Youth Handbook and assigned a peer "buddy" as an additional orientation step.

Newly admitted youth are provided a copy of both the shelter handbook and an orientation packet which requires the youth to actively participate and complete three days of assignments before moving on to the next level. Both the orientation packet and the shelter handbook address the needs of Indicator 3.02 and meet the requirements of agency policy SH 3.02. Youth, parents, and staff are provided an opportunity to date and sign indicating they participated in the orientation process.

During the review process, seven files were reviewed (three open and four closed). Of the seven files reviewed, four files did not contain a completed orientation checklist, signed or initialed by either the staff or youth. In two other files reviewed, the orientation checklist was completed; however, staff did not sign it nor the abuse hotline form.

The agency uses a "Buddy" system to help new admits transition into the facility and feel more at ease by being paired up with a peer. During this time, the "buddy" can explain the "in's and out's" of the facility and will have specific tasks to accomplish with the new admit. According to the program director, peer "buddies" are chosen based on behavior and how the staff feel they will interact with the new admit. As of right now there is no clear indication of how the "Buddy" peer system is assigned (paperwork, scoring system, etc.) for the orientation process or any verification form indicating a "buddy" was assigned. The program director indicated they do have defined "buddy" paperwork in use at their other facilities and are in the process of transitioning it here.

Exceptions:

Four out of seven files reviewed did not contain a completed orientation checklist or verification that orientation was completed with the youth.

In two other files reviewed, the orientation checklist was completed; however, staff did not sign it nor the abuse hotline form.

3.03 Youth Room Assignment

Satisfactory Limited Failed

Rating Narrative

Agency policy SH 3.03 (effective 9/13/13 and last updated 2/28/17) addresses Indicator 3.03 Youth Room Assignment.

During the initial screening and intake process staff will complete all forms appropriately indicating that all pertinent information has been obtained. Agency policy indicates "there are to be no blanks on any agency form". Staff are to complete the admission sleeping assignment form to be reviewed with the Shift Leader or designee when assigning a youth to a room. Consideration of special needs, behavioral history, age, maturity level including identification of youth susceptible to victimization, individual needs, general physical stature gang affiliation, current alleged offenses, level of aggression, attitude, sexual misconduct, demonstration of emotional disturbance mental health, and exposure to trauma, is given when assessing a youth for a bed assignment.

If any special needs are identified, an alert code is assigned to that youth in their file and on the census board/bed roster board. The bed roster provides on duty staff with room and bed location of each client and is to be used for supervision and emergency purposes.

The agency uses a "Youth Room Assignment" form along with other assessment tools to ensure consideration is given to special needs when deciding on appropriate room placement and ensuring youth are protected from the threat of harm and violence. The youth room assignment form also provides a spot for the shift leader or designee to sign off that they reviewed the assessment and approve of the room assignment.

Of the five files reviewed, all five had clear indications of special needs and alerts identified on the outside of the files. Four of the five files documented a room assignment. One file had no indication of where the youth was placed while on constant sight and sound or after they were cleared, on the Youth Room Assignment form.

Exception:

In one file there was no indication of where the youth was placed while on constant sight and sound or after they were cleared, on the Youth Room Assignment form.

3.04 Log Books

Satisfactory Limited Failed

Rating Narrative

Agency policy SH 3.04 (effective 9/13/13 and last updated 2/28/17) addresses Indicator 3.04 Log books.

All staff making entries into the log book will ensure that entries are brief and legibly written in ink. Entries with the potential to impact the security or safety of the program or youth should be highlighted. Errors should be struck through with a single line, "void" written, and then signed and dated by staff making the correction.

* Entries will also include:

* Date and time of incident, event or activity

- * Name of youth and staff involved
- * Brief statement providing pertinent information
- * Name of person making the entry with the date and time of entry and signature.

Reviews of the log books are to be completed on multiply staff levels (direct care, supervisory, etc.) and indicated with a log book entry. Reviews are to be completed by:

- * Program director or designee every week with notes chronologically entered into the logbook as to any corrections, recommendations, or follow-up required.
- * Oncoming supervisors and direct care staff shall sign and date the logbook indicating they reviewed the logbook for previous two shifts.

Log books will be retained for a period of no less than three years.

Review of log books dating back to 10/1/17 through 4/4/18 showed consistent adherence to both the indicator and agency policy. Entries were brief, legible, and to the point. Safety and security issues were clearly indicated and highlighted and there was no signs of erasure marks or white-out areas. Initial entries by oncoming staff include staff names, current weather, client counts, and acceptance of a verbal shift summary from previous shifts.

Weekly supervisor reviews and notes can be found consistently throughout the log book in red ink and include special notes, corrections, instructions, and required follow-up.

There were no exceptions to this indicator.

3.05 Behavior Management Strategies

Satisfactory Limited Failed

Rating Narrative

The agency has a written policy and procedure to ensure that a consistent and fair system of privileges and consequences are used. The agency uses the Youth Development System (YDS) which is designed to emphasize a positive and proactive environment to promote protective factors for youth.

The agency utilizes the Behavior Management System (BMS) which is called the Youth Development System (YDS), an approach that includes pieces of Advancing Youth Development (AYD) and the Character Counts program. The YDS system consists of three different phases (Orientation, Education, and Graduation). This system is designed to promote youth to display positive behaviors as well as providing ongoing feedback to youth to fulfill program expectations. The behavioral management is explained upon youth's admission, and it is written in the youth's handbook.

The program has a written description of the BMS, and it is explained during program orientation. During intake, youth is explained the program rules, expectations, and the BMS system, also called the YDS system. Youth receives the youth handbook and signs off on it at admission. The YDS system consists of three different phases (Orientation, Education, and Graduation). Youth is placed on orientation level for three days. Upon completion of orientation level, youth is placed on Education level in which youth work to be placed on the final level, Graduation. Once a youth is placed on graduation level, youth is permitted to go on outings. If youth follows six pillars (Responsibility, Respect, Caring, Citizenship, Fairness, and Trustworthiness), youth can start earning money (monopoly money) and can use it to buy the desired items from the "New Beginning Box." Staff members rate youth's behaviors and indicate the youth's level on the board in the common area called the Great Room. If youth disrupts the program, not following program rules, disrespectful to staff members or other youth, then the youth is reverted to a lower level or is placed on reflection level. At this level, youth must work on paperwork, which is designed for youth to be accountable and reflect on behaviors that help them to make the necessary corrections.

Timeout is permitted as a form of discipline and youth may not be left unattended during a timeout. During time out, their behaviors are observed for at least ten minutes in the dining room area. The program does not permit any physical aggression among youth. If youth becomes physically aggressive, the program contacts the guardian and requests for immediate removal. Lead and supervisor on duty train new hires for at least 72 hours. They are to shadow and understand the BMS system before they can be in ratio. The lead and supervisor on duty provide feedback and evaluation of staff regarding their use of BMS rewards and consequences. During an interview with the program director and one of the leads on shift, it was found that the new hires are provided with feedback verbally. There had been no incidents in which the program director had to document any disciplinary actions.

There were no exceptions to this indicator.

3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure to ensure that the agency is meeting the requirements set by the Florida Network. The agency has a policy indicating that adequate staffing is provided to ensure the safety of youth and staff.

The agency strives to maintain one staff on duty of the same gender as the youth. A staff to youth ratio of 1:6 is maintained, and additional staff is activated for coverage, whether there are two staff members and the population of the shelter, exceeds twelve youth. The full and part-time employees are contacted for shift coverage by the Program Director or designee. In the case the full and part-time employees cannot fulfill the coverage, the Program Director and Residential Supervisor are on-call on a twenty-four-hour basis for shift coverage. Staff will observe youth at least fifteen minutes while they are in the bedroom/sleeping area regardless of the time of day/circumstance. An entry will be made in the communication log book every fifteen minutes. For youth placed on Constant Sight and Sound, their whereabouts will be noted every five minutes.

The agency serves a maximum of twenty-four youth and provides services to both DCF and CIN/FINS youth. There were ten youth in the shelter at the time of the review. At the time of the review, the agency maintained the staffing ratio requirements. The agency maintains minimum staffing ratio as required by Florida Administrative Code and contract. Staff to client ratio of 1:6 is maintained, and additional staff is activated for coverage when there are two staff members, and the population of the shelter exceeds twelve youth.

In the event of a Youth Development Staff (YDS) shortage, it is expected that other staff remains on duty until relieved of the duty by another YDS. If the full or part-time employees cannot cover the shifts, on-call administrators such as Program Director or Residential Supervisors are contacted for shift coverage. The agency currently has eight female and two male staff. Due to a shortage of male staff, female staff have been covering the most of the shifts at this time. A new male staff member has accepted the offer letter and is in training at this time. The agency has posted three more Youth Development Staff (YDS) positions as of 1/4/2018. During an interview with the Vice President, it was indicated that the interviews would start, to fill these positions next week. Staff schedule and contact numbers to reach staff when additional coverage is needed are placed in a binder. The binder is accessible to staff and set at the YDS station.

The agency ensures staff use real-time when recording bed checks. A review of bed check documentation and video coverage from random nights, confirmed staff are consistently documenting bed checks approximately every fifteen minutes.

There were no exceptions to this indicator.

3.07 Special Populations

Satisfactory

Limited

Failed

Rating Narrative

The provider has a written policy and procedures in place that state shelters provide services to special populations such as Domestic Violence Respite (DV), Domestic Minor Sex Trafficking Youth (DMST), Probation Respite, and Staff Secure.

These services are provided to both male and female youth ages 10 to 17 who meet the criteria and a certain exception can be made on a case-by-case basis. YFA ensures that respite care services are appropriate to the needs of the referred youth. Shelter staff are appropriately trained and complete training for the Florida Network. If YFA determines a referred youth is not appropriate for DV respite service, YFA shall decline the referral and contact the youth's JPO and JPO supervisor to review the referral if they are available. The services can be rejected due to youth's history of fire setting behavior, sexual offenses, need for acute inpatient care, or safety risk to other youth or staff.

A Domestic Violence youth may fill a bed for up to fourteen days, per admission. If additional bed days are needed, additional seven days shall be approved but will not exceed twenty-one days. Services to youth funded under Domestic Minor Sex Trafficking (DMST) will include enhanced supervision include positive activities designed to encourage the youth to remain in shelter. Referrals for Probation Respite must be received from the Department's Juvenile Probation Officer and may be approved for up to thirty bed days per admission. Youth eligible for staff secure placement must be adjudicated CINS/FINS youth. The youth meets the legal criteria outlined in Chapter 984 F.S. for being formally court ordered into staff secure services.

The provider has not served the following special populations in the past six months: Staff Secure, Probation Respite, and Domestic Minor Sex Trafficking.

A sample of six closed files was randomly selected and reviewed for DV respite youth. Youth admitted to DV respite placement have a pending DV charge and have evidence of being screened by JAC/Detention or JPO. All of these DV youth were discharged within twenty-one days and not transitioned to CIN/FINS or Probation Respite placement. The provider initiates youth's service/treatment plan addressing goals focusing on aggression management, family coping skills, or other interventions design to reduce re-occurrence of violence in the home, after seven days of admission. Only one out of six files had service/treatment plan as most of these youth were discharged before the service plan date (seventh day). This file had a plan in place that addressed anger management, coping skills, and other interventions. All six youth received other services consistent with other CINS/FINS requirements.

There were no exceptions to this indicator.

3.08 Video Surveillance System

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure to ensure that the agency is meeting the requirements set by the Florida Network to ensure the safety of all youth, staff, and visitors.

The agency shall have cameras in interior and exterior to cover general locations of the shelter. Cameras are not to be placed in private areas such as bathrooms or sleeping quarters. The recorded video is stored for a minimum of 30 days and stored in a separate storage for the length of time needed to complete investigation. Only designated staff trained to handle the equipment and monitor footage in an ethical manner. Supervisory review of the video is conducted bi-weekly and documented to assess the activities of the facility. The cameras have the ability to record date, time and location, and backup capabilities that enable cameras to operate during the power outage.

There is a written notice that is posted on the premises for security. Cameras are in the interior and exterior general locations of the shelter where youth and staff congregate and where visitors enter and exit. The system can capture and retain video photographic images, including facial recognition, and are stored for a minimum of thirty days. No cameras are placed in bathrooms or sleeping quarters. The agency has a backup server which operates during the power outage.

A list of designated personnel who can access the video surveillance system is maintained. A designated personnel review of the video is conducted a minimum of every fourteen days and note in the video review log book. The agency has a process for a third party requesting to review the footage. This process is permitted only by the approved personnel.

There were no exceptions to this indicator.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

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

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

The shelter has a part-time Registered Nurse (RN) who oversees the medication administration process. The shelter utilizes an effective general alert system that informs direct care staff of the youth's health, behavior, or mental health status. Alerts are documented on the census board.

4.01 Healthcare Admission Screening

Satisfactory Limited Failed

Rating Narrative

It is the policy (Healthcare Admission Screening) of Youth and Family Alternatives, Inc that the youth is screened for health related conditions at the time of admission to ensure to the fullest extent possible the youth has no health or medical conditions that require immediate action. During shelter stay all youth shall receive basic monitoring for appropriate care for health issues. The policy was last reviewed on February 28, 2017.

In determining the appropriateness of admission, staff shall inquire about any issues related to medications, symptoms of tuberculosis, physical health problems, allergies, recent injuries or illness, or any other potential presence of pain or other physical distress, substance abuse and or intoxication.

Upon admission staff shall utilize the CINS/FINS intake assessment and health screening form to inquire about, observe and document the following client related issues: mental health, dental or chronic medical conditions at time of intake, if client is currently under medical treatment or on medication, physical deformities or handicap, evidence of abuse or neglect, issues related to medications, symptoms of tuberculosis, allergies, recent injuries or illness, hemophilia, asthma, cardiac disorders, pregnancy, diabetes, substance abuse, and evidence of scars, tattoos or markings.

If the program has a nurse the nurse will review the youths medical history within five business days. Any mental health and or substance abuse issues/needs assessed in the CINS/FINS intake, Health Screening, or Needs Assessment are to be addressed in the individualized service treatment plan. Whenever possible the parent should be involved in coordination and scheduling of medical appointments or care.

There were five files reviewed for this indicator (three open and two closed). All files reviewed have a health care admission screening that show current medications, existing medical conditions, recent injuries or illnesses. Files also have places for information regarding observation for illness, injury, pain, presence of scars, tattoos, or other skin markings. Other chronic medical conditions checked at intake are diabetes, pregnancy, seizure disorder, cardiac disorder, asthma, tuberculosis, hemophilia, and head injuries. In all files reviewed there was no need for coordination for medical or mental health follow up. The nurse also consistently reviewed all health care screenings within the five-day period. The program also has a clear procedure to include a thorough referral process for necessary follow up medical care for youth admitted with chronic medical conditions.

Exception:

Forms reviewed for this indicator were missing supervisor signature, or signature of approval/review.

4.02 Suicide Prevention

Satisfactory

Limited

Failed

Rating Narrative

The agency has a comprehensive system for assessing potential risk with clients if indicated. It is implemented via the Suicide Prevention policy, last reviewed on March 31, 2017.

Mental health and substance abuse screening begins prior to admission, in person, or via telephone, by utilizing the Centralized Screening Form.

If over the phone or in person the parent/ guardian reports youth is exhibiting current thoughts or gestures of harm to self or others the screener is to call 911 and document on the form the time and service that was called.

Screener is to call on call supervisor and document the name and time of the call.

The screener is to document what was said and done by the family and supervisor.

Screener is to document if the abuse registry was called; if the report was accepted who it was taken by and the referral number.

The supervisor will ensure that the family receives a follow up call from a clinical staff person within one business day for follow up and document.

Screener will complete a YFA incident report.

At time of admission if the youth responds to one of the risk questions with yes on the intake form the following should happen: Youth Development Staff (YDS) will complete the Evaluation of Suicide Risk among Adolescents Screening Tool (EIDS), YDS will score the form and mark it on the (EIDS Summary), YDS will contact on call if a counselor is not on site. An assessment will be completed by a licensed professional or an unlicensed professional under the supervision of a licensed professional. The youth will be placed on Sight and Sound supervision while awaiting assessment. Sight and sound assessment will be completed in 5 minute intervals and information regarding youth behavior and activity during observation is recorded on sight and sound log.

If at any time during the screening or at any time during a shelter stay youth may pose to be a threat to others or self, youth should be placed on One to One supervision (used while a program is awaiting removal of a youth by law enforcement or parent guardian for the purpose of a Baker Act) and 911 should be called and Baker Act procedures should be followed. One to One is facilitated by one staff member who should be of the same gender as youth when possible and will remain within arm's length of the youth at all times. Staff may give more space if needed not to exceed five feet.

Assessment of Suicide Risk and Follow up assessment of suicide risk to determine supervision needs should be documented clearly and consistently. If assessment is completed by a non licensed staff the licensed staff must sign as a reviewer and date the assessment.

There were five closed youth files reviewed. In all files suicide risk screening occurred at intake. One youth answered no to all risk questions. Once shelter manager reviewed youth information within less than twenty-four hours youth was placed on sight and sound as a result of previously being Baker Acted. All youth were placed on appropriate supervision based on the results of the suicide risk assessment. Sight and sound log was completed for all youth placed on supervision. Supervision for youth was changed once the unlicensed counselor reviewed the EIDS and asked follow up questions regarding youth's current status. Once counselor spoke to youth and the agency LMHC was contacted by phone to review findings youth was then taken off Sight and Sound Supervision. Unlicensed professional maintained clear and consistent documentation regarding who the Licensed professional was and the exact time youth was removed from site and sound.

Exceptions:

In four of the five files the CINS/FINS intake form was not signed by a supervisor.

In three of the five files the EIDS Summary form was not scored. Current shelter counselor and Program Manager communicated that the staff are not adequately trained to score the sheet. The counselor completes the score after the form is initially completed. The score is not consistently transferred to the summary page.

In three of the five files the sight and sound log was inconsistently signed by the shift lead.

4.03 Medications

Satisfactory

Limited

Failed

Rating Narrative

The agency ensures safe, uniform medication control, and management by implementing the Medication Control and Management Policy. It was last reviewed on March 29, 2017.

At the time of admission to a program youth and parent guardian will be interviewed about youths current medications. If a youth is prescribed medications the parent guardian must provide medications in the original prescription container with a patient specific label intact on the original medication container. If previous steps are covered staff is able to proceed to verification process.

Verification may occur by Staff, agency Nurse or youth counselor by contacting the pharmacy. Once contacted the script, contents on container should be verified. Verification must be documented in file and on youth verification form. Once completed medication can be loaded into the Pyxis.

All medications with the exception of refrigerated medications will be stored in the Pyxis. Only staff members that are trained in the assistance of self-administration of medication by a Registered Nurse are able to assist in the administration of medication. Staff should wash hands prior to commencing the process of medications and between each youth medication. Staff will verify 5 rights (right dose, right youth, right route, right patient, right time) before assisting with self-administration of medication.

Once youth is at ten days of medication shift leader or designated staff on duty is to complete a Low Med Alert Form and forward it to the youths assigned counselor.

Shift leader on duty shall complete Medication Release Form for all authorized discharges of any youth taking medication. YFA Shelters do not keep a supply of any Over the counter medications.

Staff members have access to the Nursing Drug Guide to research most current information regarding medication side effects and interactions. Inventories of controlled medications are completed shift to shift. A perpetual inventory is maintained on all medications in the youths individual Medication Log.

All medications are stored in the Pyxis and the agency has a minimum of two Super Users for the Med Station. There is a locked refrigerator onsite in the medication room that has a temperature of 36-48 degrees F for the storage of medications. There were no refrigerated medications at the time of the review. Shift to shift counts are conducted and documented for controlled substances. There is a sheet posted in the medication room that lists all staff that have been trained in assisting in the administration of medication. Agency has at least two superusers and their names are also posted with the specification in the medication room.

Agency did not have any sharps other than metal lice combs. These are counted at least once weekly. Controlled medications are counted each shift and a list of all current controlled medications is maintained in a Purple Binder for inventory documentation. A medication distribution (red binder) log is kept in the medication room and is used for the distribution of medication by non licensed and licensed staff. Agency nurse runs a monthly KPI report, discrepancy report at least twice weekly, and an inventory verification report two to three times per month. Agency verifies medication through contacting the pharmacy and through the use of The Nursing Drug Handbook.

There were no exceptions to this indicator.

4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

Rating Narrative

Each shelter shall have an effective medical and mental health alert system in place that ensures information concerning a youth's medical condition, allergies, common side effects of prescribed medications, foods and medications that are contraindicated or other pertinent mental health treatment information is communicated to staff. This Medical and Mental Health Alert System policy was last reviewed on March 20, 2017.

A medical alert system is in place such that when a youth comes in the shelter with allergies are documented on the CINS/FINS Intake Assessment and placed in the Medical Log in the file room.

At intake assessment a "medical alert" and an allergy label will be placed in respective order on the top left hand corner on each case record identifying each youths medical condition or allergy. Youth development Staff completing the intake documentation are to post the name of any youth with a medical alert or allergy on the Allergy, Medical and Risk Alert Board in the Medication Room, in the front of the file and note the codes on the census boards. Youth Development Staff are to document any special dietary needs and/or food allergies. Due to confidentiality rules/ laws specific documentation of alleged HIV status as reported by a youth to staff is prohibited. In the event a youth requires emergency

medical care, upon return to the facility the shelter will keep in the file a verification of receipt of medical clearance, discharge instructions and any follow up care that may be required. Staff will also ensure the "Medical Alert" and or "Allergy" labels are updated to reflect any changes as appropriate.

All staff are trained so they are fully aware of the system and able to recognize and respond to medical and mental health conditions/ allergies.

There were five youth files reviewed for this indicator (two open and three closed). In all files there had medical and allergy alert stickers placed on the top left hand corner of the file, with the corresponding alerts written on the files. All youth were placed on the appropriate alert. In one youth's file the alert form was not completed although alerts were placed on the file in appropriate places. System alerts included precautions concerning prescribed medications.

There were no instances of needed precautions for mental health issues. Staff also are provided sufficient information to recognize/respond to the need for emergency care for medical/mental health problems. Alerts are placed on the census board. The medication room also has a board with all youth listed that are assigned to take medication and how frequently. Kitchen also has a board that has youth allergy/dietary needs listed.

Exception:

One youth did not have the alert form completed.

4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

Rating Narrative

There shall be a comprehensive process for the provision of emergency and non-emergency care and staff should respond appropriately and timely to youth healthcare emergency and non-emergency events. This Episodic/Emergency Care policy was last reviewed on March 20, 2017.

All staff are to have current training in CPR/ First Aid and the use of Knife for Life. The location of the Knife for Life, Wire cutters and First Aid Kits are indicated on the egress charts. Healthcare stimulation's are conducted on at least a quarterly basis. These are to be conducted on each shift and on various emergency situations. All instances of first aid and emergency care are documented as required. All deaths or serious adverse medical events shall undergo root cause analysis within the risk management process of the Critical Incident Review Team.

The emergency preparedness/Disaster Plan ensures all staff are informed of potential emergency situations. The assigned counselor/Therapist is to contact the parent/legal guardian to make arrangements for and transportation to appointments for general medical care. In the event a Parent or guardian is unwilling or unable to transport a youth the Youth Development Staff will provide transportation. In an emergency event, the shelter will follow chain of command. However, any staff aware of a medical or mental health emergency situation is required to call 911 immediately.

The shelter keeps a Monthly Incident and Accident Review log that lists all emergencies/incidents that occurred which required medical attention or follow-up care, including but not limited to those incidents reported to the CCC. The log documents a brief description of the incident, the episodic care required, and if any follow-up care was needed.

In the last six months the agency has only had one incident in which a youth has needed transport from the facility for medical care. There is no internal incident report for this youth and there is no evidence of this incident in the Monthly Incident and Accident Review log. There was a CCC report available for review that documented all notifications to the youth's parent and to program management. The CCC report also documented a detailed description of the incident and care received.

Knife-for-life and wire cutters are maintained in the medication room. Also, first aid supplies are located in the medication room, pantry, and in each vehicle. The program has completed an Episodic/Emergency drill quarterly for the last two quarters.

Exception:

One incident of emergency medical care was not documented on the Monthly Incident and Accident Review log and did not have a corresponding incident report. The only report available to review the incident was the CCC report.

