Florida Network of Youth and Family Services Quality Improvement Program Report

Review of CHS West Palm Beach

on 09/27/2018

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 2: Intervention and Case Management	
2.01 Screening and Intake	Satisfactory
2.02 Needs Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management and Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petitiion Process	Satisfactory
2.07 Youth Records	Satisfactory
2.08 Sexual Orientation, Gender Identity/Expression	Satisfactory

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

Standard 3: Shelter Care	
3.01 Shelter Environment	Satisfactory
3.02 Program Orientation	Satisfactory
3.03 Youth Room Assignment	Satisfactory
3.04 Log Books	Satisfactory
3.05 Behavior Management Strategies	Satisfactory
3.06 Staffing and Youth Supervision	Limited
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 4: Mental Health/Health Services	
4.01 Healthcare Admission Screening	Satisfactory
4.02 Suicide Prevention	Satisfactory
4.03 Medications	Limited
4.04 Medical/Mental Health Alert Process	Satisfactory
4.05 Episodic/Emergency Care	Satisfactory

Percent of indicators rated Satisfactory:80.00%
Percent of indicators rated Limited:20.00%
Percent of indicators rated Failed:0.00%

Percent of indicators rated Satisfactory:89.29%
Percent of indicators rated Limited:10.71%
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

Marcia Tavares, Lead Reviewer, Consultant Forefront LLC

Alvin Bentley, CFO, Florida Keys Children's Shelter

Teresa Clove, Executive Director, Thaise Educational Tours

Shakela Minns, ORS, Florida Department of Juvenile Justice

Terrence Washington, Shelter Program Manager, Lutheran Services Florida Southeast

Persons Interviewed

- [ ] Chief Executive Officer
- [ ] Executive Director
- [ ] Chief Operating Officer
- [ ] Chief Financial Officer
- [x] Program Director
- [x] Program Manager
- [x] Program Coordinator
- [x] Direct- Care Full time
- [ ] Direct-Care Part Time
- [ ] Direct-Care On- Call
- [ ] Volunteer
- [ ] Intern
- [x] Clinical Director
- [ ] Counselor Licensed
- [ ] Counselor Non- Licensed
- [ ] Case Manager
- [ ] Advocate
- [x] Human Resources
- [x] Nurse

0 Case Managers
0 Program Supervisors
0 Health Care Staff

0 Maintenance Personnel
0 Food Service Personnel

0 Clinical Staff
2 Other

Documents Reviewed

- [ ] Accreditation Reports
- [x] Affidavit of Good Moral Character
- [x] CCC Reports
- [x] Logbooks
- [x] Continuity of Operation Plan
- [x] Contract Monitoring Reports
- [ ] Contract Scope of Services
- [x] Egress Plans
- [x] Fire Inspection Report
- [ ] Exposure Control Plan
- [x] Fire Prevention Plan
- [x] Grievance Process/Records
- [ ] Key Control Log
- [x] Fire Drill Log
- [x] Medical and Mental Health Alerts
- [x] Table of Organization
- [x] Precautionary Observation Logs
- [x] Program Schedules
- [ ] Telephone Logs
- [x] Supplemental Contracts
- [ ] Vehicle Inspection Reports
- [ ] Visitation Logs
- [x] Youth Handbook

3 # Health Records
3 # MH/SA Records
14 # Personnel Records
6 # Training Records
7 # Youth Records (Closed)
6 # Youth Records (Open)
0 # Other

Surveys

3 Youth 3 Direct Care Staff

Observations During Review

- [ ] Intake
- [x] Posting of Abuse Hotline
- [ ] Staff Supervision of Youth
- [ ] Program Activities
- [x] Tool Inventory and Storage
- [x] Facility and Grounds
- [ ] Recreation
- [x] Toxic Item Inventory and Storage
- [x] First Aid Kit(s)
- [ ] Searches
- [ ] Discharge
- [ ] Group
- [x] Security Video Tapes
- [ ] Treatment Team Meetings
- [ ] Meals
- [ ] Social Skill Modeling by Staff
- [ ] Youth Movement and Counts
- [ ] Medication Administration
- [x] 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

CHS Safe Harbor Shelter is located at 3335 Forest Hills Boulevard in West Palm Beach, Florida. The shelter is licensed for 12 beds by the Department of Children and Families effective through January 23, 2019. The shelter facility is located in the rear of a large campus that includes its administrative offices housed in a separate building. The Safe Harbor program is the agency's Children In Need of Services/Families In Need of Services (CINS/FINS) program which is sub-contracted with the Florida Network of Youth and Family Services (Florida Network) to provide temporary residential and non-residential services to youth and families in South Palm Beach County. Services are provided to male and female youth under the age of seventeen.

CHS continues to supplement its services to CINS/FINS youth by offering an array of skill based training through groups such as life skills training, art, music, and career coaching. The program provides structured enrichment activities for the youth through the Choices program. The Choices program is fully supported by volunteers who offer a variety of services including theatre improvisation, theater writing, art, soccer, and potting. The program also offers additional recreation activities such as: drug prevention, music, yoga, and broadcasting. All of these services are provided onsite and the shelter also converted one of its bedrooms into an indoor game room where youth are encouraged to earn privileges to play video games. The program uses a hallway closet for its Point Store where some of its donations are used as incentives for youth, in exchange for points earned.

During the past year, the former Executive Director, Julie Demar resigned. As a result, the agency used the opportunity to re-evaluate the program and transitioned the leadership of Safe Harbor in April 2018 to Regional Executive Director, Sabrina Sampson and Regional Director of Operations, Kristi Walsh.

Facility Improvements:

* Additional security camera to view basketball court area (recommended from 2017-18 QI monitoring)

* Computer Lab with new upgraded computers/technology infrastructure upgrade

* New bedding & shower curtains for client's dorms

* Artwork in kitchen

* New furniture in family counseling room

* State-of-the-art game room

* Painting of interior dorm rooms and common areas (beginning stages)

Programming Improvements:

* Restructuring of CHS Regional Model (i.e. CINS/FINS like programs).

* Hands-on Regional Executive Director (RED) & Director of Program Operations (DPO)

* Increased Safe Harbor DCF license to 12 beds from 10 bed capacity.

* New psycho-educational tools to utilize with clients

* Change in supervision with Residential Counselor to under Residential Program Manager (previously under supervision by clinical program manager).

* Hiring of part-time program nurse

* Program documentation is in the process of transitioning assessment tools, utilization of the EIDS, discontinuation of the FAMIII

* Purchase of youth entertainment equipment from donor such as indoor entertainment, kindles, blue tooth speakers, head phones, surround sound bar and Blu-ray DVD players, (2) outside entertainment - air blown inflatable deluxe movie screens, projector, BBQ grill, state-of-the-art speaker system, lawn chairs, antique popcorn machine, Miami Dolphins vs. Detroit Lions football tickets for clients/staff (October 21, 2018)

* Shelter established arrangements with a provider to address a gap in attaining Substance Abuse services for our residents (and their families). When appropriate, Drug Abuse Treatment Associates DATA) is able to provide services while youth are still in shelter, removing barriers (perceived or real) to ongoing services.

* Improved communication with DJJ in Circuit 15 as a community partner aiding in the increased Days of Care. Presentations, meeting with Palm Beach Court Judges and regular communication with DJJ have shown to be beneficial and recognized by the Network as well.

Standard 1: Management Accountability

Overview

Narrative

CHS Safe Harbor is under the leadership of a management team that consists of an Executive Director, a Director of Program Operations (DPO), a clinical supervisor, residential program manager, and a Data Management Supervisor. The residential component of the program is staffed by s residential counselor, two residential shift leaders, four fulltime and two part-time youth care workers (YCW), four relief YCWs, and a part time nurse. The program has 8-hour shifts with variations of 6am-2pm/7am-3pm, 2pm-10pm/3pm-11pm, and 10pm-6am/11pm-7am.

The agency's clinical supervisor is a licensed mental health counselor (LMHC) who oversees the agency's counseling services. The clinical component of the program includes three non-residential fulltime counseling positions. The program also utilized the services of several volunteers during the review period.

At the time of the onsite visit there was one vacant position for a fulltime YCW.

During the entrance interview of the QI visit, the DPO informed the review team of the following challenges the program has experienced in the past year:

• Residential Training files, previously managed by the former Executive Director and the former DPO, appeared to have been neglected and in need of attention, consequently lacking training and documentation. It was noted that, training Files will be going to Calendar Year, rather than employee anniversaries in the upcoming year 2019.

• There has been a delay with SkillPro access to add employees for training as well as assisting other employees who are having difficulty with sign-in issues from previous DPO. Recently, SkillPro user set-up tasks has been assigned to Residential Program Manager

• Hiring of Youth Care Staff, background checks etc.

• Vacancies in Residential CINS/FINS positions due to current wages and availability of candidates

• Retention of Youth Care Staff

• Policy & Procedures have not been updated to reflect 2018-2019 QI Standards and the improved procedures that have been slowly implemented.

1.01 Background Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The provider has a policy and procedures for Background Screening of Employees and Volunteers (CHS/7101) that was last updated 7/1/2017 and reviewed 10/2/17.

CHS policy #7101 requires all staff and volunteers to complete a Level 2 Background Screening that includes good moral character documentation, employment history checks, employment screening, criminal record checks, and juvenile record checks. Prior to hire, the provider also conducts an annual background check with the Department of Motor Vehicles and local City/County law enforcement screening. Per the agency's procedures, employees who receive a promotion must be re-screened before the promotion is effective. Additionally, per the provider's policy, personnel will be re-screened during the fifth year of their employment and every 5 years thereafter.

A total of fourteen background screening files were reviewed for 9 new staff (7 of which transferred to the CINS/FINS program from another agency DCF funded program, 1 former intern, and 1 new nurse), 4 volunteers, and 1 staff eligible for a 5-year re-screening. Eight of the 9 new employees were background screened and had evidence of a DJJ Clearinghouse/BSU approval prior to hire date; one of the 9 new hires who transferred had a DCF clearinghouse background screening in lieu of a DJJ screening. The program became aware of the missing DJJ screening prior to the onsite QI visit and immediately submitted the request to DJJ as well as reported the incident to CCC. In response to the request, a DJJ background screening approval was received effective 9/21/2018. All applicable new employees were e-verified and proof of employment authorization is on file for each employee. A 5-year re-screening was completed prior to the 5 year anniversary for one eligible staff.

All 4 interns used by the program were background screened with eligible results prior to their start dates. The clinical director provided email correspondence with the HR Coordinator verifying approval status of the interns prior to establishing start dates.

The provider completed the annual Affidavit of Good Moral Character and submitted it to the Department of Juvenile Justice Background Screening Unit via email on November 1, 2017, prior to the January 31, 2018 deadline.

The agency has a pre-employment assessment (to determine suitability) for direct-care positions and uses the SkillSurvey standardized online

tool. The tool is administered prior to hire and allows for the provider to determine a rating of suitability based on exceeding an average score measured from the responses to various skills based questions posed to references. The tool was verified to be utilized with all of the new hires and a SkillSurvey Reference Feedback Report is maintained in the HR file for each staff.

No exceptions noted for Indicator 1.01

1.02 Provision of an Abuse Free Environment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a current policy and procedure in place for the Provision of an Abuse Free Environment and Grievance policy CHS/7103. The policies were last updated 7/1/2017 and reviewed 9/27/17.

Upon hire, employees receive a team member handbook and sign receipt of the Agency's Code of Conduct (Professional Conduct) which outlines the agency's policy against workplace violence and expectation regarding the provision of a safe environment. During orientation, staff receiving training on child abuse reporting mandate and the reporting procedures. Employees are required to report all known or suspected cases of abuse and/or neglect and youth have unimpeded access to self-report. Abuse reports are maintained in the youth's file and are entered in the provider's AirsWeb incident reporting database.

The Florida Abuse Registry Hotline number, rights and responsibility, and other relevant numbers are visibly posted in the hallway on the Resident Corner board. The hotline number is also posted in the dining room and included in the Resident Handbook. Youth are informed of these procedures during program orientation.

The grievance procedure is also reviewed with the youth during intake and the program has a grievance box with forms accessible to youth in the dormitory lounge adjacent to the staff desk. Per the provider's grievance policy, youth will personally handle their grievance documents unless a request for staff assistance is made by the youth.

A total of 2 abuse allegation incidents were reported and reviewed during the onsite visit for the review period; copies of the reported incidents are on file. None of the abuse allegations were institutional. There were no reported incidents of youth being deprived of basic needs or physical abuse by program staff was reported during youth surveys conducted during the review or observed during the visit. Training files for three new staff reviewed supported the three staff received training in child abuse reporting during program orientation.

During the tour of the facility, posting of the Florida Abuse Registry Hotline number, rights and responsibility, and other relevant numbers were observed to be visibly posted in the hallway on the Resident Corner board. Youth are also informed of these procedures during program orientation and the abuse hotline number is included on the orientation checklist and in the Resident Handbook.

The grievance procedure is also posted and the program has a grievance box with forms accessible to youth in the dormitory lounge adjacent to the staff desk. Grievance procedures are reviewed with the youth during intake and verified during the review of the three residential files reviewed. There were two grievances reported since the last QI visit from one youth regarding staff's use of profanity and name calling. The grievances were successfully resolved after PM met with the staff and youth.

Per the Program Manager, the program has not taken any disciplinary actions against staff for abuse behavior toward youth including verbal or physical abuse staff during the review period.

The three youth survey indicated they feel safe at the shelter and the adults are respectful when speaking with youth. The three staff stated conditions working at the shelter have been fair, good, and very good; none of the three staff surveyed has observed a co-worker use profanity, verbally abuse, or intimidate youth.

No exceptions noted for Indicator 1.02

1.03 Incident Reporting

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a Risk Management and Incident Reporting policy and procedure (CHS/7102) which is in place to demonstrate the importance of monitoring incidents for risk management purposes and develop strategies to limit the risk. The policy was last updated 7/1/2017 and last reviewed 9/27/2017. The policy follows all requirements of the Florida Networks indicator 1.03 – Incident Reporting.

The Children's Home Society has a risk management plan which identifies and addresses significant changes in the number and severity of incidents via the incident and accident reporting process. The staff at Safe Harbor takes immediate action to address founded incidents by completing incident reports and forwarding them to CHS management staff. The management at Safe Harbor will address any themes or concerns with the program staff. The agency has written procedure for CCC reporting which states that the staff member involved, witnessing

and/or having first knowledge of an incident/accident listed in FDJJ Policy 8000 will immediately inform his/her supervisor. The supervisor will review the facts of the incident and determine whether to call the central communication center within 2 hours of learning of the incident. By the end of a shift where a reportable incident occurs there will be a CHS incident completed in AIRSWEB and forwarded to a supervisor for approval. The program staff will complete follow-up communication tasks/special instructions as required by the CCC to ensure compliance and accuracy.

There were five reportable CCC incidents within the last six months that were all called into the CCC hotline within 2 hours of discovery. All five of the incidents were accepted by CCC and were assigned case numbers. Only four of the incidents called into CCC were noted in the log book. All five CCC incidents reviewed were records in AIRSWEB which is used by the agency for incident reporting.

There was one incident on 9/17/2018 that was called into CCC within 2 hours of discovery but was not noted in the log book as required by the agency's policy.

No exceptions have been found regarding indicator 1.03, Incident Reporting.

1.04 Training Requirements

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

The agency has two policies covering the training requirement namely, First Year Training Requirements (CHS/7105), which was last updated 10/5/2018 and last reviewed 10/5/2018, and On-Going Training Requirements (CHS/7106) which was last updated 7/1/2018 and last reviewed 9/27/2018. The policies and procedures are in place to ensure that all direct care staff are appropriately trained within the first year of hire to adequately meet the needs of the sheltered youth and that all direct care staff are appropriately trained on an ongoing basis to adequately meet the needs of youth.

Training will be scheduled throughout the year and may be provided by the Florida Network, local community resources, and various local provider personnel approved or certified to deliver training. The agency will maintain an individual training file for each staff. The file will contain an annual employee training tracker form along with any other training related documents that may include certificated, sign in sheets and/or agendas for each training. All first year residential and non-residential programming staff working in direct and continuing contract with DJJ youth will receive a minimum of 80 hours of training within the first year of employment. There are additional training or in-services during the first year of employment, along with required Skillpro training.

All direct care staff who are into their second year of employment and beyond are required to complete 40 hours in-service training as well as any specific training content required by the provider’s contract.

A total of six files were reviewed, three of the files were for employees within their first year of employment but after their 120-day benchmark. The other three files were employees post three years of employment. The agency has individual training files for each staff and has been consistent with providing most of the provider’s own orientation training. The provider has only one employee that completed trainings in Skillpro. Many of the required training were completed for in-service staff with the exception of the topics required through Skillpro. All three of the first-year employees are on track to complete their required 80 hours of training. All three of the in-service staff have active CPR and First Aid certification. The dates for staff trainings files were based off their date of employment but beginning in January 2019 the staff training files will be based on a calendar year. The agency has a CINS/FINS program training plan that is currently being implemented to correct training deficiencies.

Exception:

Managing Aggressive Behavior training is not included in the agency’s training policy as required by indicator 1.06.

There are trainings and certificates missing from each reviewed employee training file. None of the first-year employees completed all required trainings within 120 days of employment. Per the provider’s orientation training, none of the first-year staff completed the entire organization’s orientation training within the first 120 days of employment.

The three-in-service staff all completed trainings but only two of the three staff completed the required 40 hours of annual trainings during the most recently completed training year. None of the in-service staff completed any of the required Skillpro trainings required.

1.05 Analyzing and Reporting Information

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a written policy and procedures (CHS/7112), updated 7/1/2017, for analyzing and reporting data for case record reviews, incidents, accidents, grievances, customer satisfaction, outcome data, and monthly review of Netmis data reports. In addition, there is a comprehensive CHS Quality Management Plan for the current FY 2018, last reviewed May 2018, that describes the agency's philosophy,

Quality Management Structure, CQI strategies, strategic planning, management/operational plans, program results/outcomes, monitoring and evaluation of performance, data collection, and communicating results.

The program has a designated Quality Manager (QM) and Quality Specialist who is responsible for the implementation and oversight of its CQI program in Palm Beach/ Broward, Treasure Coast, portion of Sun Coast (Fort Myers) Florida. In practice, the program's CQI program includes many activities that are conducted by all staff to ensure all aspects of analyzing and reporting data are consistently implemented and documented.

The program's non-residential clinical staff as directed by the program supervisor, along with QM for the residential files, conducts quarterly case record reviews. Upon completion of each record review, the QS aggregates the results and provides a copy of the aggregated Quality Management Division Evaluation report with corresponding graphs to the DPO and Program Managers. Themes, trends, and areas of concerns are discussed monthly during team meetings and data analysis meetings. Program supervisors discuss the aggregated data with direct support staff to ensure appropriate areas are addressed and responded to in a timely manner. The QS also follows up at a later date to spot check specific files to verify completion of the corrective actions.

The program's Safety Committee is facilitated by the QM/QS and includes participation of the designated shelter staff (Residential Shift Leaders). The committee is responsible for reviewing incidents and accidents, performing safety checks and fire drills and making recommendations to management on a monthly basis. Each program and site has a representative who sits on the Safety Committee. The safety committee meets on the third Thursday of each month and if unable to attend, can appear by phone. The QS facilitates the call and meeting minutes from each meeting are produced and provided to committee members (including the QM), Program Managers, and the Executive Director (ED). The Division Safety Committee Coordinator discusses safety concerns and suggestions with the ED monthly and follows up with the QS as needed. The QMS will follow up with the ED and program supervisors as needed to ensure division safety. Consumer grievances are submitted to program supervisors and reviewed weekly by the QS.

Consumer surveys are administered twice a year during the second and fourth quarters. The QS addresses consumer surveying via email and at management team meetings and notifies the program supervisors of the outcome of the surveys. The surveys are aggregated by the QS and provided to supervisors, DPO, and ED.

The provider also has a monthly Supervisors' meeting held by the Regional ED and comprised of the Director of Program Operations (DPO), Program Manager, Clinical Supervisor, QM, and QS that meets monthly to review findings of the peer reviews, grievances, incidents/accidents, satisfaction survey results, outcome data, and Netmis data reports. Strengths, weaknesses, and goals are reviewed and documented in the minutes and discussed by team meetings by supervisors and managers.

Outcome data is reviewed monthly, quarterly, and annually. Each program documents outcome data monthly into a Program Performance Report. QM updates the DQPR monthly and data is entered into the agency's Division Quality Performance Report (DQPR) into the following areas: program performance, program team minutes, safety, record review, consumer satisfaction, and outcomes. As of July 1, 2018, the agency will implement use of the Survey Monkey tool to collect and report consumer satisfaction data for all programs. Consumers will be directed to the survey tool's link from the agency webpage. The results will be aggregated by programs.

Netmis data is emailed from the Florida Network to the agency ED who sends it to the DPO for review. The DPO shares information from the report card with staff during staff meetings. Evidence of staff meetings discussion was found on the agenda for one applicable meeting during the review period that was held in July 19, 2018.

A review of peer record reviews for the 4th quarter FY 17-18 and 1st quarter of FY 18-19 was conducted. A total of 12 files were reviewed from the residential program for the two quarters. For the two quarters, Safe Harbor achieved 100% overall compliance and no areas were identified as needing improvement. The Non-residential program also completed peer record reviews of 24 total records for the same periods. The program achieved 100% compliance for each quarter reviewed. Detailed reports of the case record reviews include: ratings of the review, significant findings, data analysis, and report summary/recommendations.

Monthly meeting dates and/or minutes for the period April-September 2018 were provided demonstrating Safety Committee meetings are held to discuss trends and patterns in incidents, accidents, safety inspections, and fire drills. The Safety Committee conducts monthly analysis of the data and submits the necessary recommendations to the ED for approval. Grievances are reported to the QMS on a monthly basis via the Program Performance Report and are discussed at the monthly Data analysis meetings when applicable.

A copy of the most recent Consumer Satisfaction Survey Result for the 2nd period of FY 2017-2018 (December-June) was reviewed. Survey results are compiled for the shelter and non-residential clients separately. A total of 99 surveys were completed; the surveys resulted in a 94% satisfaction rate for Safe Harbor and 100% satisfaction rate for the non-residential program.

Program outcomes data are documented monthly by each program, incorporating the contract, Netmis, and program outcomes required by the Florida Network and DJJ QI. A copy of the Safe Harbor CINS/FINS PPR FY 2017-2018 was reviewed or both programs. The reports of the outcomes data demonstrate the provider is capturing and monitoring outcome indicators for both the residential and non-residential program.

Monthly team/staff minutes for the period April-September 2018 were reviewed and found to have documentation of discussion by QM or staff of data being discussed regarding FN Netmis data, QI activities, QM reports, and areas identified as needing improvements or changes needed from analysis.

A copy of the most recent FN Report Card received by the Program Director was submitted to the management team for review. The report includes data for the current FY to date.

No exceptions noted for Indicator 1.05.

1.06 Client Transportation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy CHS/7116 which covers transportation of youth and is in place to ensure that the transportation of clients is a safe process for direct care staff and clients in their care. The policy was last update 5/18/2018 and last reviewed 9/27/2017. The policy follows all requirements of the Florida Networks indicator 1.06 – Client Transportation.

The procedure describes a 3rd party requirement, when transporting youth, which can consist of other direct care staff, volunteers, interns, clinical or administrative staff, and other youth. The agency has a procedure for single client transportation which indicates that an employee must notify and receive approval from the residential program manager, or designee, prior to transportation. The procedure states that the approval will be documented in the log book. Employees will document number of clients at the beginning and ending of each trip, mileage, initials of the staff/driver, date and time of travel, designation and purpose. The employees will maintain an open phone line with the residential program manager, or designee, if safety concerns arise during any transport. Employees will also call the residential manager, or designee upon arrival and departure, and every 15 minutes if travel time exceeds 30 minutes. The approved drivers will maintain a satisfactory motor vehicle report (MVR) which will be obtained prior to an offer being made by human resources for employment and the MVR will be updated annually.

After reviewing the log book and van logs it was confirmed that all transportation with youth is documented accurately and consistently. When single client transportation is required, there is adequate proof that either the residential program manager or the designated person gives permission and the permission is documented in the log book. The log book is reviewed on a weekly basis to ensure all entries are correct; this also confirms that all noted approvals for single client transportation were in fact approved. Every transport was logged in the log book and van log which documented beginning and ending number of clients, mileage, initials of the staff/driver, date and time of travel, designation and purpose. All agency vehicles that have audio/video recording devices have clearly posted notices. There is a current list of 22 cleared drivers which is held by the administration of the agency. The van log has a list of approved drivers for the van that includes 15 drivers which are all on the cleared driver list.

No exceptions have been found regarding the CINS/FINS Standard 1.06.

1.07 Outreach Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has an interagency agreements and outreach policy and procedure (CHS/7104) which was last updated 5/18/2017 and last reviewed 9/27/2017. The policy's purpose is to ensure that Children's Home Society establishes outreach activities, written agreements, and informal linkages with other community-based service providers to target youth who are most at-risk to become delinquent. The policy follows all requirements of the Florida Networks indicator 1.07 – Outreach Services.

The program services, roles and goals of the Children's Home Society will be defined and described in policy and procedure manual and agency brochures that will be made available to other community agencies. The interagency agreements will define, describe and specify services, fess, scope and nature of cooperation, collaboration, and responsibilities of all agencies involved in providing program services identified as needed by parent and/or youth. Copies of all interagency agreements will be maintained in a binder by the director of program operations or designee and made available to staff as requested. Multicultural outreach will be provided to minority populations, including but not limited to Hispanic, Haitian, and African American communities and conducted by bi-cultural and/or bi-lingual staff as necessary. Trained professional speakers will be provided to organizations that request additional information on the services and resources available at the Children's Home Society and in the CINS/FINS program. A media plan will be developed with the assistance of the development staff that will reach and engage youth. The director of program operations and/or designed staff will participate in community coalitions, forums, advisory councils, and/or initiatives as directed or required and documented activities. The designated staff will have the responsibility of presenting proper information about the CINS/FINS program to these groups. All outreach actives will be documented in the NetMIS database.

The agency has been actively updating their NetMIS account with all outreach activities and services and provided a list to the reviewer of all outreach services entered in NetMIS. The agency attends or hosts meetings such as the Circuit Juvenile Justice Advisory board, Department of Safe Schools, Division of student Services, Equity & Access, Inter-Agency Network, JDAI, Principal/School Counselor Appreciation Breakfast, and secondary school professional development. The agency supplied monthly minutes which identified a representative attending each monthly meeting with the Juvenile Division meetings and DJJ Advisory Board meetings.

No exceptions have been found regarding the CINS/FINS Standard 1.07.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

CHS Safe Harbor is contracted with the Florida Network of Youth and Families to provide both shelter and non-residential CINS/FINS services for youth and their families in West Palm Beach, Florida. The program provides centralized intake and screening twenty-four hours per day, seven days per week, and every day of the year. Trained staff are available to determine the immediate needs of the family and youth. Each youth at the program receives an initial eligibility screening, CINS/FINS Intake Assessment, a needs assessment, and a service plan. The counseling component consists of a total of four (4) counseling positions (three non-residential and one residential) and a LMHC clinical supervisor; the residential supervisor is under the supervision of the residential program manager. The counselors are responsible for completing assessments, developing case plans, providing case management services, and linking youth and families to community services. Additionally, case management, individual, family, and group counseling services, substance abuse prevention education, and referrals to local community agencies are provided as needed.

The shelter program provides critical temporary shelter care services to youth meeting the criteria for CINS/FINS, DV and Probation Respite, Family/Youth Respite Aftercare Services (FYRAC), Staff Secure as well as Domestic Minor Sex Trafficking (DMST). Per the residential program manager, the program did not serve any applicable youth for FYRAC, Staff Secure, or Domestic Minor Sex Trafficking during the annual compliance review. CHS West Palm Beach is not currently contracted to provide intensive case management (ICM) services.

The program seeks to meet the needs of the youth while in care with the ultimate goal of reunification with their families. The facility has twelve beds available for both male and female youth in the CINS/FINS program and twenty-four hour awake supervision is provided for youth residing in the shelter.

As needed, CHS Safe Harbor coordinates the Case Staffing Committee, a statutorily-mandated committee that develops a treatment plan for habitual truancy, lockout, ungovernable, and runaway youth when all other services have been exhausted or upon request from the parents/guardians. The Case Staffing Committee can also recommend the filing of a CINS Petition with the court. Non-residential counseling services are provided by qualified Master's level staff who are under the supervision of a licensed Clinical Supervisor. Case file reviews revealed that the counselors monitor the youth's and family's progress in services, provided support for the families, and monitored out-of-home placement as applicable. Additionally, the program has many outside agencies with which to refer youth and families and makes multiple referrals to meet the needs of the families it serves.

2.01 Screening and Intake

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

CHS West Palm Beach has a written policy CHS/7201 that is required for the Screening and Intake indicator. The policy was last updated 7/1/2017 and last reviewed 9/27/2017.

CHS West Palm Beach intake office is located at 3335 Forest Hill Blvd. West Palm Beach, Florida for Residential and Non-Residential youth and is available 7 Days a week. The procedure indicates that during business hours the clinicians at the shelter will gather the information as it relates to screening for service eligibility for the youth. During weekend and after hours the shelter staff completes the screening for eligibility for youth. The NETMIS information is entered within 72 hours after completion. The youth and parent/guardian receive the following during intake: available service options, rights and responsibilities of youth and parent/guardian, a hand book and possible action occurring through involvement with CINS/FINS services (i.e. case staffing committee, CINS petition, CINS adjudication) and grievance procedures.

A total of 6 files were reviewed for three (3) Residential (2 closed and 1 opened) and three (3) Non-Residential youth (2 closed and 1 opened). The procedures are being implemented as it relates to this policy. The initial screenings were received either by phone or face to face by a clinician or shelter staff. In all 6 case files, information was gathered to determine the youth's eligibility for CINS/FINS services within 7 days of the initial screening. In fact, all the screenings were deemed eligible within 1 to 2 days of the referral. In all 6 case files, the youth and family received in writing: available service options, a hand book, rights and responsibilities of the youth and parents/guardians, and possible actions occurring during servicing.

No exceptions were noted for indicator 2.01.

2.02 Needs Assessment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

CHS West Palm Beach has a written policy CHS/7201 that addresses all the requirements for the Needs Assessment indicator. The policy was last updated 7/1/2017 and last reviewed 9/27/2017.

The procedure states that the Needs Assessment is initiated within 72 hours of admission for the Residential Services and, for the Non-Residential Services, the Needs Assessment must be initiated within the first face-to-face session and should be completed within three (3) visits/sessions. Both Residential and Non-Residential Needs Assessments are completed by a master's level staff. A licensed supervisor is required to review and sign the Needs Assessment upon completion. If a youth is identified as having a suicide risk behavior during completion of the Needs Assessment, the youth is referred for an Assessment of Suicide Risk conducted by or under the direct supervision of a Licensed Mental Health Professional.

A total of 6 files were reviewed for three (3) Residential (2 closed and 1 opened) and three (3) Non-Residential youth (2 closed and 1 opened). Once the youth was deemed eligible for services, a Non-Residential and/or Residential staff was assigned to the youth and then an intake session was scheduled with the client and parent/guardian. The Needs Assessment for all 6 case files reviewed were implemented and completed on the same day of intake by a master's level staff and was signed and reviewed by the Licensed Supervisor. Among the 6 case files reviewed there were no youth identified as having suicide risk behavior.

No exceptions were noted for indicator 2.02.

2.03 Case/Service Plan

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

CHS West Palm Beach has written policies CHS/7202 (Service Plans) and CHS/7203 (Service Plan Implementation, Review, and Revision) that address all the requirements for the case/service plans indicator. The policies were last updated 7/1/2017and last reviewed 9/27/2017.

The policy states that the service plan will be completed within seven (7) working days after the completion of the needs assessment. The procedure indicates that the service plan will be related to the specific needs of the youth/family as it is identified in the needs assessment. The service plan will include; responsibilities of the youth/family to complete goals, responsibilities of the staff to assist the youth/family in meeting their goals, type of services/treatment, measurable objectives, time frames for completion, frequency of services and location. The service plan is signed by the therapist, supervisor, youth and parent. The service plan will have a formal review completed every 30 days for the first three (3) months and every six months thereafter. If the service plan signatures/initials are unable to be obtained, then it must be documented within the case file indicating the reason as well as the number of attempts. At the conclusion, a discharge summary will be completed and will be signed by the youth, family and counselor.

A total of 6 files were reviewed for three (3) Residential (2 closed and 1 opened) and three (3) Non-Residential youth (2 closed and 1 opened). The case/service plans were developed on the same date or within one (1) day of the completion of the needs assessments for both Non-Residential and Residential cases. The case/service plans all addressed the following areas: identified needs and goals, type, frequency, and location, target dates, actual completion dates, date plan was initiated and signatures of the youth, parent, counselor and supervisor.

One of the Residential case files has an error relating to the service plan implementation date. Seven (7) of the pages had a date of implementation of 9/7/2018 but on the eighth page, the date was entered as 9/8/2018. The clinical supervisor reported this as a typographical error.

No exceptions were noted for indicator 2.03

2.04 Case Management and Service Delivery

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

CHS West Palm Beach has written policies (CHS/7111, CHS/7204, and CHS/7206-7207) that address all the requirements for the Case Management and Service Delivery indicator. The policies were last updated 7/1/2017and last reviewed 9/27/2017.

Clients are assigned to designated clinicians who provide services throughout their services. The agency has many collaborative agencies with which to refer youth and families. The services include but are not limited to providing referrals, completing an assessment of needs, coordinating service plan implementation, monitoring and documenting client progress. The procedure also addresses discharging a youth. It states that the youth and or family can be discharged from services prior to a successful completion under the following conditions: a) successfully completion of agreed services; b) youth and/or family no longer meets the definition of CINS/FINS; c) youth engages in behavior endangering him/herself; d) youth runs away; and e) family voluntary withdraws.

A total of 6 files were reviewed for three (3) Residential (2 closed and 1 opened) and three (3) Non-Residential youth (2 closed and 1 opened). Each youth was assigned a counselor who implemented, coordinated services, provided support to the youth and family and documented the

services in their case files. The counselors monitored the youth progress and made contacts with the family monthly in person or by phone. Only one (1) case out of the six (6) had a phone contact with the parent when it relates to meeting with the parent to sign the service plan. It was also followed with a note in the youth's case file. There was only one youth who was referred to the Case Staffing Team. That case did not require court intervention. In each of 6 case files, the youth and family were provided the required services as stated in this indicator as needed.

There were four case files that were closed/discharged. Each of the files had completed the discharge summary and the NETMIS. The 30 and/or 60-day follow-ups were completed in the required time frame.

No exceptions were noted for indicator 2.04

2.05 Counseling Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

CHS West Palm Beach has a written policy CHS/7208 that includes an array of services to be provided to CINS/FINS youth and families, including intensive crisis counseling as well as individual, group, and family counseling. The policy was last updated 7/1/2017 and last reviewed 9/27/2017.

The procedures are being implemented as their policy states. The procedure addresses the counselor's participation in services with the youth and development of a service plan which will include, but not be limited to the following services: a) intensive crisis counseling; b) parenting training; c) individual, group or family counseling; d) community mental health services; e) prevention and diversion services; f) services by volunteer or community agencies; g) runaway center services; h) special educational, tutoring, or remedial services; i) vocational, job training or employment services; j) recreational activities, and; k) homemaker or parent aide services.

A total of 6 files were reviewed for three (3) Residential (2 closed and 1 opened) and three (3) Non-Residential youth (2 closed and 1 opened). All Non-Residential and Residential services provided counseling for the youth and their families. Their presenting problems were addressed in their service plans and their progresses were documented in their individual case files. The supervisor reviewed the files monthly and documented the review by signing a note in the files.

In practice, the Residential Services offer group counseling for the youth in the shelter 5 days a week. All 3 Residential youth files reviewed demonstrated the youth participated in the group sessions.

Note that, CHS West Palm Beach policy CHS/7208 does not address the structure of the group in their policy. It is required for group services to include the following: 1) a clear leader or facilitator; 2) relevant topic – educational/informational or developmental; 3) opportunity for youth to participate; and 4) be 30 minutes or longer. The Residential Group Log form does not include the required time of the group (30 minutes or longer) nor did it include the leader or facilitator; however, the individual case file notes had the time, facilitator, topic and participation of the youth. The Florida Network policy requires the group protocol to be stated in the policy/procedure and group sessions information should be documented on the group log forms.

No exceptions were noted for indicator 2.05

2.06 Adjudication/Petitiion Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

CHS West Palm Beach has a written policy CHS/7206 that addresses all the requirements for the Adjudication/Petition Process indicator. The policy was last updated 7/1/2017and last reviewed 9/27/2017.

The policy states that the counselor schedules a Case Staffing when the youth/family are not in agreement with services or treatment, if the youth/family will not participate in services selected, if the youth is not making progress towards completion, or the parent/guardian requests a Case Staffing Review. When the counselor schedules a Case Staffing the youth, family and staffing committee is contacted within 5 days prior to the confirmed scheduling. A meeting will be convened within 7 days after a written request from a parent/guardian. A list of representatives from DJJ, CINS/FINS, school representative, youth and parent/guardian are invited to the Case Staffing as well as other interested/involved parties. The Case Staffing Committee team meets on a regular basis and when the parent/guardian is not able to attend the meeting a written copy of the Case Staffing Recommendations are sent to the parent/guardian. The Case Staffing team meets every 3rd Thursday of the month at the shelter or at the school.

One (1) applicable closed residential case file was reviewed for the Case Staffing procedures. The case followed the protocol for scheduling a

case staffing. The counselor initiated the staffing and sent letters notifying the parent and the Case Staffing team of the case staffing planned meeting. The letter was sent out in the appropriate time frame on January 2, 2017 which was more than 5 days prior the staffing on January 11, 2017. As a result, of the case staffing, the team agreed to the on-going service plan without adding additional changes. A copy of the recommendation was giving to the parent after signing it. All protocols were followed as outlined in the procedures.

No exceptions were noted for indicator 2.06.

2.07 Youth Records

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

CHS West Palm Beach has a written policy CHS/7111 that addresses all the requirements for the Youth Records. The policy was last updated 7/1/2017 and last reviewed 9/27/2017. It states that the CHS maintains confidential records on each youth involving their treatment/services. The records will be maintained for seven (7) years.

The procedures are being implemented as it is stated in the policy. Clients are assigned to designated clinicians who provide services throughout their services. The procedure states that each youth will have a confidential file created upon admission. Each case file will be marked confidential and kept in a secure locked room. Active youth records are maintained in a locked room behind the Youth Care work station and kept in a secured file cabinet in each therapist's office. All closed case files are filed in a closed file cabinet and are placed in alphabetical order. Opaque locked boxes are used when files are transported out of the office.

A total of 10 files were reviewed, three (3) Residential (2 closed and 1 opened), three (3) Non-Residential (2 closed and 1 opened), three (3) Special Populations-Residential (2 closed and 1 opened) and 1 closed Non-Residential Case Staffing file.

The open/active Residential files are kept in a locked room on a bookshelf (not a file cabinet) and did not have confidential marked on the room door; however, confidential was noted on the case files. The closed Residential case files are stored in a locked room and in a locked filed cabinet marked confidential. The Non-Residential case files are stored in a locked room and in locked file cabinets with the word confidential written on it.

The Non-Residential records are transported in black rolling cases with a digital lock on the front of it. The rolling cases have confidential marked on it. All Non-Residential Counselors are assigned a locked rolling case.

All youth case files were neat and orderly. The open Residential files were in a note book binder and the closed cases were in manila folders. The Non-Residential case files were maintained in file folders.

No exceptions were noted for indicator 2.07.

2.08 Sexual Orientation, Gender Identity/Expression

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency does not currently have a written policy and procedure in place for Indicator 2.08, Sexual Orientation, Gender Identity, and Gender Expression.

No written procedures in place.

During a tour of the facility, "safe zone" rainbow flags were posted throughout the facility in common areas and the youth bedrooms indicating that all youth are welcome and should feel safe regardless of sexual orientation, gender identity, and gender expression.

The program served one youth who met the criteria for the indicator. The youth was currently active in the program and was interviewed by the reviewer. The youth identifies as gender fluid and pan-sexual and indicated no preference with regards to being addressed by any particular pronouns, name, gender, or room assignment. No specialized support was assessed or requested by the youth nor was there a need for other clothing that affirms their gender identity.

The agency does not currently have a written policy and procedure in place for Indicator 2.08, Sexual Orientation, Gender Identity, and Gender Expression.

Standard 3: Shelter Care

Overview

Rating Narrative

CHS Safe Harbor Shelter program provides temporary residential shelter care for male and female youth identified to be at-risk. The program has adequate space for all indoor activities and a very large outdoor space for youth to exercise and/use for entertainment including tennis and basketball courts. The CINS/FINS program is allocated one dormitory in the building for youth of both genders. The dormitory, kitchen, restrooms and common areas were observed to be clean during the visit. Each bedroom is furnished with two beds, each with separate pillows, bed covering, and a closet for youth belongings.

All youth who are admitted to the program receive a copy of the Consumer Handbook and an orientation to the facility. During the admission's process, each youth receives a new CINS/FINS intake screening to identify any medical, mental health, and/or substance abuse condition and this information is provided to the assigned clinical staff. The program provides individual, group, and family counseling, as needed. Group sessions are scheduled at least five times per week. The program also has a Comprehensive Master Plan for Access to Mental Health and Substance Abuse Services in place. Interagency Agreements have been established for the provision of health education, leadership development, and substance abuse, mental health, and medical services.

The Department of Children and Families has licensed Safe Harbor as a Child Caring Agency, with the current license for twelve (12) beds, effective until January 23, 2019.

In addition to the Residential Services Manager, the shelter has two shift leaders who are responsible for the operation of their assigned shift. Counseling services to youth in the Residential program are provided by a Master's level Counselor under the supervision of a licensed Mental Health Supervisor. College Interns are also utilized by the program to assist with delivery of services.

3.01 Shelter Envonment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency's policy CHS /7302 addresses the clean and safe maintenance of all buildings and grounds and provision of well landscaped, well maintained, safe conditions, and furnishings in good condition. The policy was lasted reviewed 9/27/17.

The agency's procedure includes the following: buildings will be inspected weekly for needed repairs and for any evidence of hazardous or unsafe conditions by the Residential Program Manager, Residential Shift Leader or Data Management Staff or designee for cleanliness; repairs will be requested within 24 hours and documented on the maintenance request form; the shelter environment will be kept in a safe, clean, neat and well maintained condition; health and fire inspections will be conducted annually or as required; pest control services will be completed to ensure facility is free of insect infestation; the grounds will be landscaped and well maintained; bathrooms and shower areas are kept clean and functional; regular inspections will ensure there is no graffiti on walls, doors, or windows; each youth will be provided his/her individual bed with clean covered mattress, pillow and sufficient linens; and youth will have a safe lockable place to keep personal belongings in the program manager's office.

During the onsite review an inspection of the shelter environment was conducted. Overall, the CHS facility was clean, well maintained and in great shape. The building is free of insect infestation and there was no graffiti on the walls, doors, or windows observed. The youth bedrooms were nicely furnished and neat with sufficient linens, pillows and sailboat design which is the theme of the Safe Harbor shelter.

The program's detailed map and egress plans of facility, general client rules, grievances forms, and hotline information are posted throughout the shelter on the informational board and the living room area. The daily schedule is posted in several areas in the living room area, dining room, youth bedrooms, and information board behind the staff desk. The youth engaged in meaningful structured activities scheduled by the program. On Mondays & Wednesdays - Radio Broadcasting and Cultural Group are conducted. At least one hour of physical activity is provided daily from 4:40pm – 5:40pm for the week days. Youth are provided the opportunity to participate in a variety of faith based activities on Tuesdays with Cavalry Church.

The agency has a current satisfactory residential group care inspection report from the Department of Health as of 12/27/2017. The agency has a current DCF Child Care license for 12 beds displayed in the facility effective through 1/23/2019. The agency's annual fire inspection was conducted and the facility is in compliance as of 3/28/2018. After reviewing fire drills and mock emergency drills from dates of 4/9/2018 – 9/14/2018 there is evidence that the agency meets standard requirements.

The agency also met standard requirements regarding agency vehicles being equipped with major safety equipment including first aid kit, fire extinguisher, flashlight, glass breaker, seat belt cutter, air bag deflator.

No exceptions were noted for indicator 3.01.

3.02 Program Orientation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy CHS /7313 that provides youth with the opportunity to learn about the program and its expectations through a positive orientation process. The policy was last reviewed on 9/27/17.

Per the agency's procedures, as soon as a youth is admitted, during the intake process, each youth is provided with a discussion of the program's philosophy, goals, services, and expectations. Youth orientation includes the following as outlined in the admission / client orientation checklist: intake assessment form; safe harbor resident Handbook; a list of contraband items and materials as outlined in the residential handbook; disciplinary actions; program dress code; information about access to medical and mental health services; procedures for visitation, mail, and telephone privileges; and program's no bullying and no harassment policy requirements. Documentation of each components of the orientation is outlined in the admission/ client orientation checklist which is signed by staff and the client and kept in each file.

During the review of the Program Orientation indicator, two residential files that were active and one closed file were reviewed. The CHS Orientation provided an opportunity for the youth to learn about the disciplinary action, grievance procedure, emergency /disaster procedures, contraband and rules, physical facility layout, daily activities, room assigned and suicide alert notification. The orientation includes obtaining the signature of the youth and parent /guardian present for each file.

No exceptions were noted for indicator 3.02.

3.03 Youth Room Assignment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy CHS /7301 that assures the most appropriate unit and sleeping room assignment to all youth being admitted to the residential programs for the purpose of the youth's protection from threats of harm or violence. The policy was last reviewed on 9/27/2017.

The agency's procedures are that all youth will be interviewed and assessed upon admission to determine the most appropriate room and individual bed assignments. The following will be determined before placing a youth in a double occupancy room: the review of available information about youth's history, status and exposure to trauma, history of aggression fights or bullying, past involvement in assault or aggressive behavior, and additional factors to consider including medical concerns suicidal risks. An alert is immediately entered in the program alert system when a youth alert is identified. The residential program manager or designee will review the room assignments during the shift or within 24 hours in the shelter. Room assignment is recorded on the intake assessment form.

Three residential youth files were reviewed, 2 open and 1 closed. All files contained documentation indicating the youth room assignment. The agency has six bedrooms in the shelter with 2 beds in each bedroom. The agency recently was licensed for an increase in the amount of bed capacity for the shelter which increased from 10 to 12 beds. All files contained the youth's age; gender; history of violence; disabilities-if any; physical size; suicide risk; as well as any known criminal offenses; assault or aggressive behavior; and gang involvement. Initial interactions and observations are also reviewed.

No exceptions were noted for indicator 3.03

3.04 Log Books

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy CHS/7109 that requires the shelter to maintain a permanent, bound logbook that records all routine information, emergency situations, and incidents pertinent to shelter activities. Entries that impact the security or safety of the program and the welfare of youth are highlighted. Logs will be kept a minimum of three years. Other information may be maintained in binders. The policy was last reviewed 9/27/17.

The agency procedures indicate the logbook and/or binder will be created, appropriately labeled and maintained in each area of the facility as is appropriate to that area so as to document the activities taking place in that area. Documentation involving safety and security or emergency situations will be highlighted. All document entries should be written in black ink. Documentation will be simple, clear, and any errors crossed out with one line with the staff initialing the correction. The use of white out is prohibited. Log books will be retained for a minimum of 7 years. All entries should include date and time and the staff signature of the writer completing the entry. All Youth Care Staff / Shift Supervisors will utilize this log for sign– in and sign– out purposes. Youth Care Staff/ Shift Supervisors will read and review log at the beginning of each shift. This review will include a minimum of 2 shifts prior. Program Supervisors or designee will review the log on a weekly basis to ensure the log entries are appropriate.

The log books were reviewed from 4/21/18 through 9/24/18. The program's safety and security issues were documented; all entries are brief

and legibly written in ink without erasure and white out areas. Incidents with youth and staff involved were written with date, time, and signature are clearly documented. All recording errors are struck through with a clear line with staff initial and date. The agency supervisors and all staff reviews the logbook for the previous two shifts. The supervisor's reviews are conducted weekly, dated, signed, and also includes any recommendations or follow ups required. Supervision and resident counts are documented consistently as well as visitation and home visits.

No exceptions were noted for indicator 3.04.

3.05 Behavior Management Strategies

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a Behavioral Management Strategies policy and procedure (CHS/7305) which was last updated 7/1/2017 and last reviewed 9/27/2017. The policy's purpose is to ensure that Children's Home Society implements a point based behavioral management strategy (BMS) designed to encourage accountability and provide positive reinforcement for compliance with the program's rules and expectations. The policy follows all requirements of the Florida Networks indicator 3.05 – Behavior Management Strategies.

The goals of the BMS are to increase positive interactions between the staff and the program residents, and to shape appropriate behavior through these interactions. The program provides structured daily opportunities for residents to earn points that may be redeemed in the point store. Upon admission to the program, each youth will be given a resident handbook in which the behavior management strategy is described (BMS). The residential handbook also describes the level system and the consequences of good or poor behavior. The BMS was created in direct response to the unique population at Safe Harbor. It was designed to maintain order and security; promote safety, respect and fairness and protection of rights; promote constructive dialog and peaceful conflict resolution; and minimize the separation of youth from the general population. All employees will be trained in the BMS points and level system and NAPPI. The behavior management program is explained and reviewed with all youth during their intake to the program. Supervisors monitor the use of the BMS between staff and clients and the staff evaluations include an evaluation on this skill. The BMS is based on positive reinforcement; earned levels are never taken away from a youth, however, the level can be frozen. The BMS has three levels and the points a youth earns are decided by the staff reviewing the youth's behavior during the shift they worked with the youth. The residential program manager will review point sheets, level sheets, and behavior notes to ensure there is a correlation between the documents and ensure staff are utilizing the rewards and consequences fairly and consistently. Room restrictions, time outs or other isolating consequences are not used in the BMS implemented by the agency.

All residential handbooks given to youth during an intake have the BMS clearly explained and all reviewed client files have a form signed by the youth stating that they have received the handbook. An interview was conducted with shift leader and residential program manager, which confirmed that all staff and supervisors are completing and following the requirements of the Behavioral Management Strategies policy (CHS/7305). The agency has the BMS from their handbooks posted in their common area that it available to all youth always. The agency has a residential behavioral management system point sheet and behavioral log that is completed for each youth every day of the week. This ensures that the youth's behavior and points are accurately documented and reviewed. The points given to youth are posted every day in the morning after the nightshift staff adds all the recently earned points to the previously earned and unspent points. The BMS has clear guidelines that promote positive behavior and increase a youth's accountability. The agency does follow a point and level BMS that gives youth the opportunity once a week to use their earned points toward rewards at the point store. Points are not given for negative behaviors and positive reinforcement is used to promote good behavior. Points that are earned by a youth are never taken away. There are trainings and meetings that go over the BMS used by the agency. The supervisor reviews the use of the BMS and meets with all direct care staff to ensure appropriate use of the BMS. After reviewing youth point logs, behavior logs, and interviewing staff it was confirmed that points and levels are given to the youth fairly with safety, security, respect, and fairness. Points are not given to youth for negative behaviors and the youth are redirected when necessary. The youth are not separated unless necessary to maintain safety and security. The BMS in place supports a peaceful resolution and focuses on positive reinforcement.

A review of staff training files revealed not all employees are currently trained in NAPPI behavior management.

No exceptions were noted for indicator 3.05.

3.06 Staffing and Youth Supervision

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

The agency has written the policy CHS/7306 that ensures adequate staffing is provided for the safety and security of youth and staff. Safe Harbor ensures that all staff understands the requirements regarding supervision of youth, including youth on constant sight and sound and overnight supervision of youth. The policy was last reviewed 9/27/17.

The procedures states that Safe Harbor will maintain staffing ratios, as required by Florida Administrative Rule 65C- 14.024, of 1:6 during awake hours and 1:12 ratio during sleep hours. Overnight shifts must always provide a minimum of two staff present. Safe Harbor will strive to ensure there is at least one staff on duty of the same gender as youth. The staff schedule is completed by the Residential Program Manager. Safe Harbor maintains an employee roster with home and cell telephone numbers to access on call staff when additional coverage is needed. Youth

Care Workers will observe youth at least every 15 minutes while they are in their sleeping rooms during sleep period. Youth Care Workers will ensure 10 minutes checks required for youth with identified risk of suicide or identified as needing constant sight and sound supervision. Staff failure to complete proper youth observation may result in disciplinary action up to and including termination. All staff will afford clients with their privacy and will knock and provide a verbal command before entering the client's room.

The staff schedule and client census was reviewed for the review period during the last six months. The program has 8 hour shifts with overlapping time on each shift: 6am – 2pm/7am – 3pm; 2pm -10pm/ 3pm -11pm; and 10pm – 6am/ 11pm -7am. The program has a policy in place that meets general staffing ratio requirements. The program maintains minimum staffing ratios as required by Florida Administrative Code and contract which is 1 staff to 6 youth during awake hours and community events and 1 to 12 youth during sleep hours. The agency staff schedule is provided to staff or posted in a place visible to staff. There is a holdover overtime rotation roster that includes contact numbers to reach these staff when additional coverage is needed.

Exception:

During the review period, the agency has not met the standard for having overnight work shifts consistently maintained with a minimum of two staff present as required. The program failed to maintain at least one staff on duty of the same gender as the youth on each work shift including all overnight work shifts. The program does not meet male and female guidelines and there is no proof of effort documented each instance when requirement is not met.

The program has not consistently met the standard for staff observing youth and documenting every 15 minutes while in sleeping rooms for any reason. After reviewing the camera on site for three random overnight shifts during the past 30 days, it appears that staff are exceeding the standard 15 mins increments and not documenting in real time when completing bed room checks. During the review of the surveillance footage for overnight shifts for three dates from 9/2/2018 to 9/12/2018, reviewer observed staff conducting bed checks. The staff logbook entries were consistently documented every quarter hour on the hour; however the times observed on the recording exceeded the standard 15 minute increments during the three overnight shifts, after adjusting for the 23 minutes difference in time.

3.07 Special Populations

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has written policies and procedures outlining staff secure, domestic minor sex trafficking, domestic violence respite, and probation respite. The policy reference number is CHS/7401. The Staff Secure policy was last reviewed on 9/27/17 and the Domestic Violence/Probation Respite policy was last reviewed on 10/5/17.

The program provides services to special population youth relating to staff secure, domestic minor sex trafficking, domestic violence respite, probation respite, and Family/Youth Respite Aftercare Services (FYRAC). Youth admitted as a DV Respite client is placed for fourteen to twenty one days at the program. The program completes case plans which includes goals focusing on aggression management, family coping skills, and other interventions designed to reduce reoccurrence of violence in the home. Probation Respite referral and Domestic Violence Respite referrals come from the Department of Juvenile Justice (DJJ). Youth must be on Probation with Adjudication withheld.

A review of one closed youth record was reviewed for Domestic Violence Respite. Reviewed documentation found the youth was screened by the Juvenile Assessment Center (JAC) and had a pending charge of Domestic Violence (DV), but does not meet criteria for secure detention. The youth had not exceeded the twenty-one day length of stay in the DV respite placement. The case management record included documentation of transition to CINS/FINS. The case plan included goals focusing on aggression management, family coping skills, and other interventions designed to reduce re-occurrence of violence in the home. Reviewed documentation validated all services provided to domestic violence respite youth were consistent with all other general CINS/FINS program requirements.

A review of one open and one closed record found both youth had a Probation Respite referral from the Department of Juvenile Justice (DJJ). Reviewed documentation found one youth did not exceed the length of stay more than fourteen to thirty days. One youth was still within the fourteen to thirty-day length of stay. All case management and counseling needs were considered and addressed. Reviewed documentation validated all services provided to probation respite youth was consistent with all other general CINS/FINS program requirements. Reviewed documentation found the program does not provide intensive case management and does not have a written policy and procedures relating to intensive case management.

The program did not have any applicable youth in the program for Family/Youth Respite Aftercare Services (FYRAC), Staff Secure or Domestic Minor Sex Trafficking during the annual compliance review.

As required, the program provides Family/Youth Respite Aftercare Services (FYRAC) but did not have a written policy and procedures during the annual compliance review.

No exceptions were noted for indicator 3.07.

3.08 Video Surveillance System

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy CHS /7117 for Video Surveillance System to ensure the overall safety and personnel accountability while recording activities of all youth, staff, and visitors. The policy was last reviewed 9/27/17.

The agency procedures state that the surveillance system will capture and retain video feedback that can be stored for a minimum of 30 days. The system will reflect date, time, and location and is able to operate on a generator if there is loss of power. Cameras are prohibited in the client bedrooms or bathrooms, but are visibly located by the facility main entrance and lobby area, and in the common areas. Camera feedback is accessible to and reviewed by the Residential Program Manager, Director of Program Operations, or Executive Director a minimum of once every 14 days and documented in the logbook. Reviews include randomly selected program activities and random overnight shifts. All requests for third party review of video feedback will be managed by the DPO or the Executive Director.

The staff schedule is located in the Program Manager's office and the youth care staff office. The program has a written notice that is conspicuously posted on the premises for purpose of 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 program has met the standard to ensure the shelter is equipped with 17 functioning surveillance cameras that are well positioned; no cameras are placed in bathrooms or sleeping quarters and all cameras are visible. The agency system can capture and retain video photographic images including facial recognition up to 28 days. A list of designated personnel who can access the video surveillance system including off site capability per personnel was corrected on site. Per the Program Manager, the current camera system has the capacity to operate for several hours during a power outage.

The program has not met the standard to ensure the shelter surveillance cameras back up recordings for up to 30 days. During a random review of the surveillance footage, the videos revealed that the camera time was inaccurate and off by 23 minutes.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

Children's Home Society Safe Harbor shelter has written policy and procedures related to the admission, interviewing and room assignment of youth admitted into the program. Upon admission program staff completes the intake via an individual interview with the youth. An initial intake assessment is completed to determine the most appropriate room assignment in relation to the youth's needs and issues, the current population of the facility, the physical space available, and staff's assessment of each youth's ability to function effectively within program rules and expectations. When making youth room assignment, consideration is given to each youth's physical characteristics, maturity level, history (including gang or criminal involvement), propensity towards aggression, and apparent emotional or mental health issues.

Staff receiving the youth at the time of admission notifies the program manager, counselor and/or director of program operations of any youth admitted with special needs, mental health issues, substance abuse issues, medical needs or security risk factors as well as those at risk of suicide. At the time of this QI review the part-time licensed registered nurse (RN) position was filled. The nurse was hired February 22, 2018 to fill the position that was vacated in June 2017.

The program began utilization of the Pyxis Med-Station system in August 2016; it is stored in the locked medical room adjacent to the staff work station on the facility dormitory. Topical and injectable medications are stored separately from oral medications. A locked refrigerator is maintained in the medical room for the sole purpose of storing medication requiring refrigeration. Medication distribution records for each youth are maintained in a binder which is stored in a locked medication cabinet in the locked medical room. The shelter does not maintain any medical or hygienic sharps in the residential quarters.

4.01 Healthcare Admission Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a written policy and procedures outlining the healthcare admission screening. The policy reference number is CHS/7401. The policy became effective on January 1, 2013 and was last updated and reviewed on October 4, 2017.

The program conducts an initial intake assessment upon each youth's admission into the program. The program's registered nurse (RN) is required to conduct the health screening if he/she is onsite during the intake process. If the RN is not present during the intake, the RN will review the health screening within five business days. Staff completing the intake will review with the youth his/her past and current medical/mental health history outlined in the Department's policy. The parent of any identified youth with a chronic medical condition will be required to ensure the youth receive the necessary treatment. If the parent is unwilling to ensure this medical care is provided, the staff will ensure the youth receives the necessary treatment.

Three youth records were reviewed for Healthcare Admission Screening. Two of three were open and one was closed. Each record included a completed healthcare admission screening form. Each form was reviewed and completed by the nurse within five business days of the youth's admission. Each reviewed record had documentation reflecting the youth were either on medication, had allergies, and had current mental health issues. One of three youth was identified with an existing chronic condition (asthma). When applicable youth requiring monitoring or follow-up care, the medical records included supporting documentation. All three records included completed body charts.

No exceptions were noted for indicator 4.01

4.02 Suicide Prevention

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place entitled Suicide Assessment, policy number CHS 7403, that was last updated July 1, 2017 and last reviewed September 27, 2017. In addition, there is a Comprehensive Master Plan for Access to Mental Health and Substance Abuse Services, to meet the requirements for this indicator.

The program maintains a written Comprehensive Master Plan addressing suicide prevention and response procedures. The suicide risk screening is a part of the initial screening process. Each youth is screened for suicide risk in accordance with the Florida Network's Policy and Procedures Manual for CINS/FINS. Results are reviewed and signed by the supervisor and documented in the youth's record. Youth identified as a suicide risk during the initial assessment are seen by a license mental health professional or non- licensed mental health professional

under supervision of a licensed mental health professional within twenty-four hours. After the assessment of suicide risk, the youth is placed on one-to-one or constant sight-and sound supervision based upon the assessment results. If the youth engages in suicidal/homicidal gestures, repeatedly states he/she wishes to harm themselves or others, and/or states a specific plan for suicide, the youth will be placed on one-to-one supervision, and will be referred immediately to law enforcement for a Baker Act. Staff are required to monitor all youth on one-to-one or constant sight-and sound supervision. Staff are required to document his/ her observations of the youth's behavior at thirty-minute intervals using an observation log or shelter daily log. Youth supervision levels are not stepped down until seen by a licensed professional.

Three applicable youth records were reviewed regarding suicide prevention. Each record included a completed suicide risk assessment. Each suicide risk assessment was reviewed and signed by a licensed supervisor. Two of three youth were placed on sight-and-sound supervision until seen by a professional or non- licensed professional supervised by a licensed professional. Two youth were placed on the appropriate level of supervision. Two youth were removed from constant sight and sound supervision and placed on standard supervision. Ten-minute observations of the youth were maintained the entire time the youth were on suicide precautions. Youth on constant sight- and sound-supervision was not removed until the youth could be seen and assessed by a mental health professional. One youth was not applicable for additional assessment or supervision.

No exceptions were noted for indicator 4.02.

4.03 Medications

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

The program has a written policy and procedures outlining medication management. The policy reference number is CHS/7405. The policy became effective on January 1, 2015 and was last updated on July 1, 2017. The policy was last reviewed on September 27, 2017.

The program has a comprehensive system in place for medication management. This system addressed medication, including receipt and storage, inventories, distribution, documentation, and disposal. The program's procedures included all of the mandatory components outlines in the Department's policy. The program's written procedures require the program to: verify and document the verification of prescription medication with the pharmacy; store all medications, including controlled medications, in the Pyxis med-station which should be inaccessible to youth; maintain a minimum of two super users for the med-station; store oral medications separately from injectable and topical medications; maintain a perpetual inventory for OTC medication which must be inventoried at least weekly; inventory narcotics and controlled substances weekly; utilize a secured refrigerator only for the storage of medication with storage temperature requirements; allow only staff designated with user permissions to have access to secured medication and allow only limited access to controlled substances; inventory and count controlled substances daily with witnessed shift-to-shift counts; secure syringes and sharps with documented weekly inventory counts; utilize the Medication Distribution Log form to document distribution of medication by all staff; have the registered nurse conduct all medication related processes and procedures when the nurse is on site; and conduct a review of medication management practices at least monthly via the knowledge portal or med-station reports. A list of staff designated as a Regular User or Super User is maintained. There were four staff designated as Super Users and four staff designated as Regular Users. When the Registered Nurse (RN) is on-site, he or she will conduct all medication related processes and procedures.

An observation of the medical station found all medication stored in a Pyxis Med- Station 4000 Medication Cabinet inaccessible to youth. Reviewed documentation confirmed the program maintains a minimum of two site-specific Super Users for Med-Station. There were no injectables or topical medications during the time of the annual compliance review. However, the program's practice is to store oral medication separate from injectables or topical medication. The program has a refrigerator with a lock on it located in the same room as the Pyxis Med-Station. At the time of the review there were no medications requiring refrigeration. The temperature of the refrigerator was thirty-six degrees. The agency does not accept youth currently prescribed injectables medications. In informal interview conducted with the program's manager and registered nurse (RN) confirmed the program has not had any youth since the last compliance review requiring narcotics or controlled medication. Both program staff also indicated the program does not utilize syringes and sharps although this is listed in the program's policy. Reviewed documentation confirmed the program maintains a daily perpetual inventory for over the counter medications (OTC). The registered nurse conducts all medication related processes and procedures when the nurse is on site; and conduct a review of medication management practices at least monthly via the knowledge portal or med-station reports. The program also utilizes a Medication Distribution Log for each youth on medication. Reviewed documentation validated the log was completed by a non-licensed or licensed staff when applicable.

Three youth records were reviewed for medication management. Two of three were open and one was closed. All three records had Medication Distribution Records (MDR) for each medication the youth was taking. The MDR's were filled out completely and documented all medications were given at prescribed.

Exception:

The program manager reported during an informal interview that monthly reports of all medication discrepancies are emailed to him from Quality Management. The program was unable to provide the daily medication discrepancies log for the last six months. The QI requirement and program's policy is to clear out medication discrepancies by the end of the staff member's shift. However, this practice could not be confirmed due to the program not having a daily discrepancies log to confirm discrepancies are cleared by staff at the end of each shift.

4.04 Medical/Mental Health Alert Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a written policy and procedures regarding the medical/mental health alert process. The policy reference number is CHS/7406. The policy became effective on January 1, 2003, was last updated on October 4, 2017, and last reviewed on October 4, 2017.

The program screens all youth during the intake process for any alerts identified on the general alert form in the intake packet. The program files a general alert form in all youth's record when the youth is identified with an alert. The general alert form addresses information relating to the youth's medical condition, physical activity restrictions, allergies, common side effects of prescribed medications, food and medication contraindication, and other pertinent treatment information. The general alert form is one of several ways the program effectively communicates youth alerts to staff. The program also utilizes a general alert board to identify youth identified with alerts. The alert board is located in the program's medication storage room. This board is color-coded to reflect various youth alerts and is utilized as a quick reference tool for staff to identify the clients and their alerts without pulling the youths medical/ mental health record. The program's practice is to attach common side effects sheets to the Medication Distribution Record (MDR) for each client prescribed medication. Staff members are provided instructions on how to identify and respond to the need for emergency care and treatment as a result of medical, mental health or substance abuse problems.

Three open medical records were reviewed regarding the program's medical or mental health alert process. Each reviewed record included a general alert form reviewed by the program's registered nurse. A review of the program's general alert board in comparison with the general alert form found each youth had an alert for one or more of the following: mental health, medical, and allergies. One of three youth was lactose intolerant. A review of the alert board documented the alert. However, the general alert form did not have a color-coded sticker to identify this alert although the information was documented on the alert form. The registered nurse added the color-coded sticker while onsite. In informal interview with the program manager confirmed the program's practice. In addition, the program manager indicated staff signs the program's logbook acknowledging they have reviewed all alerts and concerns prior to starting their shift. The program manager also indicated staff are made aware of alerts and precautions during staff meetings.

No exceptions were noted for indicator 4.04.

4.05 Episodic/Emergency Care

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a written policy and procedures regarding the medical/ mental health alert process. The policy reference number is CHS/7407. The policy was last updated on August 1, 2015 and last reviewed on September 27, 2017.

The program's written procedures require the program to conduct Episodic Emergency Drills on each shift at least quarterly to focus on varying emergency situations to include detailed debriefing; critiques and corrective action follow up if necessary. All instances of the first-aid and emergency case must be documented on a running episodic or first aid/emergency care log to provide information essential for the identification of a need for additional resources and/or clinical trends. Parents are notified of all episodic and emergency care. The program is required to maintain a knife for life, wire cutters, and first aid kit on the residential unit.

A review of the program's episodic and emergency care plan found the program had five instances within the last six months requiring off-site emergency medical care. Three youth medical records were reviewed. Two of three were closed and one was open. Two youth records

included receipt of medical clearance. One youth record was not applicable for receipt of medical clearance. Each youth's parent was notified of the incident. All incidents were documented in the program's daily logbook and episodic/ emergency care log. Reviewed documentation confirmed all incidents were reported to the Department's Central Communication Center. The program had an incident report for each reviewed off-site emergency. An observation of the medical station found the program's knife-for-life, wire cutters, and First aid kits/ supplies. A review of three training files found staff were missing training relating to emergency care.

No exceptions were noted for indicator 4.05.