



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Anchorage

on 05/06/2014

CINS/FINS Rating Profile

Standard 1: Management Accountability

1.01 Background Screening	Satisfactory
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

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

Standard 3: Shelter Care

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

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

Standard 2: Intervention and Case Management

2.01 Screening and Intake	Satisfactory
2.02 Psychosocial Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management and Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petition Process	Satisfactory
2.07 Youth Records	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:100.00%
Percent of indicators rated Limited:0.00%
Percent of indicators rated Failed:0.00%

Rating Definitions

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

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

Review Team

Members

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

Lydia Breaux, Delinquency Prevention Specialist, Florida Department of Juvenile Justice

Cheri Brandies, President/CEO, Arnette House Inc



Quality Improvement Review

Anchorage - 05/06/2014

Lead Reviewer: Keith Carr

Patricia Rock, Shelter Services Manager, Lutheran Services Florida Northwest

Tracey Ousley, Regional Director, CDS Family and Behavioral Health Services

Persons Interviewed

- | | | |
|--|--------------------------|-------------------------|
| <input checked="" type="checkbox"/> Program Director | 4 Case Managers | 2 Maintenance Personnel |
| <input checked="" type="checkbox"/> DJJ Monitor | 3 Clinical Staff | 3 Program Supervisors |
| <input type="checkbox"/> DHA or designee | 1 Food Service Personnel | 7 Other |
| <input type="checkbox"/> DMHA or designee | 0 Health Care Staff | |

Documents Reviewed

- | | | |
|--|--|--|
| <input type="checkbox"/> Accreditation Reports | <input checked="" type="checkbox"/> Fire Prevention Plan | <input checked="" type="checkbox"/> Vehicle Inspection Reports |
| <input type="checkbox"/> Affidavit of Good Moral Character | <input checked="" type="checkbox"/> Grievance Process/Records | <input checked="" type="checkbox"/> Visitation Logs |
| <input checked="" type="checkbox"/> CCC Reports | <input type="checkbox"/> Key Control Log | <input checked="" type="checkbox"/> Youth Handbook |
| <input type="checkbox"/> Confinement Reports | <input checked="" type="checkbox"/> Logbooks | 6 Health Records |
| <input checked="" type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 6 MH/SA Records |
| <input type="checkbox"/> Contract Monitoring Reports | <input type="checkbox"/> PAR Reports | 10 Personnel Records |
| <input type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 12 Training Records/CORE |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 11 Youth Records (Closed) |
| <input type="checkbox"/> Escape Notification/Logs | <input type="checkbox"/> Sick Call Logs | 13 Youth Records (Open) |
| <input type="checkbox"/> Exposure Control Plan | <input checked="" type="checkbox"/> Supplemental Contracts | 3 Other |
| <input checked="" type="checkbox"/> Fire Drill Log | <input checked="" type="checkbox"/> Table of Organization | |
| <input checked="" type="checkbox"/> Fire Inspection Report | <input type="checkbox"/> Telephone Logs | |

Surveys

- | | | |
|---------|---------------------|---------|
| 7 Youth | 6 Direct Care Staff | 7 Other |
|---------|---------------------|---------|

Observations During Review

- | | | |
|---|--|--|
| <input checked="" type="checkbox"/> Admissions | <input checked="" type="checkbox"/> Posting of Abuse Hotline | <input checked="" type="checkbox"/> Staff Supervision of Youth |
| <input type="checkbox"/> Confinement | <input checked="" type="checkbox"/> Program Activities | <input checked="" type="checkbox"/> Tool Inventory and Storage |
| <input checked="" type="checkbox"/> Facility and Grounds | <input checked="" type="checkbox"/> Recreation | <input checked="" type="checkbox"/> Toxic Item Inventory and Storage |
| <input checked="" type="checkbox"/> First Aid Kit(s) | <input checked="" type="checkbox"/> Searches | <input type="checkbox"/> Transition/Exit Conferences |
| <input checked="" type="checkbox"/> Group | <input checked="" type="checkbox"/> Security Video Tapes | <input type="checkbox"/> Treatment Team Meetings |
| <input checked="" type="checkbox"/> Meals | <input type="checkbox"/> Sick Call | <input type="checkbox"/> Use of Mechanical Restraints |
| <input type="checkbox"/> Medical Clinic | <input checked="" type="checkbox"/> Social Skill Modeling by Staff | <input checked="" type="checkbox"/> Youth Movement and Counts |
| <input checked="" type="checkbox"/> Medication Administration | <input checked="" type="checkbox"/> Staff Interactions with Youth | |

Comments

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

Rating Narrative

All ACH staff members were well prepared and participated upon request throughout the duration of the 2-Day onsite QI Review.

Joel Booth, ACH Program Administrator demonstrated excellent preparation, leadership, and knowledge of the ACH CINS/FINS programs, operation and staffing.

Strengths and Innovative Approaches

Rating Narrative

Anchorage Children's Home of Bay County operates the Hidle House Youth Shelter. The Shelter is located on a very large and spacious property adjacent to a major roads and intersection in the city. The shelter and administration building is located and several acres of land, is extremely well maintained and has a full-time maintenance staff person to maintain the upkeep of the property.

The agency has solid community support from various local service organizations. The agency provided the reviewer evidence of recent donations of numerous new clothing items. The agency has large room on site that houses numerous new clothing items. The agency has received numerous donations such as groups donating gifts and money for our youth during the holiday season.

The agency employs a licensed clinical supervisor that has been employed with the agency for several years. She provides clinical oversight to residential and non-residential counselors providing a very thorough and professional continuity of therapeutic services. The agency has maintained consistency in the management and operations of the residential shelter. The Shelter Manager and Assistant Shelter Manager are consistently employed and have been in place for nearly four (4) years. This has provided a level of consistency in the agency's shelter operations.

Anchorage Children's Home currently implements a monthly and quarterly recognition program. Employee of the month will receive a \$25 gift card and the employee of the quarter receives a \$75 gift card. Additionally, an employee of the year is recognized at the agency's annual dinner. Recognizing employees for their dedicated service is an integral part of maintaining employee morale.

The agency maintains outreach efforts that include two (2) local grants that support the agency's street outreach-based programs.

Standard 1: Management Accountability

Overview

Narrative

The Anchorage Children's Home of Bay County, Inc. (ACH) provides both Residential and Non-Residential CINS/FINS services for youth and their families in Bay, Gulf, Calhoun, Holmes, Jackson and Washington Counties. The residential program and non-residential offices are located at 2121 Lisenby Avenue in Panama City, Florida. The agency's executive Director oversees the residential and non-residential components of the program, including the volunteer and outreach initiatives. The agency's Program Administrator is responsible for supervising the operations and programming of the agency on a day to day basis. The shelter is licensed by the Department of Children and Families.

The program's Emergency Disaster Plan has been approved by the Florida Network. The program's emergency response plan and hurricane plan has not revised and has been unchanged since 2012. The agency maintains a Universal Agreement for Emergency Disaster Shelter. The current emergency plan was last signed by the agency Executive Director in 2013. The agency administrative offices and youth shelters are all co-located on the property under the same roof. In the event of an emergency, the program can shelter on site and has been rated up to a level three and four hurricane category rating.

The agency maintains key partnerships in the community with major local service providers, as well as a broad range of community-based organizations and entities. The agency continues to maintain strategic local partnerships with the local school system, law enforcement, social services and cultural and arts programs. The program requires new hire 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. The agency does utilize the Florida Network, computer-based trainings and training delivered in house by ACH staff members and other. Annual training is tracked according to the employee's date of hire.

1.01 Background Screening

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedures in place for this indicator. The procedures in place outline specific steps required by the applicant and Human Resource to meet this standard, but timeframes are not included in the policy.

A review of 10 employee files was completed. These files were comprised of nine (9) new employees and one (1) five year re-screen. Of the 9 new employee files reviewed all background screenings were completed prior to the date of hire documented in the employees file. None of the 9 employee files reviewed met the requirement for an exemption. The one five year employee re-screened is not due until August 21, 2014.

The annual affidavit of compliance with Level 2 Screening was completed January 8, 2014, prior to the January 31, 2014 deadline.

There were no exceptions documentd for this quality improvement indicator.

1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

Rating Narrative

The agency has a detailed policy to address the general requirements of this indicator. A total of six (6) randomly selected Direct Care staff members across all work shifts were selected to complete the Florida Network online Quality Improvement survey. Of these completed surveys, 6 out of 6 surveys reported that they never witnessed youth ever been sent to their room or an isolation room for punishment. Staff report that the never observed a co-worker telling a youth that they could not call the Abuse Hotline or ever seen a youth being sent to their room or an isolation room for punishment. In addition, all 6 staff reported that they never observed a co-worker using profanity when speaking to youth. Six of the 6 staff reported that they never observed youth being placed in rooms as a form of isolation or witnessing a co-worker using threats, intimidation, or humiliation when interacting with residents.

At this time of this onsite QI Review, a total of seven (7) CINS/FINS youth were available to complete an online QI youth survey. Of these completed surveys, all 7 residents surveyed reported that they felt safe in the youth shelter. A total of three youth surveyed knew about the Abuse Hotline. All youth surveyed reported that they have not heard staff use profanity and all adults are respectful when talking to them or other youth. A total of six (6) out of 7 youth surveyed have not heard an adult threaten them or other youth.

Five (5) out of 7 youth reported that they are familiar with the Grievance Process. Five (5) out of 7 youth surveyed that they have never been sent to their room for punishment. All youth surveyed reported that they have you been instructed what to do in case of a fire.

A review of the Grievances reported by youth admitted to the youth shelter in the last six (6) months was conducted on site by the reviewer. The process for resolving grievances involves the agency policy that requires a response to all grievances submitted by a resident within seventy-two (72) hours of receiving the written resident grievance. All documented grievances were addressed within the specified timeframe.

There are exceptions for this indicator. Four (4) out of 7 residents reported that they did not know about the abuse hotline available to them to report abuse at this shelter. Three out of 7 youth surveyed that they could not show or tell where the abuse hotline number was located in the shelter. A total of one (1) out of 7 youth surveyed have heard an adult threaten you or other youth. Two (2) out of 7 youth reported that they were not familiar with the Grievance Process. Two (2) out of 7 youth surveyed that they have been sent to their room for punishment.

1.03 Incident Reporting

Satisfactory
 Limited
 Failed

Rating Narrative

The agency has a detailed policy and procedure in place for this indicator. Completed a review of 7 incidents recorded within the last 6 months. Copies of all incidents were available and maintained in one individual binder. Narratives are legible, clear, concise and very detailed. Only 1 of the 7 incidents was outside the 2 hour reporting time. What was consistently noted throughout the review were the duplicate reports on the same incident resulting in multiply discrepancies relative to reporting time in date and time of incident and date and time of report. As an example, an incident reported as occurring on 01/03/2014, documents date and time of incident as 4:58 pm and 4:45 pm and date and time of report as 5:08 pm, 4:45 pm, 4:41 pm and 7:22 pm. An incident that occurred on 03/09/2014 has the date and time of report recorded as 6:32 pm, 6:35 pm and about 6:30 pm and date and time of report as 8:10 pm, 9:48 pm and 8:20 pm. It was also difficult to determine if the date and time of report was the actual time incidents are reported to CCC as staff interviewed on site state that the time is used to record when an incident is reported internally to another staff. Further interviews with staff suggested CCC report time is recorded in another section on the form which may or may not identify with the date and time of report at the top of the form.

The agency may consider that the program put into place a procedure or procedures for reporting that specifically addresses the manner in which date and time of incidents and date and time of reports are accurate and consistent. Further commendation is if the date and time of report at the top of the form is not used to record the actual time report called into CCC it should be stated in that area or the form needs revision.

1.04 Training Requirements

Satisfactory
 Limited
 Failed

Rating Narrative

That agency has detailed training policies related to this indicator. The agency Training year operates from October 1 to September 30 of each year. A total of ten (10) training files (Five first-year, five annual training) were reviewed to assess the agency's adherence to this indicator. All five first-year staff files reviewed were found to be in compliance with requirements and recommended trainings. These files contained a total of a minimum of 80 hours for these first year staff members. In review of five staff for annual training, all staff received a minimum of 24 hours within the past year. One of these five staff, did not have documentation of updated CPR/First Aid. Per an interview with the Assistant Residential Manager, the staff is scheduled for CPR/First this month. One staff did not have documented evidence of Universal Precautions trainings. However, Asst. SSM indicated this is taught during CPR/First Aid. Five files did not indicate Cultural Competency was received. However, Program Administrator indicated this is conducted during staff's initial time of hire. Greg Edward, CPR/First Aid Cert. on file, received 6/6/12, expire 6/6/14. Allison Wilkes, CPR/First Aid Cert. on file, received 7/23/12, expire 7/23/14. Sylvester Jones, CPR/First Aid Cert. on file, received 8/27/13, expire 8/27/15.

Exceptions are noted for this indicator. Agency documentation of trainign topics and hours are not clear as listed in some staff members training files and do not always match with training titles listed in the quality improvement training indicator and Florida Network training polices.

1.05 Analyzing and Reporting Information

Satisfactory
 Limited
 Failed

Rating Narrative

The agency has a policy that is in place addressing procedures for Service Satisfaction Questionnaires, Record Review and Grievances. Interviewed Program Administrator, Joel Booh, and the program collects data quarterly. Reports are generated to review and track incidents, youth incidents on shift, pattern of same staff during incidents, types of incidents, number of incidents in certain areas (i.e. runs, med errors), comparison report of previous year occurrences of absconders, major incidents between the youths served (i.e. deaths, medical errors, institutional abuse), quality of our services, 180 day-follow-ups to determine where a youth is residing since services, accidents and grievances. Copies of data reports collected are included in this report. Customer satisfaction data is done quarterly as well. Overall outcome data is reviewed with Senior Management (i.e. grievances). The Program Administrator inputs data and extracts information to determine trends. Clinical staff does peer reviews every quarter and he generates a report to forward to all appropriate personnel. Counselors do case record review reports.

The agency follows protocol when collecting data and reporting. Data collection is assigned based on what the data is to be collected. Counselors handle clinical, Senior Management handles Human Resources, Financial Manager handles data relative to finances of the agency. Data is collected and forwarded to the Program Administrator for input in the system. Senior Management reviews data to assess contract performance and Clinical staff does same.

The agency has a policy on analyzing data and performance. Interviewed Program Administrator, who indicated the program collects data quarterly. Quarterly case records are reviewed by counselors. Incidents, accidents and grievances are review by senior management. NetMis data is collected. Customer satisfaction data is collected at the end of the youths stay, put in a sealed envelope. All data collected is forwarded to Program Administrator for input in system. Youth Outcomes Measured: (i.e. 180 Day follow-ups, Absconders: Trends, number of occurrences, days of the week, shifts, comparisons of absconders from year to year, number of unusual incidents, etc.). HR Outcomes Measured: Senior Management gathers data (i.e. Vacancies, New Hires, Staff Recognitions, Performance Reviews, Risk Management-Grievances-staff, Workers Comp, Disciplinary Actions and training). All data collected is forwarded to Program Administrator for collection/input.

No exceptions are noted for this quality improvement indicator.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

Anchorage Children's Home Residential and Non-Residential Counseling Program provides CINS/FINS counseling services for youth and their families in Bay, Gulf, Calhoun, Holmes, Jackson and Washington Counties in Florida. The ACH CINS/FINS program continues to maintain working partnerships with local service organizations. The ACH program has referral agreements to provider CINS/FINS services, as well as maintains office space at various community sites in the Florida Panhandle area. Anchorage Children's home primarily provides both individual and family Counseling services. The program offers a highly experienced Licensed Clinical Director and other residential and non-residential counseling staff members. The program conducts screenings that are conducted by youth care staff and counselors twenty-four hours a day, seven days a week. The screening counselor will either refer the youth and family to one of the program's counselors, or will make a referral for the family to another appropriate community agency, according to the youth's zip code. The program also offers case management and substance abuse prevention education. Referral and aftercare referrals are made if deemed necessary. Once CINS/FINS eligibility is confirmed, the youth is admitted to the program and is provided counseling services. Following this phase, a case plan is developed for each client. If needed, the agency can conduct counseling home visits on a case by case basis to offer support the client and their family and to ensure continuity of CINS/FINS service and increase a successful completion of the case plan. If deemed applicable and after further evaluation, Family and Individual Counseling is offered by ACH with shelter care as a possible option for youth that need additional support services.

The ACH non-residential program also offers an intervention called a Case Staffing Committee meeting to address non-productive outcomes for either or both the youth and their family. The youth along with their family, school board representative, Department of Juvenile Justice attorney and representatives from other social services agencies meet to collectively address the services that are being provided by the program to address the status of these cases. The outcome of these meetings, result in the development of a Plan of Service that meets the needs of the youth and family members. The Case Staffing Committee can also recommend a CINS Petition to be filed in court to order participation with additional treatment services to assist resolve issues faced by the youth and their family.

2.01 Screening and Intake

Satisfactory

Limited

Failed

Rating Narrative

The ACH program has CINS/FINS specific policies and procedures that addresses Screening and Intake practice and protocols. The policy and procedures are comprehensive and cover the requirements of the indicator. A random selection of four (4) Non-residential files and 4 residential files were reviewed with three (3) open and one closed for each. Of the 4 non-residential files reviewed, all files had the information required by the indicator with one exception of the screening being late. However, the counselor made many attempts to complete the screening within the timeframe. Three of the 4 residential files contained all the required information. One file did not have the voluntary placement form containing confirmation that parents/youth are provided required information in writing.

Exceptions were noted for this quality improvement indicator. One non-residential file did not have a screening within 7 days of referral, however the counselor called 4 times to schedule a screening and the parent re-scheduled during that time period. One residential file did not have the CINS/FINS Voluntary Placement Agreement which indicates that the parent was provided with the required information in writing.

2.02 Psychosocial Assessment

Satisfactory

Limited

Failed

Rating Narrative

The ACH program has CINS/FINS specific policies and procedures that addresses Psychosocial Assessment practice and protocols. The policies and procedures are comprehensive and cover the requirements of the indicator. A random selection of four (4) Non-residential files and 4 residential files were reviewed with three (3) open and one closed for each. All psychosocial assessments were completed, signed, and reviewed by the supervisor within the required timeframe. Three youth were identified in the psychosocial assessment as being at an elevated risk of suicide and two suicide assessments were completed as a result.

The agency policy and procedure states that the supervisor will sign off on all psychosocial assessments within three days. All but one of the psychosocial assessments reviewed met this requirement. This timeframe and adherence to it would indicate best practices on the part of the clinical staff.

There are exceptions documented for this indicator. One psychosocial assessment was not completed: the assessment of scores was left

blank. One identified elevated risk was not followed by a suicide risk assessment.

2.03 Case/Service Plan

Satisfactory

Limited

Failed

Rating Narrative

The ACH program has CINS/FINS specific policies and procedures that addresses Case and Service Planning practice and protocols. The policies and procedures are comprehensive and cover the requirements of the indicator. A random selection of four (4) Non-residential files and 4 residential files were reviewed with three (3) open and one closed for each.

The policy and procedure requires that the agency complete Case Plans and have the supervisor review and sign them within 72 hours which is above and beyond the indicators requirements. However there is no specified time for Case Plan review. It is stated that the review will be ongoing as needed. The indicator specifies every 30 days for the first three months, and every six months thereafter.

Of the 4 non-residential files reviewed all were completed within 7 days of completion of the psychosocial and all had individualized and prioritized goals, service type, frequency, location, persons responsible, target and actual completion dates as applicable and all required signatures. One Case Plan was signed by the clinical supervisor 13 days after completion. 3 of the 4 non-residential Case Plans were reviewed when applicable with one not signed by the clinical supervisor, one 90 day review was not signed by the clinical supervisor and one had only one goal signed off by the clinical supervisor.

Of the 4 residential files reviewed all were completed within 7 days of completion of the psychosocial and all had individualized and prioritized goals, service type, frequency, location, persons responsible, target and actual completion dates as applicable and all required signatures. Of the 4 Case Plans one was signed by the Clinical Supervisor 13 days after development. All Case Plans had a designated the date the Plan was initiated.

The reviewer of this indicator reports a number of observations. It was difficult to find the specific information in policy and procedure as there was several policy and procedures that address Case Plans. The development date of the non-residential Case Plans had to be assumed by the signature date of the participating parties and none of the four had an initiation date. The development date of the residential Case Plans had to be assumed by the signature date of the participating parties.

There are no exceptions documented for this indicator.

2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

Rating Narrative

The ACH program has CINS/FINS specific policies and procedures that addresses Case Management and Service Delivery practice and protocols. The policies and procedures are comprehensive and cover the requirements of the indicator. A random selection of 4 non-residential and 4 residential files were reviewed. Three (3) closed and one open non-residential and 3 open and one closed residential. All files showed documentation of comprehensive case management and service delivery. A counselor was assigned to all cases. The counselor/case manager established referral needs, coordinated service plan implementation, monitored family progress, and provided support for the family.

There was no out of home placement in the files reviewed. Only one client was in need of case staffing and referral to the case staffing committee was made and appropriate case management followed. A petition was not necessary.

The reviewer of this indicator documented some specific observations. The 180 day follow-up was designated in the discharge summary, but none were due. One non-residential case had a referral for the mother to receive substance abuse counseling and there was no documentation of follow-up with mother as to whether she participated in counseling.

There were no exceptions documented for this indicator.

2.05 Counseling Services

Satisfactory

Limited

Failed

Rating Narrative

The ACH program has CINS/FINS specific policies and procedures that addresses Counseling Services and modalities and protocols. The policies and procedures are comprehensive and cover the requirements of the indicator. A random selection of four (4) Non-residential files and

4 residential files were reviewed with three (3) open and one closed for each.

All youth and families reviewed received counseling services in accordance with the case/service plan. The program provides individual/family counseling as evident in the files reviewed. However one residential case had no documented contact for the past 10 days. The youth's presenting problems were addressed in the psychosocial assessment, the initial case/service plan and case/service plan reviews. All case/service plan reviews were completed within the required time frame and signed by the applicable parties. One of the 4 non-residential clients was not due for a case/service plan review and 3 of the 4 residential clients were not due for review. All files documented case notes for all counseling services provided. Ongoing internal process that ensures clinical reviews of case records and staff performance was apparent.

The group log for the shelter was reviewed. The indicator calls for group counseling 5 days/week for shelter residents. The calendar showed scheduled groups 5 days per week for the most part. There were weeks where group was not planned 5 days/week and on some weeks the majority of the groups were physical activity. Physical activity does not fall within the parameters of group counseling. It was explained that client participation is documented in each individual clients file.

The reviewer for this indicator documented some observations for consideration. The ACH should consider a sig-in sheet for group counseling to document that groups were provided and for more accurate documentation of group attendance.

There were not exceptions documented for this indicator.

2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

Rating Narrative

The ACH program has CINS/FINS specific policies and procedures that addresses Adjudication and Petition practice and protocols. The policies and procedures are comprehensive and cover the requirements of the indicator. A random selection of four (4) Non-residential files and 4 residential files were reviewed with three (3) open and one closed for each.

One (1) file for Adjudication/Petition Process was provided as the total sample available for review. Sample size is extremely small to thoroughly evaluate the agency's performance in this area. The client was referred by her mother on 8/5/13, a telephone call was made on 8/28/13 to mother with the Case Staffing date of 9/10/13. Due to the school representative not attending the staffing, it was cancelled. On 9/19/13 a telephone call was made to the mother with the re-scheduled date of 10/2/13. The Case Staffing was conducted on 10/2/13 with the mother, the youth, the chairperson, the case manager and the school representative. A case staffing consent was signed and a case staffing recommendation form completed. The mother of the client chose to discontinue the petition process, stating that counseling was a waste of time and she was aware that counseling was a condition of the case staffing recommendations.

According to Florida Network of Youth and Families Policy and Procedures states for this indicator: Case Staffing must occur within 7 days of parents request. The Case Staffing did not occur for 58 days following parental request. Further, Case Staffing Committee must include a representative from the Department of Juvenile Justice and the local school system. The case staffing committee did not include a representative from DJJ. Also, within 7 days of the Case Staffing a written report must be provided to the parent/guardian outlining the committees recommendations and reasons for them. There was no documentation of a written report to the parent.

There are exceptions documented for this indicator. There is no indication of an established Case Staffing committee with whom the agency has regular communication. There is no indication of an internal procedure for the case staffing process, that includes a schedule for committee meetings

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

There is a policy in place for this youth records indicator. The monitor reviewed 13 closed files and 8 open files. All of the closed files were marked confidential and maintained in a secure file cabinet in a secured records or storage room. Two of the 8 open files were not marked confidential one was observed in the counselor's office and one was one of the files pulled for review. Open files are kept in the assigned counselor's office stored either on an open rolling file cabinet or on open book cases. Counselor interview suggest when not in their offices the files are secured via counselor locking their doors and the counselor having physical custody of the key. Access to the counselor's offices is through a secured area.

There are no exceptions documented for this quality improvement indicator.

Standard 3: Shelter Care

Overview

Rating Narrative

The ACH program provides residential CINS/FINS services at its Hidle House youth shelter that is located in city limits area of Panama City, Florida. The ACH residential program has adequate staffing and maintains a residential shelter licensed for and maintains a maximum of twenty (20) beds in the shelter. The shelter has eight (8) large bed rooms that house two (2) beds in room. The facility has a dayroom area that is adjacent to the youth work station. The facility has a spacious lay out that includes an activity room, computer room, reading area, cafeteria, industrial kitchen and a outside snack and sitting area. All medications are stored in secure locked closet behind locked cabinets inside a converted closet next to the youth care worker station. The agency utilizes a metal wand detector, emergency equipment and an updated video camera system. The agency has a general alert board for immediate notification of the resident's status and general information board. The agency's screening process notifies the residents of their rights, rules and the Abuse Registry number.

The Hidle House shelter is managed by a Residential Shelter Manager, an Assistant Shelter Manager, a Clinical Supervisor/Licensed Mental Health Counselor, four (4) Residential Case Managers, a Life Skills Coordinator, a Maintenance Coordinator and a Maintenance Specialist and thirteen (13) Youth Care Specialists and an Administrative Assistant. The program conducts group sessions to clients a minimum of five (5) days a week on various topics that address issues including substance abuse prevention, anger management, effective communication, leadership skill building and many others. The agency also utilizes a behavior management system that is used consistently across all off its residential programs.

3.01 Shelter Envonment

Satisfactory

Limited

Failed

Rating Narrative

The shelter is neat, clean and well maintained. Furnishing are in good repair and there was no graffiti on the walls, furnishings, etc. Bathrooms, and shower areas are clean and functional. Each youth has his/her own bed with a pillow, linens, and a colorful spread and storage space. The shelter has locked cabinets to store youth's personal belongings when requested. There is adequate lighting in all areas of the facility and it is free of insect infestation.

The shelter has adequate lighting throughout and the program is free of insect infestation. Pest control service occurs on a monthly basis. Current health and fire inspections show no deficiencies. Inside recreation areas include a room equipped with a pool table, an air hockey table, a keyboard, a snack area and a television area.

A tutor provided by the Bay Area Shool System comes in twice a week to assist youth with school work. Additionally, the shelter gets alot of support from nearby Tyndall Air Force base. Personnel from the base visit twice a week and do activities with the youth. The schedule is posted in the dayroom.

The grounds are well maintained and include alarge outdoor court area and green space for recreation. They include space for basketball, soccer, volleyball and a nice gazebo. There is a large covered porch for use by staff and youth as well. Inside recreation areas include a recreation room equipped with a pool table, air hockey table, keyboards and a large screen t.v. In addition, the shelter activity schedule includes daily physical activity, faith based activities, homework time and quiet time to read. The schedule is posted in the dayroom. On the shelter tour, an exit light on the girl's side of the day room was not working properly. Maintenance staff had already identified the problem and corrected it the same day.

There was one exceptions documented on this facility tour. A medium sized safety pin was found in the medicine cabinet of the resident's bathroom on the female side of the dormitory. The safety pin was removed during the tour and secured in the youth care workers office for disposal.

3.02 Program Orientation

Satisfactory

Limited

Failed

Rating Narrative

Written policy and policy and procedure is in place that outlines the orientation process for youth entering the shelter. Once a counselor has completed an intake process, a Youth Specialist is assigned to complete an orientation with the youth. Each youth is given a Client Handbook that covers information such as program rules, behavior management strategies visitation, telephone use, contraband as well as other material. Additionally, the other required areas are covered and documented with youth and staff initials on the Admission Checklist. The grievance procedure is reviewed and youth have access to grievance forms in the dayroom. The abuse hotline number is also posted.

Eight residential files (4 open, 4 closed) were reviewed for this indicator. All eight files contained documentation of the required process occurring on the day of intake. The orientation process was confirmed through an interview with the Acting Shelter Manager.

Policy and procedure is in place for this indicator. A Youth Specialist conducts a program orientation process on the same day as the intake occurs. Each youth receives a handbook and the required elements are covered with the youth and documented on the Admission Checklist that both youth and staff initial.

This process was confirmed by a review of 8 residential files (4 open, 4 closed.) and a discussion with the Assistant Shelter Manager.

No exceptions noted.

3.03 Youth Room Assignment

Satisfactory

Limited

Failed

Rating Narrative

Policy and procedure is in place to govern the collection and review of information used to consider when assigning youth rooms. During the intake process, the agency staff gathers information including physical characteristics, height, weight, general physical stature, level of maturity as well as the other required elements. The Residential Case Manager/ designee assigns all incoming youth to room. The room assignments are listed in the Daily Log as well as on the Room Assignment/Supervision Checklist and the Client Board.

Four open and four closed files were reviewed for this indicator. Of the eight files reviewed, all eight files had documentation of the required elements used to review and consider in making room assignments. Six of the eight files had the assigned room number documented on the Room Assignment/Supervision Checklist, two did not. All eight room assignments were documented in the Daily Log and on the Client Board.

Required information is gathered at intake and used to make a room assignment. 4 open and 4 close residential files were reviewed for Youth Room Assignment. All the files had completed Room Assignment/Supervision Checklist, however, 2 open files had no documented room number recommendation on this form. However, all eight room assignments were documented in the Daily Log and all current youth's room numbers are listed on the Client Board.

3.04 Log Books

Satisfactory

Limited

Failed

Rating Narrative

Agency policy and procedures mandates that the shelter maintains a permanent bound Daily Log book to communicate between staff members and to maintain a legal record of the daily care and program occurrences.

The program uses a 5 color coding system to highlight different types events. Routinely documented events include youth comings and goings, appointments, youth behaviors, emergency situations, safety and security matters, medical information, medication distribution, and petty cash reviews.

Program staff review and document the pages reviewed and the supervisor documents weekly reviews of the logbook.

All entries met the indicators requirements. No incidences of use of whiteout were found.

This process was verified by a review of 6 months of logbook entries and through a discussion with the Assistant Shelter Manager.

The program uses a permanently bound book to record daily occurrences in the shelter. A five color coding system is utilized to highlight different types of events. The logbook is reviewed as required by incoming staff who document the reviews appropriately. The Assistant Shelter Manager documents a weekly review of the logbook.

Six months of logbooks were reviewed.

No exceptions were noted.

Rating Narrative

The agency has multiple policies outlining their Behavioral Management Strategies. The shelter uses the Self Management Point System which is built upon the foundation of teaching social skills. Upon intake each youth is given four target skills. A daily point system is used to allow youth to earn both positive and negative points which are recorded on a point sheet. Youth earn points by displaying appropriate social skills in their daily interactions. Additional points may be earned or lost through participation in educational activities and study time. Negative behaviors such as running away, fighting, contraband, etc. result in an automatic point loss. Negative behaviors are addressed through corrective teaching and when unsuccessful, crisis teaching is used to de-escalate a situation.

Youth must have a minimum of 10,000 points at point total time to earn privileges for the following day. Privileges are earned on an all or nothing basis. They include TV video games, MP3/Ipod use, phone calls and outing. Additional privileges such as allowance, Resident of the Day and Resident of the Week may be earned. Extra points can be "banked" and used to purchase items in the shelter store.

Staff receive training in Advancing Youth Development, Crisis Intervention/Conflict Resolution, Establishing Rapport, Point Sheets, Positive Reinforcement and Logical Consequences. Shelter supervisors are involved daily in observing and modeling implementation of the behavior management system. Utilization of the behavior management system is reviewed with Youth Specialist staff during their annual evaluation.

Agency policy and procedure prohibits use physical restraint. The program uses only verbal de-escalation.

You are not allowed to discipline other youth and group discipline is not imposed. The shelter uses room restriction as a time out to allow a youth to get their behavior under control, rather than to punish misbehavior. when a youth is in room restriction the bedroom door must remain open and staff must check in with the youth in 10 minute intervals. Policy and practice prohibit use of room restriction for youth who are out of control or are suicidal.

Policy and practice dictate that disciplinary measures do not deny youth of things such as meals, clothing, sleep, etc.

Policy and practice was confirmed through a review of training files, logbooks and an interview with the Assistant Shelter Manager.

The agency has multiple policies in place outlining behavioral strategies. The shelter uses the Behavior Self Management System which is built upon the foundation of teaching social skills. A daily point system is used where points both negative and positive are earned and recorded on a

point card. A minimum of 10,000 points must be earned daily to gain privileges for the following day.

All staff receive training in behavior management during their orientation process. Additionally, supervisors observe staff and model appropriate use daily in the shelter.

The program uses verbal de-escalation only. Crisis Teaching is used to de-escalate a crisis situation until a youth is able to respond appropriately.

Only staff discipline youth and group discipline is prohibited. Room restriction is used as a time out to allow a youth to get their behavior under control, not as a punishment. Disciplinary measures do not deny youth any of the forbidden services such as meals and snacks, sleep, correspondence, etc.

No exceptions noted

3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

Rating Narrative

There is an agency policy identifying the staffing and gender requirements. The required ratio is 1:6 during awake hours and 1:12 during sleeping hours.

The staffing schedule reflects that there are regularly 3 staff on the first and second shifts and 2 on the overnight shift. The Youth Specialist and the Residential Counselors schedules are posted in the office and visible to staff. At times there is no male staff on a shift however, the agency has made efforts to hire male staff to be in compliance and has recently been successful and will have new male staff beginning soon.

An on-call system is utilized to fill necessary shifts. A roster of the staff and their phone numbers is available in the Daily Log book and in the On-Call notebook.

Bedchecks are conducted at 10 minute intervals during sleeping hours which exceeds the required 15 minute interval. Staff document the bedchecks in the Daily Log. A review of video tape for two different dates confirmed that bedchecks are being done regularly as documented.

The bedchecks observed on video were at times in conflict with the agency's policy as a female staff was observed conducting male bedchecks and a male staff was observed conducting female bedchecks on the same shift.

The agency's bedcheck policy does not reflect the requirement for overnight shifts to have a minimum of 2 staff present, however; they comply in their practice.

There is an agency policy identifying the staffing and gender requirements. The required ratio is 1:6 during awake hours and 1:12 during sleeping hours.

The schedule reflects 3 staff on the day shift, 3 on the second shift and 2 on the overnight shift. The staff schedules, shelter and counselor, are posted in the office and visible to staff. At times there are two females on shift. The agency has made efforts to hire males and has recently

done so but he is not on the schedule yet.

An on-call system is utilized to fill necessary shifts. A roster of staff is available in the Daily Log and in the On-Call notebook.

Bedchecks are conducted at 10 minute intervals during sleeping hours, which exceeds the requirement of 15 minute checks. A review of video tape confirmed that bedchecks are being done timely.

The bedchecks observed on video were sometimes in conflict to agency policy as females were observed conducting male room checks and vice versa.

The agency policy does not reflect the requirement for overnight shifts to have a minimum of 2 staff present, however; they comply in practice.

3.07 Special Populations

Satisfactory

Limited

Failed

Rating Narrative

Domestic Violence Respite:

The agency did not have Domestic Violence Respite youth in the past six months.

There is no policy in place for this specialized population.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The ACH program provides screening, counseling and mental health assessment services. The agency has a Residential Shelter Manager and Assistant Shelter Manager that oversee the daily operations and responsibilities of the program. The AFC Counselor staff members are trained on a standard training regimen. Staff members 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 mental health and health related risks. Specifically, the agency utilizes screening and a CINS Intake form to determine eligibility and various screening methods to determine the presence of risks in the youth past mental health status, as well as their current status. 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 youth shelter.

The agency provides assistance to all youth admitted to the program that require medication. The agency provides medication distribution training to all direct care staff members, first aid response, CPR, first aid, fire safety, emergency drills and exercises 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. The agency has an initial suicide screening process. In addition the agency has a LMHC Clinical Supervisor and senior counselors that are the key members conduct the assessment phase of the suicide assessment process.

The agency has a full complement of staff of both male and female staff members across all three (3) work shifts. Agency training files indicate that direct care staff members received standard annual training that includes crisis intervention, first aid, CPR, suicide prevention and medication distribution training. During this onsite QI review, the agency provided an up to date list of more than six (6) random agency staff members that have received medication distribution training and are authorized to provide distributed medication to residential clients.

4.01 Healthcare Admission Screening

Satisfactory
 Limited
 Failed

Rating Narrative

The agency has developed a policy to address the major requirements of this Quality Improvement indicator related to Healthcare Admission Screening. The current policy focuses on general health care and specifically medical care for routine, acute and chronic medical conditions.

The agency currently screens all youth admitted in to the residential and non-residential CINS/FINS program for general health care issue. The agency policy is current and was last revised in 20 and was recently signed by the agency Executive Director and representative of the Board of Directors on April 1, 2013. The agency maintains a medical alert screening system in place to ensure that all youth admitted to ACH programs are screened for acute medical and health conditions. All clients are screened during intake and information is documented. Screenings are conducted by direct care staff members. A health screening form is completed on each youth at admission to determine any past or current health and medical conditions, mental health or dental needs or acute or chronic medical conditions a youth may have. Staff members are required to report any health/dental complaints or needs that arise during a resident's stay to the resident's Counselor. Residential Counselors make appointments and Youth Specialist transport to and supervise youth on all appointments. Any medical treatment received during the shelter stay is documented in the client file and parent/guardian are notified accordingly.

All health information is captured on the ACH Health Screening and Physical Health Screening forms. These forms capture the current Medical Alert Status; Recent Condition (32 Conditions); Recent Hospitalizations; Current Medical, Dental, or Mental Health Complaints; Current Physician; Current Medications; Need for Auxiliary Aids, Assistive Technology, and Services or other Special Accommodations. In addition, the agency also documents special dietary needs on the Special Dietary Needs Form. The agency also documents family medical history in the client's psycho-social assessment.

A randomly selected group of six (6) client files were reviewed to assess the agency's adherence to the requirements of this standard. A total of three (3) open and two (3) closed cases were selected. All cases reviewed contain documented evidence that verify and confirm that the agency conducted health screenings that fully document findings from screenings and interviews of youth admitted to the Hidle House CINS/FINS program. Youth were all screened for the aforementioned medical conditions on the health screening and physical health forms.

No exceptions were noted for this quality improvement indicator.

4.02 Suicide Prevention

Satisfactory
 Limited
 Failed

Rating Narrative

The agency was reviewed on site. The current policy addresses the requirements of the indicator. The agency policy has not required an update and has not been updated since the last on site QI review in 2013. The agency has one (1) Licensed Mental Health Counselor whose license is in effect through March 31, 2015. As of February 2014, the agency has recently revised several steps of its internal suicide risk assessment process. In the past, the counseling staff members were responsible for conducting an immediate EIDS and a suicide risk screening on site. The new process requires that after hours when counselors are not available that all YCWs must ask the 1-6 policy-based Suicide Risk Screening questions. These questions are included in the agency's Shelter Intake Assessment when a youth is admitted to the program after business hours. If counselors are present during normal business hours an EIDS is then administered on the client. If deemed necessary, a Residential Counselor may be contacted by residential staff member to come in to youth shelter to conduct an Assessment of Suicide Risk.

The agency's suicide screening system is a multi-step process. The shelter utilizes three (3) levels of supervision: one on one; constant Sight and Sound and Elevated supervision. The agency screens for suicide by completing an Evaluation of Imminent Danger for Suicide (EIDS) tool. The process still requires a youth to score a positive answer in Criteria 1 of Suicide Risk Summary Scoring and/or scoring 5 or more positive answers in Criteria 2 must have an assessment of suicide risk completed immediately.

A review of five (5) files was conducted on site. The five (5) youth were placed on sight and sound and elevated supervision. All EIDS and Suicide Risk Assessment documents are completed as required; contained reviews by the agency's licensed clinician and documented supervision counts. The agency's observation log sheets document counts on an average of 10 minutes. The agency does set a pre-determined period for review prior to removal from this status. All removal from the documented supervision status is determined on a case-by-case basis. Counselors must review all documents to determine current status, behavior and temperament prior to removing. The counselors also review each case with the licensed staff member prior to removing.

Exceptions were noted on this indicator. The agency's ten (10) minute counts are being conducted on the ACH Elevated Supervision Log form. A review of five (5) client files indicates that all elevated supervision counts are being conducted on exactly 10 minute intervals and does not reflect real-time counts. Actual time that counts are being conducted must be the manner in which supervision times are documented by direct care staff members.

4.03 Medications

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy on medication. The current policy on medication has not changed since the last DJJ QI review in May of 2013. The current medication policy is detailed and addresses the safe and secure storage, access, inventory, disposal and administration of medication in accordance with the DJJ Health Services Manual. The agency's Assistant Shelter Manager is primarily responsible for the agency's medication distribution process. This staff person acts as the lead in medication distribution training for all new hires and retraining of on-going staff members.

The program maintains a typed list of all staff that are authorized to have access to secured medications, and limited access to all controlled substances.

The medication for all residents are stored in a separate, secure area, which is inaccessible to youth. Specifically, the medication is stored in a locked closet area that is located within the Youth Care Worker station. The agency's prescribed medications are locked in a large wood cabinet behind one (1) lock. One cabinet is designated for controlled/narcotic medications and prescribed medication and it is equipped with two (2) locks. There is an additional cabinet that houses all over the counter medications. All oral medications are stored separately from topical medications. The agency places all oral medications on 3 different shelves in the cabinet. The agency places all inactive/disposal medications on the top shelf in the locked medication cabinet. All refill medications are stored on the middle shelf. All active or current medications are stored on the bottom shelf. All medications are placed in a baggie with the respective youth's name. Oral and topical medications are stored in their original containers. The agency maintains a small refrigerator that is used exclusively used for medication storage. However, there was no medication that required refrigeration during the time of the review. In addition, there were no injectable medications on site.

Shift-to-shift counts are completed across three (3) work shifts on a daily basis. A perpetual inventory count is conducted and documented for controlled and prescribed medications. Non-controlled is counted on a perpetual basis and when given. All over the counter (OTC) are accessed regularly and are inventoried weekly by maintaining a perpetual inventory. Agency OTC counts for October 2013 indicate that the majority of counts were conducted as required.

The agency utilizes a Medication Distribution Record to capture major information related to each youth admitted to the youth shelter on a daily basis. The MDR includes name, date of birth, picture, allergies, side effects, staff initials, youth's full name and initials, staff member initials and name. In general format and layout of the MDR is user-friendly and the document completed by hand.

Sharps are permitted in the facility. The sharps used in the shelter included nail clippers, shaving razors, tweezers and scissors. The agency keeps an inventory of these items on a 1 page sheet sharps log. The agency also maintains several first aid kits. The agency also utilizes bio hazard waste disposal bins.

A total of six (6) residents' Medication Distribution Logs (MDL) were reviewed on site to determine accuracy and completion. The agency's MDR captures all major information related to each youth and their medication specific information. The MDR includes name, date of birth, picture, allergies, side effects, staff initials, youth's full name and initials, staff member initials and name. The format of the MDR is functional and user-friendly. The agency has a medication verification process that is completed by the assigned counselor. The counselor is required to complete the medication verification early in the admission and intake process. Counselors contact the pharmacy that completed the prescription per the information that is provided on the medication container that they receive from the parent/guardian. Once the medication is successfully verified the counselor documents the verification in the client's file and also informs the residential YCW staff that the medication can continue to be distributed.

The agency has a practice to notify the parent or guardian when the prescribe medications of the resident are low. The agency uses a medication receipt form at the admission/intake stage to capture when medications are signed in our out by parent/guardian.

There were exceptions to this quality improvement indicator. The agency's medication disposal practice stores all medication left or not picked up by the resident's parent or guardian. At the time of this on site review, the inactive shelf had a total of eight (8) or more residednth medications that had been stored awaiting disposal on the Inactive shelf. The agency does maintain a medication drug disposal log that captures all medications discarded by the agency. The medication disposal record sheet indicated that medications were last disposed of on January 24, 2014.

There was one (1) incident documented as being reported to the DJJ CCC and no documented follow up evidence of re-training of personelle file documentation. In addition, the agency's medication practice is sometimes inconsistent as medication is documented in either the logbook or the client's progress notes on an intermitten basis.

A March 15, 2014 medication error was called in to the DJJ CCC due to the agency given a resident there medication at the wrong time. This incident did not include any evidence of documentation to verify that the agency had conducted a counseling, re-training on the staff that committed the medication error.

4.04 Medical/Mental Health Alert Process

Satisfactory
 Limited
 Failed

Rating Narrative

Four open and four closed residential files reviewed. Mental and medical health alerts are identified by red, green or yellow dots on binder of open files and on the face of closed files. A legend is created for the dot system. Red dot: Mental Health, suicide/homocide, history of inappropriate behaviors. Yellow dot: Asthma, diabetics, allergies requiring immediate attention. Green dot: Resident has a history of running away. Medical, mental health condition and food Health alerts are identified in screenings, admissions intakes, progress notes, suicide risk evaluation, and on a board in the YCS office. A notice of Special Dietary Needs form is completed if a youth has food allergies, placed in his/her file and copy given to the Dietary Specialist. A white dot is to alert counselors of youth who are elevated and on site and sound. Tour of the facility and interview with Assistant Shelter Manager, Sylvester Jones verified information reviewed.

Policy is in place to address timely identificaton of youth needs. Eight residential files reviewed. Four open/four closed. An extensive Mental, Medical health to include dental care and food health alert process is in place. Red, yellow, green and white dots system is used to identify particular alerts. Notes are made in the youths file throughout that alerts staff of emergencies and concerns. A board in the YCS office indicates specific alerts for youth. Food alerts are noted on a Dietary Needs Form and copies are given to the Dietary Specialist for review and use. Health screenings and physical exams are conducted by a licensed physician. Medical Consent Form is in place as supporting documents.

No exceptions!

4.05 Episodic/Emergency Care

Satisfactory
 Limited
 Failed

Rating Narrative

Two Episodc/emergency Care done since January 2014. Knife or Life and wire cutters are located YCS office locked and vans ? First Aid

Kit/supplies are located YCS office area and vans. All staff are trained on emergency medical procedures.

Live Emergencies:

Off site emergency services obtained. Parents were notified, CCC was notified timely. Log and incident reports are kept accordingly. Knife for life is located in the YCS office locked. First aid kits are located in various areas, several being in the YCS office area.

Quarterly Emergency Drills:

1/24/14, Youth Disturbance, 4:40 am; **1/28**, You not responding to a door knock, 4:40 pm; **2/26**, Fighting in van, 5:47 am; **4/7**, Staff illness, 5:45 pm --suggested have youth talk with counselor if traumatized; **4/7**, Youth cutting, 12:30 pm -Suggested putting youth on sight and sound until Counselor arrives.

Live Emergency Care

Off site emergency services obtained timely. Parents notified and CCCC notified timely. Log book(s) and incident reports are kept accordingly. Knife for Life is located in the YCS office locked and tool in vans as well. First Aid kits are located in various areas of the agency, several being YCS office and vans.

Reviewed two live report of Episodic/emergency: **1/2/14**, youth was CINS, but ES at time of incident. **4/14/14** Staff responded appropriately, EMS, appropriate staff personnel and parent(s) notified timely. Youth discharged from hospital and shelter.

Quarterly Emergency Drills

Drills were conducted on each shift and executed appropriately. Suggestions were made to get counselor involved when youth are traumatized of particular incidents and put youth on sight and sound until counselor arrive when critical incidents occur.

No Exceptions!