



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Anchorage Children's Home
Residential Program

June 5 - 6, 2019

Compliance Monitoring Services Provided by

 **FOREFRONT**



Quality Improvement Review

Anchorage Children's Home – June 5 - 6, 2019

Lead Reviewer: Ashley Davies

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

Percent of indicators rated Satisfactory: 85.72%

Percent of indicators rated Limited: 14.28%

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 & Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petition Process	Satisfactory
2.07 Youth Records	Satisfactory
2.08 Sexual Orientation, Gender Identity, Gender 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 & Special Populations

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

Percent of indicators rated Satisfactory: 100.00%

Percent of indicators rated Limited: 0.00%

Percent of indicators rated Failed: 0.00%

Standard 4: Mental Health /Health Services

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

Percent of indicators rated Satisfactory: 100.00%

Percent of indicators rated Limited: 0.00%

Percent of indicators rated Failed: 0.00%

Overall Rating Summary

Percent of indicators rated Satisfactory: 96.43%

Percent of indicators rated Limited: 3.57%

Percent of indicators rated Failed: 0.00%



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Rating Definitions

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

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

Reviewer

Members

Ashley Davies, Consultant-Forefront LLC, Florida Network of Youth and Family Services

Ken Phillips, Regional Monitor, Department of Juvenile Justice

Theresa Clove, Executive Director, Thaise Exposure Tours

Sherl Craft, Counseling Supervisor, Lutheran Family Services NW

Nitara LaTouche, Operations and Management Consultant, Forefront LLC



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Methodology

This review was conducted in accordance with FDJJ-1720 (Quality Assurance Policy and Procedures), and focused on the areas of (1) Management Accountability, (2) Intervention and Case Management, and (3) Shelter Care/Health Services, which are included in the Children/Families in Need of Services (CINS/FINS) Standards (July 2018).

Persons Interviewed

- | | | |
|--|---|---|
| <input type="checkbox"/> Chief Executive Officer | <input checked="" type="checkbox"/> Executive Director | <input type="checkbox"/> Chief Operating Officer |
| <input type="checkbox"/> Chief Financial Officer | <input checked="" type="checkbox"/> Program Director | <input checked="" type="checkbox"/> Program Manager |
| <input type="checkbox"/> Program Coordinator | <input checked="" type="checkbox"/> Direct – Care Full time | 1 # Case Managers |
| <input type="checkbox"/> Direct – Part time | <input type="checkbox"/> Direct – Care On-Call | 1 # Program Supervisors |
| <input type="checkbox"/> Volunteer | <input type="checkbox"/> Intern | _____ # Food Service Personnel |
| <input checked="" type="checkbox"/> Clinical Director | <input checked="" type="checkbox"/> Counselor Licensed | 1 # Healthcare Staff |
| <input checked="" type="checkbox"/> Counselor Non-Licensed | <input checked="" type="checkbox"/> Case Manager | _____ # Maintenance Personnel |
| <input type="checkbox"/> Advocate | <input checked="" type="checkbox"/> Human Resources | _____ # Other (listed by title): _____ |
| <input type="checkbox"/> Nurse – Full time | <input checked="" type="checkbox"/> Nurse – Part time | |

Documents Reviewed

- | | | |
|---|--|--|
| <input type="checkbox"/> Accreditation Reports | <input checked="" type="checkbox"/> Table of Organization | <input checked="" type="checkbox"/> Vehicle Inspection Reports |
| <input checked="" type="checkbox"/> Affidavit of Good Moral Character | <input checked="" type="checkbox"/> Fire Prevention Plan | <input type="checkbox"/> Visitation Logs |
| <input checked="" type="checkbox"/> CCC Reports | <input checked="" type="checkbox"/> Grievance Process/Records | <input checked="" type="checkbox"/> Youth Handbook |
| <input checked="" type="checkbox"/> Logbooks | <input type="checkbox"/> Key Control Log | 7 # Health Records |
| <input type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Fire Drill Log | 3 # MH/SA Records |
| <input type="checkbox"/> Contract Monitoring Reports | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 11 # Personnel /Volunteer Records |
| <input type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 10 # Training Records |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 5 # Youth Records (Closed) |
| <input checked="" type="checkbox"/> Fire Inspection Report | <input type="checkbox"/> Supplemental Contracts | 5 # Youth Records (Open) |
| <input type="checkbox"/> Exposure Control Plan | <input type="checkbox"/> Telephone Logs | _____ # Other: _____ |

Surveys

- | | | |
|------------------|------------------------------|-------------------------|
| 1 # Youth | 4 # Direct Care Staff | 0 # Other: _____ |
|------------------|------------------------------|-------------------------|

Observations During Review

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

Comments

Additional Comments regarding observations, other important findings of interest, etc.

Strengths and Innovative Approaches

Anchorage Children's Home was in the direct path of Hurricane Michael On October 10, 2018. As a result, the shelter sustained catastrophic damage and was closed from October 10, 2018 until February 4, 2019 to repair all damages. A majority of the shelter was flooded and had to be demolished and rebuilt. During this time of closure, the agency lost 25% of their direct care staff. There was a loss of 75% of the housing in area surrounding the shelter. Many staff members lost their housing. At the time of the on-site review this was still an on-going issue. This has directly impacted the shelters ability to hire new staff. Due to the staff shortage and housing situation in the surrounding areas the shelter was currently operating at a maximum capacity of twelve youth instead of the twenty youth they are currently licensed for. This has also given them the ability to temporarily shut off and use the back portion of the youth shelter for the agency's transitional living program. The building used for that program was destroyed by the hurricane.

This current on-site review covered documentation from February 4, 2019 (the day the shelter re-opened) through the first day of the on-site review. A majority of the documentation and youth files prior to October 10, 2018 (the day of the hurricane) was either destroyed or waterlogged. Recent closed files, prior to October 10, 2018, were stored in a storage room inside the shelter and were accessible during the on-site review. Older files that had been moved to an outside storage shed were not accessible during the review due to the shed being destroyed. If requested documents could not be provided due to hurricane damage this will be noted under the applicable indicators.

Standard 1: Management Accountability

Overview

Anchorage Children's Home (ACH) operates the Hidle House Youth Shelter. The agency is a well-established, not-for-profit organization located in Panama City, Florida. The agency is led by Mr. Joel Booth, Executive Director. The agency provides both residential and non-residential CINS/FINS services or youth and their families in Bay, Gulf, Calhoun, Holmes, Jackson, and Washington counties. The residential program and main non-residential offices are located at 2121 Lisenby Avenue in Panama City, Florida.

The agency has a total of eleven (seven full time and four part time) youth care specialist (YCS), one program administrator, one executive director, one shelter manager, one registered nurse, three residential case managers, four non-residential counselors, one clinical supervisor, one human resource director, one administrative assistant, one business office manager, one maintenance coordinator, one financial



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director, one development director, and one PQI/training director. At the time of the review there were five YCS positions vacant (three full time and two part time) and two non-residential counselor positions vacant. The agency provides residential and non-residential services through its direct care and residential and non-residential counseling staff. The agency maintains several on-going community partnerships, conducts outreach activities and hosts local community-based organizations to provide services to the youth and families it serves.

The program requires new hires and on-going staff members to complete first year and annual trainings. The agency has an individual training file for each employee, with training provided through a broad array of local service provider options and other industry specific resources. Annual training is tracked according to the employee's date of hire. The agency does utilize the Florida Network, computer-based trainings.

1.01 Background Screening of Employees/Volunteers

Satisfactory

Limited

Failed

Anchorage has a Background Screening policy, ACH-ADM-HR-009, that was revised on 3/6/17 and reviewed, signed and approved by Joel Booth, Executive Director and a member with the Board of Directors on 7/9/18. The agency has a New Employee Hires policy, ADM-HR-026, that was revised and approved by Joel Booth, Executive Director and a member with the Board of Directors on 7/9/18 that addresses a pre-assessment tool is used to determine suitability.

The policy requires that all employees are screened prior to employment and employees are re-screened at the 5 year anniversary of employment. The HR department tracks this data and ensures that all appropriate personnel are re-screened according to the requirements. The new hire policy is the current policy that addresses all non-degreed candidates that are selected for an interview will complete a suitability assessment for employment and results for the screen will assist with generating interview questions for the candidate.

The agency completes a screening on volunteers that meets statutory and contractual requirements and requires volunteers to be screened in the same manner as employees of the facility.

The agency requires that student interns having direct contact with children meet the same background screening requirements as employees of the facility.



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Guest speakers, performers, ministers or other occasionally visiting personnel who interact with youth on an occasional basis do not need to be background screened if they are under the constant and direct supervision of background screened staff.

10 new hire employee files were eligible to be reviewed for pre-screening to demonstrate that background screening was completed prior to hiring.

4 out of 10 files reviewed showed evidence that the background screening was completed prior to hire date. 6 employee files had the background screen completed after the actual date of hire. The HR Director advised that there can be delays due to the inability to submit both DCF and DJJ screens at the same time.

1 employee file meets the criteria for 5-year re-screen and showed evidence this was completed on 3/28/19 prior to the 4/22/19 5 year anniversary.

The Berke assessment is used for the pre-screening to determine suitability in working with youth. The agency has a written policy that addresses suitability assessment; however, it specifically mentions this is the process for 'non-degreed candidates' and does not address that it is completed for all staff working with youth. The policy doesn't discuss the pass rate criteria currently, but the agency finds it beneficial in the hiring process to utilize the recommended questions that assist with gaining a more in-depth understanding of any scores that may appear low.

During an interview with the PQI Director, it was clarified that the agency is utilizing the Berke assessment tool to determine all staff meets suitability to work with youth and this is not limited to just non-degreed applicants.

8 staff met the criteria for having a pre-employment assessment prior to employment. All eligible staff received the pre-screening suitability assessment prior to the hire date. The program uses the tool to incorporate questions during the interview to assist with determining the applicant will be a good fit for the position.

Exceptions:

6 out of 10 files reviewed did not have evidence that the background screening was completed prior to the date of hire. 2 staff were missed by 1 day. The remaining staff files reviewed were missed by 3 weeks or more.

Due to the facility closure from hurricane damage, the annual affidavit of compliance was not submitted to the BSU prior to January 31st. The facility was closed from October 10, 2018 through February 4, 2019. However, the Human Resource Director provided documentation that this requirement was met prior to the completion of the onsite review on June 6, 2019.

1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

The program has a written policy and procedures addressing a Code of Ethics for all program staff. A review of the policy found it was signed by the Executive Director March 4, 2019. The program also has a policy entitled Abuse/Neglect Reporting which was reviewed and signed by the Executive Director on January 7, 2019.

All employees of the program are mandatory reporters of any suspected abuse or neglect. Any suspected abuse or neglect will be immediately reported to the Florida Abuse Hotline. In addition, any youth who discloses information which may indicate abuse or neglect will be given immediate access to a telephone and assistance in contacting the Florida Abuse Hotline. The program's Code of Ethics requires all staff are to be trained and perform professionally in their positions and to work together to accomplish the agency mission of serving, protecting, and strengthening youth, their families and communities. All team members are expected to maintain professionalism with youth. Team members are not permitted to involve youth in their own personal lives, but are encouraged to maintain healthy professional objectivity by not taking the negative actions and attitudes of the youth personally.

The program has a Code of Conduct which prohibits the use of physical threats, abuse, profanity, or intimidation. Upon hire, each staff member is required to sign for and receive an employee handbook which outlines the standards of conduct for employees. A sample of three staff personnel records, which include two youth specialists and one assistant shelter manager, were reviewed and confirmed this practice. A review of the program's employee handbook also included information for new employees concerning abuse reporting requirements. The handbook noted every Anchorage employee is a mandatory reporter of abuse and neglect under Florida statute. The handbook also lists the emergency hotline numbers for staff to utilize if necessary. Emergency numbers for the Florida Abuse Hotline were also observed posted in program areas.

Five staff training records were reviewed and included evidence all received training on child abuse reporting requirements and procedure.

The program affords youth the opportunity to contact the Florida Abuse Hotline to report allegations of abuse or neglect if they choose. According to the shelter manager, calls made to the Florida Abuse Hotline by youth are documented within the chronological notes of the youth's case management record. In addition, the program documents any contact made to the hotline and Central Communication Center (CCC) on the Anchorage Children's Home Unusual Incident Report form. These forms are maintained in an incident reporting binder. A review of the incident reports documented did not

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reveal any calls made to the Florida Abuse Hotline for the scope of the annual compliance review. The shelter manager was interviewed and stated the program has not had any incident this reporting period which required management to take action to address an incident of physical and/or psychological abuse, verbal intimidation, use of profanity, or excessive force by staff.

The program has a grievance process which allows for youth who are dissatisfied with services to document any complaints with this formal process. The grievance process suggests youth attempt to resolve issues first with their counselor or appropriate staff. However, if a resolution has not occurred, they have the right and opportunity to submit a formal grievance. An interview with the shelter manager revealed the program has not had any grievances submitted by youth for the scope of the annual compliance review. Grievance forms are available upon request. Once youth complete the form, they are placed in a locked drop box which is located in the large common area. The shelter manager reported the box is checked two three times weekly by administration. Direct care workers are not permitted to handle the grievances documented. The grievance process is also included in the youth handbook which is provided for each youth upon their orientation and intake to the program.

Exceptions:

No exceptions are noted for this indicator.

1.03 Incident Reporting

Satisfactory

Limited

Failed

The agency has a policy named, Florida Department of Juvenile Justice Incident Report Procedures, ACH-HH-SS-009 that was revised on 3/5/18 and last reviewed by Joel Booth, Executive Director and a member with the Board of Directors on 3/4/19.

Additionally, the agency has a policy, Unusual Incidents, ACH-HH-PM-006 that addresses the completion of the incident reporting form used for any reportable incident that was last revised on 3/5/18 and approved on 3/5/19 by Joel Booth, Executive Director and a member with the Board of Directors.

The agency has a procedure that provides guidance to all team members that are trained to respond to unusual incidents and requires team members to document the incidents using the Unusual Incident Form and in the daily log.



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The Shelter Manager or assigned designee is the person available to all youth care specialists for on-call supervision. According to the policy, they will monitor the documentation by the next business day and as needed for on-call supervision. The procedure outlines some examples of reportable incidents and requires team members to immediately notify the Shelter Manager, Supervisor designee, or on-call Supervisor regarding the incident including details on youth involved and how, staff present or involved, a complete description of the incident that occurred, a description of the corrective action taken, the effect the corrective action, and any other alternatives taken to remedy the situation. Staff are required to notify the DJJ Central Communications Center within 2 hours of the reportable incident or becoming aware of the incident. Staff must complete the Unusual Incident Report Form as soon as possible after the incident is resolved and prior to leaving the shift. The completed report is submitted to the Shelter Manager's box for review.

Staff are also required to notify all applicable parties including; the parent/guardian, DCF or CPI or CBC Case Manager, as soon as possible but no later than the end of shift and document this on the Unusual Incident Report form.

The program uses a paper form 'Anchorage Children's Home Unusual Incident Report' form to document all incidents that occur within the program. All incident reports are reviewed and signed by the program supervisor and the program administrator on the incident report log form. The form includes a place to indicate; name of the youth and demographic information, the program type, narrative of the incident, type of incident, who the incident is reported to with the name, date and time it is reported. The form specifies whether the incident applies to youth, program or staff/adult and includes sign off for staff completing the form, supervisor and the program administrator with the date completed. There is a section for supervisory review and follow up and indicates the need for additional follow up and if additional parties need to be notified.

The agency has an electronic log system that is used for documenting all activity in the program. Incidents that may impact program disruption are logged in the electronic logbooks. Medication errors are logged in the medication logs for the individual youth per interview with the program administrator.

There was evidence of follow up communication and the staff promptly responded to special instructions or inquiries from the CCC within the 24-hour timeframe specified in the email correspondence.

3 out of 4 reportable incidents were reported to the CCC within the required 2 hour time frame. 1 incident was reported outside of the 2 hour time frame due to the youth changing status from CINS FINS to being sheltered with DCF on the same day. It was reported to CCC on 6/5/19 and accepted.



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1 incident reported that a CINS FINS youth was in an altercation and wanted to press charges on the other youth but the PCPD advised the guardian would need to be contacted to give permission to press charges. There was no arrest made to the knowledge of the agency and therefore a CCC report was not needed at the time of the incident.

Exceptions:

No exceptions are noted for this indicator.

1.04 Training Requirements

Satisfactory

Limited

Failed

The agency has a policy named, Professional Development, ACH-HH-PM-008 that was revised on 2/28/14 and last reviewed by Joel Booth, Executive Director and a member with the Board of Directors on 3/4/19. Additionally, the agency has a policy, Professional Development Plan, ACH-ADM-HR-029, that was revised 6/6/11 and reviewed on 3/4/19 by ED Joel Booth and a member of the Board of Directors.

The procedure requires each team member to attend training as scheduled by the Shelter Manager and Program Administrator. Each training member has a training record that is reviewed semi-annually. Trainings are provided through on-site orientation, training sessions in conjunction with staff meetings, formal in-service training sessions, and off-site training. Each team member is required to have 80 hours of training within the 1st year of employment and at least 40 hours every year after. Additionally, at least 8 hours of training must be in mental health-related issues. All staff that is employed in a caregiver role, shall receive parent preparation training in accordance with Section 409.145(2)(e), F.S., prior to any unsupervised contact with children. Each team member that attends training must sign or complete an agency in-service attendance form. If the training is off-site, a certificate of completion or proof of attendance must be submitted to the PQI/Training Director.

The agency has a procedure for the professional development plan that provides opportunities for learning and skill enhancement is available to all employees and is reviewed at least annually.

The agency has an annual training plan that was last revised in April 2019. The training year is defined as the employee's anniversary date of hire. It provides a comprehensive overview of which trainings are required and which trainings will be covered during

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orientation for direct care staff. The agency maintains an individual training file for each staff member including training checklist and the subsequent evidence such as certificates or a printout of the DJJ SkillPro individual training report.

The facility was not accepting youth during the time of facility closure from October 10, 2018 through February 4, 2019. Staff were utilizing this time to complete trainings online when possible and cancelled trainings were re-scheduled and offered for those that had to miss an in-person training session due to the facility closure.

5 out of 5 files of direct care staff were either on target to meet their annual requirement of 40 training hours or have already met the annual requirement.

All 5 staff files reviewed for annual training show completion of the required training; CPR, First Aid, Managing Aggressive Behavior (for all direct care staff), Fire Safety Equipment, PREA, Sexual Harassment and Human Trafficking 101. The only training missed was Suicide Prevention 1 and 2 in SkillPro which is required annually.

The agency uses suicide prevention and a crisis intervention training to meet the 2-hour suicide prevention requirement. The PQI Director states that the crisis intervention training includes some additional elements of suicide prevention and advises staff on what to do if a youth reports suicide ideation and how to handle certain situations. The agency was providing an internal suicide prevention every year but not completing the DJJ SkillPro suicide prevention 1 and 2 yearly for all staff. After discussion with the PQI Director, it was explained that the interpretation of the standard and the policy was not clear and they were not aware this was an annual requirement in DJJ Skillpro previously.

All 5 new hire files reviewed completed the following training within the required 120-day timeframe: program orientation; Mental Health and Signs and Prevention of Substance Abuse; Behavior Management; Child and Adolescent Development; Child Abuse: Recognition, Reporting, and Prevention; Confidentiality; and Universal Precautions.

5 new hire files were reviewed and met all of the 120-day requirements for training except for CINS FINS Core training in 3 of the files. 1 file was missing the first aid certification and 1 file had CPR and first aid that recently expired in April 2019.

All required training that is to be completed within the 1st year is showing as complete or the staff member still has time remaining and is on target to complete within the required timeframe.

At the time of the review, each new hire had obtained a minimum of 64 hours of training or more and will be on target to complete all of the 80 hours of training within the 1st year required timeframe.



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1 staff completed the Managing Aggressive Behavior training within the 120-day requirement. 2 staff missed this timeframe due to the facility closure as a result of the hurricane damage but has supporting documentation the training requirement is fulfilled and the 2 remaining staff are scheduled to complete at the next makeup session on 6/18/19.

Exceptions:

5 out of 5 files reviewed for the yearly skillpro suicide prevention training reflected staff are not completing this training annually due to a misunderstanding of the policy.

1 file (GL) showed that staff hired on 6/18/18 did not have a current CPR or first aid certification. The certifications recently expired in April 2019.

1 file ((RH) was missing evidence of a certificate for first aid in the file.

3 out of 5 new hire files reviewed completed the CINS FINS Core Training outside of the 120 day requirement, however, all 5 files did show evidence that the training was completed in the training record. Example: DOH 6/18/18 CINS FINS Core Training completed 5/26/19, DOH 12/28/18 CINS FINS Core Training completed 6/4/19, DOH 9/7/18 CINS FINS Core Training completed 6/4/19

1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

The agency has several policies to address this indicator; Performance Quality Improvement Program (PQI Program), ACH-ADM-PQI-004 that was revised on 4/15/16; Internal Program Reviews, ACH-ADM-PQI-006 last revised on 11/10/14; Risk management, ACH-ADM-PQI-007, last revised on 12/10/14; Client Satisfaction, ACH-ADM-PQI-008, last revised on 11/10/14; Record Review, ACH-HH-PM-011 that was revised on 3/3/08 and all were last reviewed by Joel Booth, Executive Director and a member with the Board of Directors on 3/4/19.

The procedure PQI Program procedure outlines the 4 leveled tier system and the responsibilities of each staff affiliated with their respective tier. For example; Level I – Board of Directors/Executive Director, Level II – Senior Management Team, Level III – Program Representatives, and Level IV – Direct Care Staff. PQI is monitored monthly, quarterly and annually across the various levels and is designed to identify and meet the evolving service needs of the client population, stakeholders, and the community.

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The Internal Program Reviews and Record Review procedures outlines the process involved with reviewing all programs at least annually for quality improvement purposes and a comprehensive detail of what is involved with all responsible parties involved. The area of assessment includes: individual case and record review, stakeholder feedback/satisfaction, unusual incident and grievance data, outcome and goal measurements, staff and client feedback, data review, corrective actions, and contract monitoring results.

The record reviews occur on a regular basis. When record reviews are conducted the program has a uniform tool that is used to assess the required areas of the file to assess if the consumer record is current and adequate in addressing the specific needs of the individual.

The Risk Management procedure covers the risk management process and discusses the reviews that occur quarterly during the Senior Management meetings. The process includes a Safety Committee that identifies issues or concerns that can be immediately addressed by a program staff representative or maintenance coordinator during the quarterly meetings and presents any identified concerns that need to be presented to the Senior Management Team for further review. The ED updates the Board of Directors on any risk management issues.

The Client Satisfaction procedure indicates that each Program Director is responsible for the collection of client satisfaction information and is monitored at least quarterly. All staff are required to work to provide quality services which result in a high rate of client satisfaction. Consumer feedback is obtained through 2 formal methods; client surveys and the grievance process.

The agency has a very robust program that meets all the requirements of the indicator.

Anchorage's performance quality improvement program has a flow chart that outlines the four-tier level process and provides documentation and a visual breakdown of parties responsible for each tier-level. All direct care staff are separated into 7 different committees based on the program that is affiliated with an assigned representative.

During an interview, with the PQI Director, the program was thoroughly discussed and it was evidenced that the process and documentation is clear, concise and the supporting documentation is maintained in an organized manner. The PQI Director explained that meetings are held without supervisors' presence to allow for staff to meet in their individual committees and provide candid suggestions and feedback. The representative for each committee meets directly with the PQI Director to allow the feedback or suggestions identified to be shared in Senior Management Meetings.

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Documentation showed evidence that the program completes record reviews and reviews the incidents, accidents and grievances on a quarterly basis. Customer satisfaction is reviewed quarterly with Tier 2 team Senior Management staff and bi-annually with Tier 3 level staff.

Outcome data and NetMIS data reports are reviewed on a monthly and quarterly basis by program staff and senior management. Any areas of concern identified are addressed through the PQI process and there is documentation to show how changes are modified and/or improvements are made and involves staff on all levels.

A random sample of program meeting minutes, PQI meeting minutes, and Senior Management Team meeting minutes were reviewed and it was noted that all requirements are being communicated and shared with all levels of staff. There is evidence that staff are able and prompted to provide feedback and this is included in meeting minutes. For example, the minutes in April 2019 included staff suggestions related to the point system and behavior management system like allowing youth to pick out evening snacks or favorite meals with the food manager and ways to increase youth's availability to the point store by receiving additional points for being on level 1.

Additionally, the PQI Meeting minutes for April recognized the Employee of the Quarter was Yolanda Humes who was nominated by several of her coworkers for all of her hard work and support during the re-opening of the shelter for the quarter Jan-Mar 2019.

Exceptions:

No exceptions are noted for this indicator.

1.06 Client Transportation

Satisfactory

Limited

Failed

The agency has a policy in place to address transporting of clients This policy was revised on April 15, 2016. This policy was reviewed on March 14, 2019 by the executive director. This policy provides details on use of personal vehicles, limits to vehicle use, and safety standards when operating vehicles.

The procedures state that youth cannot be transported in personal vehicle unless approved by the program manager. When personal vehicles are used, staff members accept liability for any injuries, accidents, and damage that results.

The procedures state that agency vehicles have a fire extinguisher, first aid kit, seat beats, and a knife for life. Every person has to have a seat belt that is to be used at all

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times while vehicle is in operation. Staff to client staff ratio during transport is 1:6. Agency vehicles are also not be used for personal tasks without prior approval from the program manager.

The procedures state that whenever possible a third party needs to be present to avoid 1:1 transports. This helps to avoid situations that put the youth or staff in any real or perceived danger or harm as well as to reduce the chances of allegations of inappropriate conduct by staff or client. The third party can be an approved volunteer, intern, agency staff, or youth. When a third party is not available, approval must be obtained by the program supervisor and documented in the shelter log and transportation log. This policy applies to same sex and opposite sex staff and youth.

The shelter has two vans that are utilized to transport clients. The staff maintain a transportation log detailing the number of clients being transported, staff conducting the transport, destination, and mileage. All logs reviewed for the last four months were completed in their entirety. Both vehicles were noted to have all safety equipment including fire extinguishers, first aid kit, jumper cables, and seat belt cutter/window punch device.

During the last four months the shelter has held to the policy of 1:6 staff to client ratio with any exceptions approved by a supervisor. Transportation logs are maintained inside the vehicles and supervisor approval was noted for all 1:1 transports. The supervisor's initials were documented on the logs recognizing and approving these transports. The logs demonstrated clients being taken to a variety of appointments including court, medical appointments, school, and other places that fall within the guidelines of acceptable transports.

Exceptions:

No exceptions are noted for this indicator.

1.07 Outreach Services

Satisfactory

Limited

Failed

The program has a policy in place that references outreach services in the layout of an outreach plan. The plan is entitled Public/Community Involvement (ARC-ADM-PQI-003), which addresses the key elements of this indicator. This policy was last reviewed and signed by the executive director on March 4, 2019.

Hide House has had representation across a variety of different community outreach activities and meetings including emergency housing, continuum of care group, a housing subcommittee group, human trafficking task force, juvenile justice council, and

Circuit 14 children's council. This demonstrates a high level of engagement within the community. Minutes and sign-in sheets were provided for these meetings.

The agency also has numerous cooperative agreements that demonstrate great partnerships across agencies. These agencies include DCF, DJJ, Big Ben Community Based Care, Agency for People with Disabilities, National Safe place, Zoo World, Bay Arts Alliance, and Emerald Bay Academy.

Exceptions:

No exceptions are noted for this indicator.

Standard 2: Intervention and Case Management

Overview

Anchorage Children's Home (ACH) residential and non-residential programs offer CINS/FINS services to youth and their families in Bay, Gulf, Calhoun, Holmes, Jackson, and Washington Counties. Currently, the agency has a Licensed Mental Health Counselor (LMHC) who serves as the clinical supervisor and provides oversight for both residential and non-residential services. The agency also has four non-residential counselors (AFC) and three residential case managers (RCM). There were two AFC positions vacant.

Three non-residential counselors have offices off-site while the other three, as well as, the three RCM's have offices on-site, or within the primary agency location. All three RCM's have bachelor's degrees, as well as the four AFC's. Both the residential shelter manager and program administrator have a master's degree in social work. The clinical supervisor has a master's degree in counseling/psychology and is also a Licensed Mental Health Counselor (LMHC).

The residential cases are reviewed as a team, with the residential shelter manager and RCMs, twice a week. During this meeting staff discuss youth behavior, youth progress, and discharge planning. The program administrator and clinical supervisor occasionally join the weekly meetings depending on the census and risk level of youth in the program. Clinical staffing meetings are held once a month with the program administrator, clinical supervisor, RCMs, and youth care specialists (YCS).

The non-residential cases are also staffed as a team once a week and include the clinical supervisor and all AFCs. During staffing meetings, youth progress and case plans are reviewed as well as any relevant clinical concerns including mental health needs and suicide assessments.

The non-residential program also conducts case staffing meetings to address identified problems and non-productive outcomes for both youth and their family. The case staffing committee can also recommend CINS Petitions to be filed in court to order chronic status offenders to participate in additional treatment services to assist and resolve serious non-delinquent issues.

2.01 Screening and Intake

Satisfactory

Limited

Failed

Anchorage has a written policy and procedure for residential and non-residential programs that addresses all the key elements of this indicator. The policy was updated 1/7/2019 for non-residential and 3/4/2019 for the residential program. The policy was signed by the executive director.

Referrals for services are accepted twenty-four hours a day, seven days a week. Screenings for eligibility are attempted with all youth and families referred for services. Centralized intake services are also available to youth and their families twenty-four hours a day, seven days a week.

During normal business hours, referrals are received by support staff who then direct the referral to a counselor. The counselor then attempts to reach the family referred to complete a screening and determine eligibility for services. If a counselor is not available at the time of the referral, then the on-call counselor/case manager will attempt to complete the screening. "Walk-ins", or any youth or family that arrives on site without an appointment are met by a counselor/case manager who completes eligibility screening with the family. An on-call schedule is in place to ensure youth and families have access to 24/7 intake services. If an intake occurs within regular business hours the intake is completed by a counselor or case manager on site. After-hour intakes are completed by the on-call staff or a trained youth specialist.

There were five non-residential files reviewed (two opened and three closed) and five residential files reviewed (one opened and four closed).

All ten files documented an eligibility screening was completed within seven calendar days of referral. All ten files documented the youth and parent received, in writing, available service options, rights and responsibilities, and a parent/guardian brochure. All ten files also documented the parents and youth received information on possible actions occurring through involvement with CINS/FINS services and grievance procedures.



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Exceptions:

No exceptions are noted for this indicator.

2.02 Needs Assessment

Satisfactory

Limited

Failed

Anchorage has a written policy and procedure for residential and non-residential programs that addresses all the key elements of this indicator. The policy was updated 1/7/2019 for non-residential and 3/4/2019 for the residential program. The policy was signed by the executive director.

For residential services, a needs assessment must be initiated within 24 hours of admission. The needs assessment is typically completed at the time of intake by the residential case manager (RCM). However, if a youth specialist completes the intake, then the needs assessment will be completed within 72 hours by an RCM. For non-residential services, the assigned counselor completes the needs assessment with the youth and family within 72 hours of admission into services. Most often this occurs during the intake process.

There were five non-residential files reviewed (two opened and three closed) and five residential files reviewed (one opened and four closed).

All five residential files reviewed documented the needs assessments were initiated within one to two days of admission. All five non-residential files reviewed documented the needs assessment was completed within two to three face to face contacts. The Needs Assessments were completed by bachelor's level counselors and were reviewed by the Licensed Mental Health Supervisor. All ten needs assessments were signed with the counselor and supervisor's signature along with their credentials.

Out of the ten files reviewed only one had an elevated risk of suicide as a result of the needs assessment. An Assessment of Suicide Risk was conducted under the direct supervision of a licensed professional.

Exceptions:

No exceptions are noted for this indicator.

2.03 Case/Service Plan

Satisfactory

Limited

Failed

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Anchorage has a written policy and procedure for residential and non-residential programs that addresses all the key elements of this indicator. The policy was updated 1/7/2019 for non-residential and 3/4/2019 for the residential program. The policy was signed by the executive director.

The policy states that the case plan is initiated at the start of services and updated as necessary based on progress made by the youth and family. The case plan provides a summary of the presenting issues, goals to be addressed as well as strategies/objectives for meeting those goals. In addition, the case plan is created with input from the youth as well as the parent/guardian.

For non-residential and residential services, the case plan is initiated at intake. The case plan is completed by the assigned counselor within 72 hours of completing the Needs Assessment. It is reviewed every 14 days and updated to note progress or new goals needed.

There were five non-residential files reviewed (two opened and three closed) and five residential files reviewed (one opened and four closed).

All ten files reviewed documented a case plan was developed within seven working days of the needs assessment. All ten case plans included: individualized and prioritized goals, service type, frequency, and location, persons responsible, target dates for completion, actual completion dates, signature of the youth, parent, counselor, and supervisor, and date the plan was initiated.

All applicable files were reviewed for progress within thirty and sixty days of intake as evidenced by the youth, parent, counselor, and supervisor's signature along with the date of the review. There were no files applicable for a ninety-day review.

Exceptions:

No exceptions are noted for this indicator.

2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

Anchorage has a written policy and procedure for residential and non-residential programs that addresses all the key elements of this indicator. The policy was updated 1/7/2019 for non-residential and 3/4/2019 for the residential program. The policy was signed by the executive director.



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The case management policy states that through advocacy and case management, staff will assist families and youth who have a variety of needs. It references external referrals will be made to address needs that are not provided by Anchorage. In procedure, case management services are provided to every referred client. At intake, a case manager is assigned to the client.

For non-residential cases, the counselor also provides case management services. These services are documented in progress notes in individual client files.

There were five non-residential files reviewed (two opened and three closed) and five residential files reviewed (one opened and four closed).

All ten files documented a counselor was assigned to the case. All five applicable files documented the counselor established referral needs, coordinated referrals to services, and monitored out-of-home placement. All ten files documented the counselor coordinated service plan implementation, monitored the youth's/family's progress in services, and provided support for families. In one of the files the youth was referred to the case staffing committee. Two applicable files documented referrals for additional services upon discharge from the shelter. All ten files documented case monitoring. All seven applicable files documented case termination notes.

There were three files applicable for a thirty day follow up and it was completed as required in all three cases. Two files were also applicable for a ninety day follow up and those were also completed as required.

Exceptions:

No exceptions are noted for this indicator.

2.05 Counseling Services

Satisfactory

Limited

Failed

Anchorage has a written policy and procedure for residential and non-residential programs that addresses all the key elements of this indicator. The policy was updated 1/7/2019 for non-residential and 3/4/2019 for the residential program. The policy was signed by the executive director.

Residential Case Managers/counselors provides the following service modalities: individual and family sessions (at least 1x weekly), facilitate group sessions (5x weekly), and assess in crisis intervention as needed. All counseling services are warranted according to the youth's service plan.



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Non-Residential Counselors meet weekly with their assigned youth and offer family sessions as needed.

There were five non-residential files reviewed (two opened and three closed) and five residential files reviewed (one opened and four closed).

All ten files reviewed documented the youth's presenting problems were addressed in the needs assessment, initial service plan, and service plan reviews. All ten files documented case notes were maintained for all counseling services provided and documented the youth's progress. All ten files documented the youth and families received counseling services in accordance with the service plan. Individual and family counseling was provided by the program. All ten files documented on-going clinical reviews of the case and staff performance.

The five applicable residential files documented group counseling was provided at least five days a week. All groups reviewed were at least thirty minutes in length, documented a clear leader, documented a clear and relevant topic, and provided an opportunity for youth engagement.

Exceptions:

No exceptions are noted for this indicator.

2.06 Adjudication / Petition Process

Satisfactory

Limited

Failed

Anchorage has a written policy and procedure for residential and non-residential programs that addresses all the key elements of this indicator. The policy was updated 1/7/2019 for non-residential and 3/4/2019 for the residential program. The policy was signed by the executive director.

The process is in place for youth who have previously demonstrated behavioral symptoms which meet criteria for chronic running away, habitual truancy, and persistent disobedience of the reasonable and lawful commands of a parent that are not specifically the result of a developmental disability or a psychiatric disorder.

The procedure in place outlines that if the case staffing committee recommends a CINS petition for a youth, a case manager will be assigned to the case and is expected to prepare the documents necessary or the DJJ attorney to file a CINS petition in court. The documents will be completed within twenty-one days of the case staffing and forwarded to the Clinical Supervisor. The case manager attends court hearing and



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serves as the Anchorage representative. The case is reviewed every thirty days with a staffing team and at least quarterly with the entire case staffing committee.

There were five non-residential files reviewed (two opened and three closed) and five residential files reviewed (one opened and four closed).

There was only one youth out of the nine files reviewed that was referred to the Case Staffing Committee. The youth was first staffed with the Anchorage staffing team which consisted of the counselor and the Licensed Mental Health Supervisor. At this staffing the youth was referred to the Case Staffing Committee. The family was notified by letter within five days of the staffing as well as by phone. The youth and the guardian participated in the staffing and signed the attendance sheet. The youth and parent were provided and signed the new service plan along with a written notification of the case staffing recommendations.

The case staffing included the Licensed Mental Health Supervisor, the counselor, the youth, parent, and two school representatives.

Exceptions:

No exceptions are noted for this indicator.

2.07 Youth Records

Satisfactory

Limited

Failed

Anchorage has a written policy and procedure for residential and non-residential programs that addresses all the key elements of this indicator. The policy was updated 1/7/2019 for non-residential and 3/4/2019 for the residential program. The policy was signed by the executive director.

All client records are stamped confidential and kept within a locked filing cabinet inside a locked office. No file or portion thereof is taken off of property at any time without the knowledge and prior consent of the Program Manager, supervisor or designee from the specific program. When it is necessary to transport a file(s), the file(s) will be secured in a locked, opaque container that is marked confidential.

There were five non-residential files reviewed (two opened and three closed) and five residential files reviewed (one opened and four closed).

All ten youth files reviewed were marked confidential and maintained in a secure room, inside locked file cabinets that were also marked confidential. All open files were in a binder and closed files were placed in a yellow folder. The agency uses an opaque, locked, rolling container, marked confidential, to transport files. All files reviewed were



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maintained in a neat and orderly manner. The youth files are accessible only to the program staff as reported by the Licensed Mental Health Supervisor.

Exceptions:

No exceptions are noted for this indicator.

2.08 Sexual Orientation, Gender Identity, Gender Expression

Satisfactory

Limited

Failed

The agency has a policy in place titled Sexual Orientation, Gender Identity, and Gender Expression that addresses the requirements of this indicator. The policy was put into effect March 4, 2019 by the executive director.

Youth will be addressed by their preferred name and gender pronouns. All staff, service providers, and volunteers are prohibited from engaging in any form of discrimination or harassment of the youth based upon their actual or perceived sexual orientation, gender identity, or gender expression. All staff, service providers, and volunteers who have intentional contact with youth will have knowledge of this policy. Areas in which youth reside or are served will have signage indicating the program is a safe space of all youth regardless of actual or perceived sexual orientation, gender identity, and gender expression. Youth will be identified in the logbook and all public-facing documents by their preferred name and gender pronouns. Youth are to be assigned a room aligning with their gender identity, or the program will provide specific documentation as to why other room assignment was determined to be suitable. Youth will be provided with hygiene products, undergarments, and clothing that affirms their gender identity or gender expression.

The shelter has copies of the Zine located in the dayroom and counseling hallway for staff, youth, and visitors to take and read. There was documentation in a sample of three training files reviewed that staff received LGBTQ training.

The shelter has signage located throughout the dayroom, hallways, counseling offices, and lobby entrance indicating the program is a safe space for all youth regardless of actual or perceived sexual orientation, gender identity, and gender expression. The agency has updated the Needs Assessment to document which gender the youth identifies with if the youth is transgender, what the youth's preferred name is, and documents what pronouns the youth would like to use.

The shelter has had one transgender youth admitted in the last year. This youth was a female transitioning to a male. This youth a preferred male name to be used and wanted to use male pronouns. A review of the youth's file documented the preferred names and pronouns were used on documents. The youth was able to dress how they

preferred which was a more masculine style. The youth was able to sleep in a normal room and was not isolated.

Exceptions:

No exceptions are noted for this indicator.

Standard 3: Shelter Care and Special Populations

Overview

The Anchorage Children's Home (ACH) provides residential CINS/FINS services at its Hidle House Youth Shelter that is located in city limits area of Panama City, Florida. The shelter facility is located in the rear of the property. The shelter contains two side entries for shelter and for counseling services respectively. The ACH residential program is currently licensed by DCF for a maximum of twenty beds in the shelter and is also COA accredited.

The facility is equipped with a large day room with sleeping rooms on each side. In addition, there is an additional activity room with more sleeping rooms located in the back part of the main day room. This area is separated by doors, however, is used when at full capacity. At the time of the review this area was closed off and being temporarily used for the transitional living program due to the building that was housing the program being destroyed during Hurricane Michael. At the time of the review the shelter was only accepting a maximum of twelve youth at once due to staffing and housing issues that were directly impacted by the hurricane. At the time of the review there was one CINS/FINS youth in the shelter.

3.01 Screening and Intake

Satisfactory

Limited

Failed

The program has written policy and procedures regarding Shelter Environment which are all current and signed by the executive director March 4, 2019.

The program has written policy and procedures concerning the shelter's environment which include procedures for transportation of youth, facility maintenance, key control, vehicle maintenance and repair, youth counts, and logbook entry requirements. The procedures are developed to help ensure the shelter environment is safe, clean, neat, and well-maintained. The program provides structured daily programming to engage youth in activities to help improve social skills and development.

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A walk-thru of the facility found furnishings in good condition. The program was free of insect infestation. The facility grounds were maintained. Bathroom and shower areas were clean and functional. There was no graffiti observed on the walls of program areas or youth rooms. Each youth had an assigned and individual bed. All bed linens appeared clean, with covered mattresses, pillows, sufficient linens, and blankets. Each youth has an assigned locked drawer which is used to keep their personal belongings when requested.

The outside of the building behind the kitchen and maintenance office found several paint buckets and tools which were being sorted and prepared to be transferred into a new metal storage building located outside the program near this area. There were no youth present during the walk-thru conducted. The maintenance manager reported this area was off limits to youth.

Program doors were all found secured. Secure program areas were found locked and had to be accessed utilizing an electronic key system. Egress maps and emergency exit signs for evacuation routes were seen posted and visible to both staff and youth. The program posts emergency numbers for the Florida Abuse Hotline within the youth common area.

The facility washer and dryer were observed in a secured area. The lint collectors were seen to be clean. The program has a main supply of cleaning agents and chemicals kept in this area within two locked metal storage lockers. Inventory forms were kept attached to the outside of the lockers. A review of the inventory form found it to be up to date. A Material Safety Data Sheet (MSDS) binder was located with the lockers. A review of the MSDS was done and compared with the chemicals in this area and found all items had a corresponding MSDS with the exception of four items. This issue was brought to the attention of the maintenance manager who printed new MSDS for these items and provided this to the reviewer. Additional chemicals were stored in a locked maintenance building outside the facility structure. A review of the chemicals and flammables within this building found them stored and inaccessible to youth. There was a corresponding MSDS binder in this area. The items within the building had a corresponding MSDS with a few exceptions: Liquid Plumber, Windex Outdoor, and Scotts Outdoor Cleaner. Prior to the end of the annual compliance review, the program's maintenance manager updated the MSDS binder to include all sheets for items which were originally noted as missing. The revised MSDS binder includes a photo of the item with the corresponding sheet for easier identification.

The program maintains their annual facility fire inspection documentation which was observed to be in compliance with local fire marshal and fire safety codes within their jurisdiction. The Fire Inspection Report was completed January 31, 2019. No issues were noted or documented by the Fire Safety Inspector completing the forms. All annual fire safety equipment inspections were valid and up to date (i.e. extinguishers, sprinklers, alarm system, and kitchen overhead hood). Documentation was provided indicating the program completes a minimum of one fire drill per month with a reaction time of two minutes or less. A review of this documentation for the scope of the annual

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compliance review found drills were completed as required for all three shifts each month. There were four drills which documented reaction time outside of the two-minute requirement. The times were documented as four and a half minutes, one for three and a half minutes, and one for three minutes. In addition, the program provided evidence they completed at least one mock emergency drill per shift per quarter.

The program has a current Satisfactory Residential Group Care Inspection Report for the Department of Health and current food menus posted and visible to staff and visitors. A walk-thru of the kitchen area was completed. The walk-in cooler and freezer were observed and food clean, with no food spoilage observed. Items within the cooler were labeled and dated. The dry storage area was also found to be clean and properly stored and secured. An interview with the food service manager revealed all appliances are currently working properly.

Observations found the program posts separate activity schedules for weekends, weekdays during school, and summertime activities. The information is found posted in the youth common area. A review of the schedules found youth are engaged in meaningful, structured activities seven days a week, such as counseling, life and social skills training, recreation, and education. At least one hour of physical activity is provided daily, and built into leisure time, according to the shelter manager. The shelter manager also reported youth are provided opportunities to participate in faith-based activities for those who choose to. Youth have been off-site for visits to local churches and have been provided bibles if they request one. In addition, daily programming includes opportunities for youth to complete homework and access age appropriate books for reading. The program's schedule documents Enhance Learning Time is done during the morning, and Study Time is provided in the evening prior to bedtime.

Exceptions:

No exceptions are noted for this indicator.

3.02 Program Orientation

Satisfactory

Limited

Failed

The program has a written policy and procedure entitled Intake/Orientation Process. The policy was reviewed and signed by the executive director on March 4, 2019.

The program's procedure indicates the need for newly admitted youth to make a successful transition into the program, they must be provided program expectations and rules within the initial twenty-four hours of their intake. The program's on-call counselor and/or youth specialist will provide youth a client handbook and discuss with each new intake their rights, responsibilities, grievance, and abuse reporting procedure.

There were five youth files reviewed for program orientation requirements. Four of five youth had evidence they received a comprehensive orientation and were provided a

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youth handbook within twenty-four hours of their intake. Youth sign off a form indicating receipt of the item. One of the five records did not include this signature page. The youth's intake date was documented as May 23, 2019, and their handbook receipt date was indicated as June 4, 2019. An interview was done with this youth who denied receiving the handbook upon admission but did indicate program rules and expectations were discussed with her by the assigned case manager. The orientation and handbook discuss areas such as the disciplinary action explained, grievance procedure, emergency procedures, rule for governing contraband, daily activities offered, and a listing of emergency numbers such as the Florida Abuse Hotline. Each youth was given a room assignment based on a room assignment assessment form completed.

Exceptions:

No exceptions are noted for this indicator.

3.03 Room Assignment

Satisfactory

Limited

Failed

The program has a written policy and procedures which is entitled Room Assignment. The policy was reviewed and signed by the executive director March 4, 2019.

Room assignments are made according to information obtained through an assessment process for the youth. Information is gathered in considering the youth's physical characteristics, maturity level, history of delinquency, aggression, and sexual misconduct. Room assignments are given to increase the potential for the youth's positive adjustment. Room assignments are documented on the program's log. Male and female youth are not authorized to share the same room.

There were five youth files reviewed for processes in place to include initial classification of the youth for determination of room assignment. All five youth files included a Room Assignment/Supervision Checklist Form within the intake section. In addition, each had an Evaluation of Suicide Risk Among Adolescents Form completed at their initial screening. The room assignment forms included a review of each youths' history, status and exposure to trauma. Determining factors for room assignment also included the youth's age, gender, history of violence, disabilities, physical size and strength, gang affiliation, suicide risk, and sexually aggressive behavior. The program documented their internal alert system by color coding each youth record with a circular sticker indicating what alert status they are on, such as the following: Yellow – medical alert, Red – Mental Health, and Green – History of running.

Exceptions:

No exceptions are noted for this indicator.

3.04 Log Books

Satisfactory

Limited

Failed

The program has a written policy and procedures entitled Log Documentation. The policy was signed indicating a review by the executive director on March 4, 2019.

The program utilizes an electronic log system. The log is maintained in the staff office or administration office area. The areas are kept secured and inaccessible to youth. The electronic log is to be used by staff for official use only. Youth are not permitted to use the device. The program uses a color-coding system to highlight entries emphasizing their specificity. Log narratives and entries are to be written in professional and clear language to accurately reflect the events which occur.

The program has a process in place to document daily activities, events, and other major occurrences using an electronic logbook system. The system is called Note Active. An interview with the shelter manager revealed staff are assigned an electronic notepad or laptop and are required to keep the device with them at all times when providing supervision. In the event of technical difficulties, a paper log system is developed temporarily to capture all required information. Log entries are made and automatically generate the date, time, and person completing the entry. Staff also can sign or initial their name after their entry using a stylus or their finger. Examples of this practice were observed. Log entries are also required to be highlighted based on their category: issues regarding special attention needed are in pink. medication or medical issues are highlighted in yellow, intake/discharges/abscond cases are done in green, and staff or residents departing or returning to campus for outside events or appointments are highlighted in blue. All entries were observed legibly written. The program also documents youth counts and supervision and status updates for residents every thirty minutes during the day, and at ten-minute intervals during sleep hours. Entries which were made in error are deleted using the void function on the system. All significant issues observed documented included the names of the youth and staff involved, with the date, time, and signature of the staff. Samples were also observed showing a review of the log entries weekly by the supervisors.

Exceptions:

No exceptions are noted for this indicator.

3.05 Behavior Management Strategies

Satisfactory

Limited

Failed

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The program has a series of written policies and procedures addressing their behavioral management which include: Behavioral Intervention, Discipline Policy, Room Restriction/Time Out, and Self-Management System. The policies were all reviewed and signed by the executive director March 4, 2019, with the exception of the Discipline Policy, which was signed May 6, 2019.

Program staff are required to provide behavioral intervention with youth as needed. Youth specialist develop effective rapport with the youth while maintaining a therapeutic environment. Youth specialists must be consistent with their applications of the behavioral management system in order for youth to know what their expectations are from the program and staff. A goal for team members seeking to assist youth in changing their negative behaviors must be to establish a respectful relationship with them. The program's behavioral management approach is built upon the foundation of teaching social skills while using the fundamental concepts from trauma informed care, Managing Aggressive Behavior, and Quality Parenting. Throughout a youth's stay in the program, they will work on adherence to program rules and expectations which preparing for program departure. Youth may earn or lose privileges based on their behavior.

The BMS promotes order, safety, security, respect, fairness, and protection of youth rights. It provides constructive discipline which encourages youth to meet their behavioral expectations. The BMS provides positive reinforcement opportunities and recognition while minimizing separation of youth from the general population. According to the shelter manager, the program's BMS has changed since the last annual compliance review. The current BMS is a three-tier system which youth are able to earn more privileges as they advance through the levels. The system consists of three levels, with three sub-levels within each (i.e. Level 1a, b, c; Level 2 a, b, c; and Level 3 a, b, c). The program's BMS is designed to gain compliance with program rules, influence positive behavior, and increase youth accountability. The BMS uses a variety of rewards and incentives such as television time and video games, access to cell phone, off-site special outings, later bedtimes, and special snacks.

In addition to the level system, the program has a point card system. Youth are responsible for carrying their own point card and may receive additional bonus points daily for behaviors exhibited outside of normal day-to-day responsibilities and expectations. Each Friday, the youth who are on Level 1 or Level 2 are given the opportunity to spend points on special items such as jewelry, games, puzzles, hygiene items, and toys. The items were observed stored and secured in the shelter managers office.

An interview was done with a youth concerning the BMS. The youth was able to accurately describe her current level. The youth demonstrated knowledge of the system by identifying each level in the BMS and discussing the rewards and incentives attached to them. The youth also discussed program rules, consequences and expectations. The program has a master BMS level board displayed in the youth specialist office area

which is connected to the common area and is clearly visible for staff and youth. The youth names are each on a magnetic chip which is placed on their appropriate and current level.

Each youth is informed of the program's rules, expectations, and BMS during their orientation to the program. A review of five youth files revealed each contained evidence the youth and parent sign for and receive notification of the shelter's BMS. In addition, the staff conducting the orientation initials on the admission checklist indicating they discussed a review of the client handbook and BMS with the youth.

A total of ten staff training files were reviewed and found evidence each staff has been trained in the theory and practice of the program's BMS.

An interview with the shelter manager revealed supervisors are required to monitor the use of rewards and consequences delivered by their staff. This is completed during daily review of the program's log, through trainings and staff meetings, and during the annual performance evaluation process. Examples of staff meetings were provided which found evidence the BMS implementation was discussed. A sample of three youth specialist performance evaluations were reviewed which included a review and evaluation of the staff's ability to identify and address negative behavior of youth, issues which motivate it, their ability to intervene according to training and the agency milieu, their modeling of the appropriate behavior and attitudes expected to build necessary coping and social skills for the youth. In addition, the shelter manager reported surveys are given randomly to staff to request their feedback for programming issues. Examples of these surveys were provided which included questions and staff feedback to shelter administration concerning the program's BMS.

Exceptions:

No exceptions are noted for this indicator.

3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

The agency has a policy and procedures to address this indicator titled Staffing Requirements and Scheduling. This policy was last reviewed by the executive director on March 14, 2019.

The procedures state that the agency will maintain a 1:6 staff ratio during wake hours and a 1:12 ratio during sleeping hours with a female and male staff on duty when possible. The procedures also state that the schedule is completed by the shelter manager on a monthly basis by the 20th of the month and is posted in a visible place for staff to see. When a staff is sick or has an emergency, the lead youth specialist or

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shelter manager makes coverage arrangements. The agency maintains an on-call staff that can assist in coverage as well.

The staff schedules were reviewed for the last four months starting in February 2019 when the shelter re-opened after the hurricane. Schedules were completed on a monthly basis and the current month's schedule was posted in the staff office. There was also an additional posting in the same staff office just below the monthly schedule detailing open shifts to help with shortages. The shelter has five open positions which has made it necessary to have case managers and supervisors count as available staff during normal working hours. These vacancies are directly related to the impact of hurricane Michael and displacement of staff.

A random selection of days were reviewed from the past four months. There were five days reviewed each month. All three shifts for each day were reviewed to determine if ratios were met. The agency maintains an appropriate staff to youth ratio of 1:6 during wake hours and 1:12 during sleep hours with the help of case managers and supervisory staff. The agency maintained two staff members on the night shift as well as all other shifts. Out of the twenty shifts reviewed there were three over night shifts that did not have a male staff on duty.

Video surveillance was reviewed to determine if the frequency of bed checks were held within fifteen minutes intervals. Dates chosen included May 6, 2019 at 2:30am, May 10, 2019 at 11pm, and May 11, 2019 at 3am. Bed checks were done at an average of ten-minute intervals and corresponded with documentation of bed checks reviewed in the log book.

Exceptions:

No exceptions are noted for this indicator.

3.07 Special Populations

Satisfactory

Limited

Failed

The agency has policies and procedures in place for Staff Secure, Domestic Violence Respite, Probation Respite, Domestic Minor Sex Trafficking youth, and Family/Youth Respite Aftercare Services (FYRAC). The agency does not have a policy in place for Intensive Case Management as the agency does not provide that service. These policies were last reviewed by the executive director on March 14, 2019.

Domestic Violence Respite (DV) services are designed to assist youth that have been arrested on a domestic violence charge. They are screened at local detention centers where they do not meet detention criteria and cannot immediately return home. DV



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respite is short term and designed to facilitate services and supports for safe return of the youth to his or her home and minimize the risk to re-offend.

Probation Respite services are designed to serve youth that are currently on probation with adjudication withheld and referred by the Department's Juvenile Probation Officer. Probation respite is designed to facilitate services and supports to reduce or eliminate the youth's risk to re-offend and for the safe return of the youth to his or her home.

Domestic Minor Sex Trafficking services are designed to serve domestic minor sex trafficking youth approved by the Florida Network who may exhibit behaviors which require additional supervision for the safety of the youth or the program. DMST services provide a more intensive staffing and individualized service than the short-term shelter services, but provided in the same unlocked, living environment and facility as temporary and voluntary shelter services.

For staff secure youth the assigned case manager will coordinate placement of all court ordered youth with the appropriate provider agency as provided by the Florida Network of Youth & Family Services. Coordination of placement will include, but not be limited to, transportation of youth, transfer of documentation related to service history and custody; and communication regarding mental health, substance abuse, medical and other pertinent needs. The assigned Case Manager will ensure that the youth has necessary items such as prescribed medications, adequate clothing, and personal items permitted by the receiving agency.

All youth served under the FYRAC contract must be referred by DJJ for a domestic violence arrest on a household member and/or the youth is on probation regardless of adjudication status and at risk of violating. All FYRAC referrals must have documented approval from the Florida Network office.

The agency has only had one special population youth since reopening in February 2019 which was a youth referred for probation respite services.

The youth was on probation at the time of referral and was referred by the juvenile probation officer through an email. The youth's length of stay was determined at admission as thirty days. The case plan was developed with input from the parent and youth. Services provided to the youth were consistent with all other CINS/FINS program requirements. The youth's stay did not exceed thirty days.

Exceptions:

No exceptions are noted for this indicator.

3.08 Video Surveillance System

Satisfactory

Limited

Failed

The agency has a policy and procedure in place titled Video Surveillance System. The policy was last reviewed on March 14, 2019 by the executive director.

The agency has video surveillance that operates 24 hours a day, 7 days a week to monitor and capture activity to ensure the safety of all youth, staff, and visitors. The system is meant to proactively deter any misconduct, and ensure any incidents are recorded for review

The agency ensures video and images are secured on a secured network and access to the video surveillance system and recordings is limited to personnel designated by the Program Administrator. Staff are authorized to view recordings and trained to do so in professional, ethical, and legal manner.

Supervisory review of video is done bi-weekly and documented in the Video Surveillance Log. Review is conducted by the Program Manager or designee. Each review includes a random sample of two-day shifts and three overnights shifts. The Video Surveillance Review form includes dates, times, and shifts reviewed; as well as any significant findings. The Program Manager will notify the Program Administrator of any concerns/findings that require further review.

Anchorage ensures video is stored for a minimum of 30 days unless the video is associated with a specific incident that is requested for review. If a video is being used in an investigation it is kept until said investigation is complete. In the case of video being used as evidence in a criminal/civil proceeding it is kept indefinitely, or until otherwise directed by DJJ.

The shelter has cameras that are operable and visible in all areas that are utilized by youth with no cameras in the bedrooms or bathrooms. The agency has signage on all entries into the building as well as several internal glass doors stating that cameras are in use. This is done to deter misconduct and to ensure the safety of staff and the youth.

There is a backup battery system that is used to power the surveillance system in case of a power outage. This backup system while provide for twenty-four hours of usage. Requests for view of the surveillance system by an outside agency is enacted through email. The agency will download the data on to a thumb drive to be provided to the requested agency. The agency is able to access thirty days' worth of data.

There are two designated individuals who can access the surveillance system in order to review its content for accountability purposes. There was documentation video surveillance footage was reviewed at least every fourteen days, with a random sample of day and night shifts.

Exceptions:

No exceptions are noted for this indicator.

Standard 4: Mental Health/Health Services

Overview

The Anchorage Children's Home (ACH) program provides screening, counseling, and mental health assessment services to eligible clients in the service region. The agency has a program administrator and residential shelter manager that oversee the daily operations and responsibilities of the program. The direct care staff members are trained to conduct screenings, assessments, and notify all staff members of conditions and risks of all youth admitted to both residential and non-residential CINS/FINS programs. The agency provides risk screening and identification methods to detect youth referred to their programs with behavioral issues and/or mental health conditions and risks. The agency also screens for the presence of acute health issues and the agency's ability to address these existing health issues. The residential program uses a general alert board to inform all staff members on each shift of the health and mental health status of all youth in the shelter.

The agency provides assistance to all youth admitted to the program that require medication. The agency provides medication distribution training to select direct care staff members. The agency has a registered nurse (RN) on schedule for a total of twenty hours per week. The RN provides all medication distribution training. All medications are stored in an automated medication cart called the CareFusion Pyxis MedStation 4000. The Pyxis machine is stored inside a secured closet in the residential service area.

The agency does provide all staff with first aid response, CPR, fire safety, emergency drills and exercises training and training on suicide prevention, observation, and intervention techniques. At the time of this onsite Quality Improvement review, the agency has an active and functional suicide risk screening process. In addition, the agency has a Licensed Mental Health Counselor (LMHC) Clinical Supervisor and trained counselors that are the key members in conducting the assessment phase of the suicide assessment process.

4.01 Healthcare Admission Screening

Satisfactory

Limited

Failed

The agency has a policy in place titled Medical Care for Routine, Acute, and Chronic Medical Conditions that addresses the requirements for this indicator. The policy was last reviewed on March 4, 2019 by the Executive Director.

A Health Screening Form is completed upon each youth's admission to the program to determine any dental, medical, or mental health needs or acute or chronic medical conditions a youth may have. The Residential Case Manager will follow-up with the parent/guardian of any CINS/FINS youth who have identified medical issues/concerns that require further follow up. All medical/dental care for CINS/FINS youth will be coordinated directly by their parent/guardian. The Shelter Nurse will review all health screening forms and help coordinate care/services for residents as needed.

Documentation at intake is required for youth diagnosed with chronic medical conditions that identify: Qualified professionals making the evaluation, specific diagnosis, current evaluation and/or follow-up information, individual functional limitations identified with the condition, and any adverse effects to the general public from exposure or possible contaminants associated with the illness. During clinical staffing's any youth identified with medical concerns will be staffed to ensure all required documentation has been received and all required medical services and/or follow-up is provided in a timely manner.

There were five youth files, one open and four closed, reviewed for Healthcare Admission Screening. All five files documented a healthcare screening was completed on the day of admission. In four of the files this screening was completed on the Health Screening Form by a case manager or the Registered Nurse. In the last file this screening was completed on the Shelter Intake Assessment form. This form is used when youth are admitted after hours and no case manager is on-site, so the youth specialist completes the screening on this form. Four of the five files documented a review of the healthcare screening by the Registered Nurse (RN); however, there was no date when the review was conducted so it was unable to be determined if it was conducted within five business days. The last file did not document a review of the healthcare screening by the RN. None of the youth had a chronic condition requiring any type of medical follow-up. There are procedures in place to make arrangements with the parent or guardian for any needed medical appointments.

Exceptions:

Out of the five files reviewed, four did not have a date when the Registered Nurse (RN) reviewed the healthcare screening and one file did not document a review of the screening by the RN.

4.02 Suicide Prevention

Satisfactory

Limited

Failed

The agency has a policy in place titled Suicide Prevention and Intervention that addresses the requirements for this indicator. This policy was last reviewed on March 4, 2019 by the Executive Director.

At intake, a full suicide risk screening must be completed by the Residential Case Manager or Counselor on each youth entering the shelter. The full risk screening is completed using the Evaluation of Imminent Danger for Suicide (EIDS) tool. In cases when the youth is admitted to the shelter and a Counselor or Case Manager is not present, a Youth Specialist will complete an intake screening using the six suicide risk screening questions on the Shelter Intake Assessment Form. If the youth answers "yes" to any of the questions they will be placed on constant sight and sound supervision until a full Suicide Risk Assessment is completed within twenty-four hours.

The agency has three levels of supervision. One-to-one supervision is used for those youth whose behavior has escalated to making suicidal or homicidal statements or gestures, and/or stating a specific plan to carry out a suicide/homicide. It is also used for youth waiting for transportation to a Baker Act facility. The second level supervision is constant sight and sound. This is used for youth who are identified as being at risk of suicide but are not expressing current suicidal thoughts or threats. The last level of supervision is elevated supervision, and this is for youth who are not at significant risk of self-harm and can remain in the shelter without further evaluation off-site. This level of supervision is a step down from constant sight and sound.

The shelter employs three Residential Case Managers who are supervised by the Clinical Supervisor who is a Licensed Mental Health Counselor (LMHC). One of the case managers has been employed by the agency since 2017 and had previously completed the suicide risk assessment training with the LMHC. The other two case managers were hired after the last on-site quality improvement review and documentation was provided to show they had completed the five supervised suicide risk assessments with the LMHC and all suicide risk training required.

There were three youth files available for review of youth who had been placed on suicide precautions, one open and two closed. All three files documented the youth were placed on suicide precautions at intake due to issues identified during the screening process. All three youth remained on constant sight and sound supervision until assessed by a qualified professional. All youth were seen and assessed using a Suicide Risk Assessment within twenty-four hours. All Suicide Risk Assessments were completed by a counselor and either documented the LMHC was present during the assessment or documented a telephone consultation with the LMHC and was signed by the LMHC the next time on site. The supervision level was not changed or reduced until



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approved by the LMHC. All three youth were placed on standard supervision after this first suicide risk assessment was completed. All three files contained a chronological note which documented a telephone conversation with the youth's parent/guardian notifying them of the positive screening, placement on suicide precautions, and results of the Suicide Risk Assessment. There were ten-minute observations documented the entire time the youth were on sight and sound supervision. Any youth on suicide precautions sleep in their bedrooms with a staff member positioned outside the door or sleep on the couch in the dayroom and ten-minute checks are maintained.

Exceptions:

No exceptions are noted for this indicator.

4.03 Medications

Satisfactory

Limited

Failed

The agency has a policy on Medication Management that was last reviewed on March 4, 2019 by the Executive Director.

The agency has procedures in place for the use of the Pyxis Med-Station 4000 Medication Cabinet. There are procedures for the verification of medication. There are procedures for documentation relating to medication administration and refusal of medication. There are also inventory and disposal procedures. All procedures comply with the Florida Network's Policy and Procedure Manual for CINS/FINS.

The agency provided a list of fifteen staff who are trained to supervise the self-administration of medications. The Registered Nurse (RN) is listed as the Super User of the Pyxis Med-Station, as well as, the shelter manager and assistant shelter manager.

The shelter has an RN on-site Monday thru Friday from approximately 7:30am till 1:00pm. The RN will distribute any needed medications when on-site. Direct care staff distribute medications in the mornings before the RN arrives, in the evenings, and on the weekends.

The RN trains all staff on the use of the Pyxis Med-Station and the medication administration process at hire. This training is conducted on two separate days, one day to review policies and paperwork and one day to review the Pyxis Med-Station. The RN also conducts an additional refresher training for current staff members during the year.

All medication is stored in the Pyxis Med-Station, including over the counter (OTC) medications which are stored in the top and bottom bins of the Med-Station. Prescription medications are stored in the second and third drawers of the Med-Station.

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Medications are verified at admission using one of the four approved methods by the Florida Network.

The RN reported there have been no major discrepancies with the Pyxis Med-Station. There have been minor discrepancies, mainly involving staff hitting the wrong number when inventorying medications. For the past three months there have been between six and seven discrepancies each month. At the time of the review the RN was clearing out discrepancies so discrepancies that occurred during the hours the RN was not on-site would not be cleared out by the end of the staff's shift. There were no current open discrepancies at the time of the review. The shelter has never had a discrepancy involving a controlled substance.

The RN completes a weekly inventory of all medications on-site. Trained direct care staff complete an inventory every shift of all the controlled substances. This inventory is documented on the youth's Medication Oversight and Inventory form. An inventory of the medication is completed every time it is given, and a perpetual inventory is maintained. Inventories for OTC's are documented on the individual medication log for each OTC.

The shelter has a system in place for refrigeration of medication if needed. However, there was no medication that required refrigeration during the time of review. The thermometer inside the refrigerator was not working properly so it was unable to be determined what the actual temperature of the refrigerator was. There is a separate locked cabinet where sharps are stored. All sharps are also inventoried weekly and as used. The youth must use disposable razors which are discarded on the red sharps box after use.

The RN prints-out four different reports from the Knowledge Portal each month: a Discrepancy Report, a Summary by Transaction Type Report, a User Summary Report, and a Profile Overrides Report. These reports are printed out on the first of every month. The RN also goes into the Knowledge Portal at least once a week to view different reports.

There was currently one youth in the shelter currently on medications. This file as well as two additional closed files were reviewed to verify the medication administration process. The agency uses the Medication Oversight and Inventory form to document all medications administered to youth. This form documents the youth's name, medication, strength, date of birth, prescription, pharmacy, physicians name, expiration date, beginning count, reason for the medication, instructions for use, distribution, inventory, signatures of staff and youth. A picture of the youth is located in front of this form in the medication logbook and side effect information is located behind this form. All Medication Oversight and Inventory forms reviewed for the three youth documented that all medications were given at prescribed times. If a medication is running low the RN will contact the parent at least a week beforehand and notify them a refill needed. The RN will continue to contact the parent until the refill is brought in.

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The RN maintains a medication disposal log. The RN will dispose of any medications left at the facility once a month. The medications are put into a Ziploc bag with coffee grinds and soap and smashed thoroughly and mixed in. Then the Ziploc bag is disposed of. Any medications disposed of each month are documented on the log and signed by the RN and a witness.

Exceptions:

No exceptions are noted for this indicator.

4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

The agency has a policy titled Medical/Mental Health Issues Alert that addresses the requirements for this indicator. The policy was last reviewed on March 4, 2019 by the Executive Director.

All "Medical Alert" conditions are communicated through documentation in the youth file in progress notes, Health Screening Form, Psychosocial Assessment, and Daily Log and are communicated verbally at clinical staffing/team member meetings by the Program Administrator or designee. All team members are informed of any "Medical Alert" or "Mental Health Alert" conditions pertaining to each youth that might result in the need for team members to recognize and respond to the need for emergency care and treatment because of these medical problems. A youth's file will be marked with a colored dot placed on the outside of the binder for easy identification. There are three different colored dots used: Red dot = Mental Health Diagnosis or history of mental health concerns, Yellow dot = Medical Alert and/or on medication, Green dot = History of running.

There was one youth currently in the shelter. This file and four closed files were reviewed for the Medical/Mental Health Alert process. The agency uses colored dots on the spine of the youth's file to indicate applicable alerts. The alerts documented on the spine of the file corresponded with information documented on screening forms inside the file, in all five files reviewed. There is also an alert board located inside the staff work area in the shelter that documents all youth in the shelter and any alerts or allergies they may have. Alerts were appropriately documented on the alert board for the one CINS/FINS youth in the shelter.

Exceptions:

No exceptions are noted for this indicator.

4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

The agency has a policy in place for Emergency Medical Care that was last reviewed on March 4, 2019 by the Executive Director.

Procedures state all team members are to be trained in CPR, first aid, and crisis intervention training and are to respond immediately and calmly to emergency situations. In the event a youth needs emergency medical, dental, or mental health care, team members initiate all necessary immediate response techniques and services available to provide life-sustaining care.

The shelter has had no instance of off-site episodic emergency care incidents in the last six months. However, the shelter has conducted two medical emergency drills during this review period. One drill was in September 2018 and the other drill was in June 2019. The was closed due to hurricane damage from October 10, 2018 until February 4, 2019 so there were no drills conducted during that time frame.

The shelter has multiple first aid kits located in the residential shelter and the transportation vans. The RN re-stocks the kits when they are used and inventories them every couple of months for expired items. The knife-for-life and wire cutters are maintained in a locked cabinet in the staff work area.

A review of a sample of training files revealed staff are certified in CPR and first aid and have received training in crisis intervention.

Exceptions:

No exceptions are noted for this indicator.