



**QUALITY IMPROVEMENT
PROGRAM REPORT
FOR**



Anchorage Children's Home of Bay County, Inc.

**2121 Lisenby Avenue
Panama City,
(Local Service Provider)**

***Review Date(s):
May 31, 2012 – June 1, 2012***

CINS/FINS Rating Profile

Program Name: **Hide House -CINS/FINS**
 Provider Name: **Anchorage Children's Home**
 Location: **Bay County / Circuit 14**
 Review Date(s): **May 31 – June 1, 2012**

QA Program Code: **N/A**
 Contract Number: **V2021**
 Number of Beds: **20**
 Lead Reviewer: **K. Carr**

Indicator Ratings

1. Management Accountability		
1.01	Background Screening of Employees/Vol.	Satisfactory
1.02	Provision of an Abuse Free Environment	Satisfactory
1.03	Incident Reporting	Failed
1.04	Training Requirements	Satisfactory
1.05	Interagency Agreements and Outreach	Satisfactory
1.06	Disaster Planning	Satisfactory

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

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

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

2. Intervention and Case Management		
2.01	Screening and Intake	Satisfactory
2.02	Psychosocial Assessment	Satisfactory
2.03	Case/Service Plan	Satisfactory
2.04	Case Management and Service Delivery	Satisfactory
2.05	Counseling Services	Satisfactory
2.06	Adjudication/Petition Process	Satisfactory

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

Overall Rating Summary

Satisfactory Compliance:	89%
Limited Compliance:	0%
Failed Compliance:	11%

Methodology

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

Persons Interviewed

<input checked="" type="checkbox"/> Program Director	<u> 2 </u> # Case Managers	<u> 2 </u> # Maintenance Personnel
<input type="checkbox"/> DJJ Monitor	<u> 1 </u> # Clinical Staff	<u> 2 </u> # Program Supervisors
<input type="checkbox"/> DHA or designee	<u> 1 </u> # Food Service Personnel	<u> 1 </u> # Other (listed by title):
<input type="checkbox"/> DMHA or designee	<u> </u> # Healthcare Staff	<u>Executive Director</u>

Documents Reviewed

<input type="checkbox"/> Accreditation Reports <input checked="" type="checkbox"/> Affidavit of Good Moral Character <input checked="" type="checkbox"/> CCC Reports <input type="checkbox"/> Confinement Reports <input checked="" type="checkbox"/> Continuity of Operation Plan <input checked="" type="checkbox"/> Contract Monitoring Reports <input type="checkbox"/> Contract Scope of Services <input checked="" type="checkbox"/> Egress Plans <input type="checkbox"/> Escape Notification/Logs <input type="checkbox"/> Exposure Control Plan <input checked="" type="checkbox"/> Fire Drill Log <input checked="" type="checkbox"/> Fire Inspection Report	<input checked="" type="checkbox"/> Fire Prevention Plan <input checked="" type="checkbox"/> Grievance Process/Records <input type="checkbox"/> Key Control Log <input checked="" type="checkbox"/> Logbooks <input checked="" type="checkbox"/> Medical and Mental Health Alerts <input type="checkbox"/> PAR Reports <input checked="" type="checkbox"/> Precautionary Observation Logs <input checked="" type="checkbox"/> Program Schedules <input type="checkbox"/> Sick Call Logs <input type="checkbox"/> Supplemental Contracts <input checked="" type="checkbox"/> Table of Organization <input type="checkbox"/> Telephone Logs	<input type="checkbox"/> Vehicle Inspection Reports <input type="checkbox"/> Visitation Logs <input checked="" type="checkbox"/> Youth Handbook <u> 7 </u> # Health Records <u> 6 </u> # MH/SA Records <u> 9 </u> # Personnel Records <u> 11 </u> # Training Records/CORE <u> 17 </u> # Youth Records (Closed) <u> 7 </u> # Youth Records (Open) <u> 6 </u> # Other: <u>Logbook,</u> <u>Incidents, Outreach Information,</u> <u>Disaster Plan, Grievances</u>
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Surveys

<u> 3 </u> # Youth	<u> 3 </u> # Direct Care Staff	<u> 0 </u> # Other: <u> </u>
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Observations During Review

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

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

Rating Definitions

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

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

Review Team

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

Keith D. Carr, Lead Reviewer, Principal Consultant, Forefront LLC
Latrice Covington, Contract Manager, Office of Prevention and Victim Services . DJJ
Bruce Morton, Management Review Specialist, DJJ Bureau of Quality Improvement
Kevin Winship, LMHC, Residential Director, Capital City Youth Services, Inc.

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

Strengths and Innovative Approaches

The Anchorage Children's Home of Bay County, Inc. (ACH) operates the Children in Need of Services/Families in Need of Services (CINS/FINS) program in Circuit 14 that includes Bay County/Panama City, as well as Calhoun, Gulf, Holmes, Jackson and Washington Counties.

The purpose of the residential and non-residential CINS/FINS Program is to reduce juvenile crime while assisting, supporting and strengthening the youth and families that meet status offender eligibility requirements. The Anchorage Children's Home of Bay County's CINS / FINS Program has two (2) components: residential and nonresidential services, designed to help families whose youth exhibit risk factors that make them more susceptible to becoming involved with Juvenile Delinquency or Dependency system. The youth served in the CINS / FINS program are youth that have not been adjudicated delinquent and who have not been adjudicated dependent, but are at risk for adjudication without intervention services. These risk factors include school problems and truancy, family behavioral problems and ungovernability, runaway behaviors or homelessness, poor peer relations, and or the use of drugs and/or alcohol and lockout youth.

The Anchorage CINS/FINS program reports a new Program Manager for the Street Outreach Program that was hire in February 2012. The program reports that it operates a DCF funded Independent Living Program.

The agency also participates in a Dog Therapy program to assist clients with social problems and acts as an alternative method to assist youth with their presenting problems during their shelter stay. The agency also has a Project Playdo creative art program for residents in the program.

The agency is a participating local Meals-on-Wheels Program on a weekly basis.

The agency is also participates in the National School Lunch Food Registry program. The agency reports that the Rockefeller Foundation provided funding to assist with Case Management Services and Housing Assistance. The agency also added a position to their SOAR program which is a DCF Challenge Grant funded initiative.

The agency was re-certified by the Council On Accreditation (COA) in June of 2011. The Council on Accreditation (COA) partners with human service organizations worldwide to improve service delivery outcomes by developing, applying, and promoting accreditation standards.

Standard 1: Management Accountability

Overview

The Anchorage Children's Home of Bay County is now under the leadership of Steve Blumenthal, Executive Director. Joel Booth is the Program Administrator of the CINS/FINS Program. The agency has a total of one (1) licensed staff members. The program has one (1)

Clinical Supervisor, 1 Human Resources Director, 1 Shelter Manager, 1 Assistant Shelter Manager, 2 Residential Case Managers, 3 AFC Counselors, thirteen (13) Youth Specialists, 1 Life Skills Coordinator, 1 Food Manager and 2 Maintenance staff members. At the time of this onsite review, the program reports that there is 1 vacant CINS/FINS position (Youth Specialist) in the program.

The program serves male and female youth between the ages of ten to seventeen (10-17) years that are status offenders (locked out, runaway, ungovernable and/or truant, homeless, abused, neglected, or at-risk). The program provides a full range of residential and non-residential services designed to maintain family structure, reduce truancy, as well as prevent and reduce the number of children that enter the Department of Juvenile Justice (DJJ) as status offenders and the Department of Children and Families (DCF). Residential services provided include counseling, referrals for a broad range of needs, behavior management and reunification assistance, diversion alternative placement services and respite. The non-residential services program consist of individual and family counseling and case management services. The CINS/FINS program is an official designated Safe Place site. The Department of Children and Families has licensed the Anchorage Children's Home of Bay County CINS/FINS Program as a Child Caring Agency (CCA), with the current license in effect until November 9, 2012.

1.01: Background Screening of Employees/Volunteers	Satisfactory Compliance
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The agency has a comprehensive policy that requires all prospective employees and current employees (5 year rescreens) to be appropriately screened. The policy addresses screening requirements and procedures for all prospective new hires, transfers and interns. The agency provided a full current roster of Residential and Non-Residential staff members.

A review of eleven (11) staff member personnel files was conducted to determine compliance with this standard. Of these files, ten (10) background screenings were new or recent hires and one (1) was a five (5) year rescreen. The review of the file that required a 5 year rescreen revealed that the screening was completed 60 days prior to the employee's 5 year anniversary date. Two (2) other employees listed on the agency's personnel roster are due for 5 year rescreenings prior to their anniversary dates later this Calendar year. All background screenings conducted for new hires were completed and met all requirements for this standard. The agency also conducts local law enforcement background, driver's license checks and reference checks.

The agency has also demonstrated and provided evidence that the Annual Affidavit of Good Moral Character has been submitted to the DJJ Background Unit prior to the January 31 deadline.

1.02: Provision of an Abuse Free Environment	Satisfactory Compliance
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The agency has a specific policy that addresses the abusive or threatening behavior according to the provisions in the DJJ QA Standard 1.02. A review of a combination of various reports over the last six (6) months and agency documents were used to assess the agency's adherence. The review of this standard included a full review of eleven (11) internal agency grievances, four (4) reported incidents in the DJJ CCC database recorded for Anchorage Children's Homes of Bay County, ten (10) internal agency incidents, two (2) ACH Verbal Warning documents, three (3) youth surveys and 3 staff member surveys.

A review of the agency Employee Discipline and Separation Policy was conducted. A review of DJJ CCC incidents revealed the following incident types including; Medical Incidents; Program Disruption, Mental Health/Substance Abuse; Youth Behavior Incidents; and Medical Incident. A review of the internal ACH Unusual incidents revealed primarily medication errors and minor physical injuries.

At the time of this onsite program review, the agency did not have any DJJ CCC incidents, internal grievances or internal ACH Unusual incidents that involve a staff members Use of Force within the last six (6) months. The review of the 2 Verbal Warnings indicate issues related to non-performance in the workplace (No Show at Meetings and Texting while Supervising Youth)

A total of eleven (11) internal agency grievance reports were reviewed to determine the agency's adherence to this standard. None of the 11 grievances reflect any evidence of unsafe conditions, threats to safety or intimidating conditions in the residential shelter.

A total of three (3) staff member surveys and four (4) youth surveys were conducted. Of these surveys, none of the staff member surveys revealed responses regarding an abusive or threatening environment. One of the 4 youth surveys report that ACH staff members do not threaten them verbally or to confine them to their rooms, but staff do issue threats to take youth behavior management points away. All youth surveys report that staff members are knowledgeable of safety requirements, grievance policy and abuse reporting contact numbers. Other reports from youth grievances indicate that staff members are experiencing challenges in communicating with youth. Youth grievances indicate that staff members' reactions are impulsive and curt in their interactions with youth. Staff members appear to be reacting rather than responding with a structured therapeutic or behavior management focused responses. Staff members' ability to interact more effectively could be greatly enhanced by trainings such as Advancing Youth Development.

No other documents, incidents, or surveys submitted involve any significant evidence of abuse, threats of harm or intimidation to youth.

1.03: Incident Reporting

Failed Compliance

The agency has a general policy and procedure regarding Incident Reporting. The policy requires that all staff report eligible incidents to the DJJ CCC within two (2) hours of becoming aware of the incident. The Bureau of Quality Improvement conducted a search for all ACH of Bay County related incidents that occurred within the last six (6) months.

The review of this standard included a review of four (4) reported DJJ CCC incidents and eleven (11) ACH Internal Incidents. The DJJ CCC incident types included Program Disruption, Youth Behavior, Mental Health/Substance Abuse, and a Medical Incident. In 4 out of 4 incidents, all were reported in less than 40 minutes of the caller gaining knowledge of the incidents. All cases are documented as being reported well within the 2 hour reporting time requirement.

Of the eleven (11) ACH Internal Incidents, the review revealed that six (6) of these internal incidents were medication errors. None of the 6 medication error incidents found during the review were reported to the DJJ CCC. As of January 25, 2010 all agencies must report when staff members neglect to distribute medications as required under Reportable Incident Types for CINS/FINS. Errors in reporting these 6 internal incidents to the DJJ CCC center on medication errors which fall

under the Complaints Against Staff Incidents . Medical Neglect Category. The agency reports that it was not aware that they were required to report any medication errors to the DJJ CCC.

The reviewer for this standard asked if the agency could provide any evidence of the agency follow up with the staff that committed the medication errors. The agency provided a copy agenda from a February 2012 staff meeting that indicated the recent increase in medication errors. The staff meeting document only list that %here have been several missed medications+. The agency had no further documentation or other evidence demonstrating that documented Incidents are identified, reviewed and interventions are applied and process is reevaluated for on-going corrective action as needed. The agency reports that it will review the incident report policy and continues to ensure that all staff members reporting eligible incident must be cognizant of the 2 hour time requirement at all times.

1.04: Training Requirements

Satisfactory Compliance

The agency has a training policy that addresses the minimum CINS/FINS training requirements on an annual basis for both residential and non-residential staff members. The agency's training policy includes details on training topics and hours for first year and on-going staff members.

The agency records and tracks all training hours for each employee by each employee's individual anniversary date. The agency has a designated Human Resource staff person that handles all personnel functions located onsite. However, training is maintained by the agency Program Administrator. Each employee has evidence of an individual training log that is maintained in a 3-ring binder that includes a training log with topics hours and includes supporting documentation such as sign-in sheets, training records and certificates. The provider agency conducts orientation training to all residential and non-residential staff members through a combination of training sources that include the Florida Network, local area and in-house trainers.

A total of nine (9) staff member training files were reviewed to assess the agency's adherence to the First Year and On-Going Staff Member Training topics and hours. A review of four (4) First Year training files contained evidence of staff member participating in all major training topics including CINS Core, Suicide Prevention, Crisis Intervention, CPR, First Aid, Title IV-E, Universal Precautions, Cultural Competency as well as others. All new hires have evidence of training hours and topics with eighty (80) hours of training documentation. The review of the On-Going staff member training files revealed that 4 out of 5 staff has topics and hours that meet the annual 40 hour training requirement. All staff members have evidence of the required training topics and hours including CPR/First Aid training. The current FNYFS policy effective through June 30, 2012 requires a minimum of 24 annual training hours for On-Going employees.

The reviewer confirmed the completion of training for new hires that includes Program Orientation, CINS/FINS Core Training, Substance Abuse, DJJ Civil Rights Training, Stages of Adolescent Development, Supervising Volunteers, Administrative Procedures and Program Goals, Gang Awareness, Understanding Child Behavior, Emergency Preparedness, NAPPI, Title IV-E, Reporting Abuse, Fire Extinguisher/Fire Safety, Netmis Training Lab, Food Safety Training, Central Communications Call-in Log, Suicide Awareness and Prevention, Substance Abuse, Cultural Diversity, Domestic Violence, Cultural Diversity, Prevention, Reporting and Services to Missing Children, Trauma Informed Care and logbook Policy Training.

At this time, the agency does not require new hires to receive priority training topics by a certain date such as within 30, 60 or 90 days of hire. The agency was advised of the five (5) new training topics offered online by the Florida Network of Youth and Family Services.

1.05: Interagency Agreements and Outreach

Satisfactory Compliance

Review of agency's policy on outreach and partnerships was reviewed during this onsite program review. In addition, the review for this indicator included review of agency publications to include the agency's CINS/FINS Guide focusing on parents which is available in English and Spanish was a part of the review for this indicator. Various outreach materials were reviewed as well as documentation to track the agency's recent outreach activities and events. It is recommended that the agency consider utilizing NetMIS as an optional record keeping system to document all outreach activities.

A review of the most recent partnership agreements signed by the agency was conducted. There are interagency agreements with various agencies for alcohol and other drug use/abuse, adolescence/adolescent behavior, parenting classes/family functioning, and youth educational issues. There is a designated staff member to coordinate and provide outreach services.

Outreach is documented in NetMIS. The agency provided outreach and services to Bay, Calhoun, Gulf, Holmes, Jackson, and Washington counties. There are various community service agreements for community-based educational and extracurricular activities for youth and residents. There is a cooperative service agreement with the Bay County Health Department that ends June 30, 2011 with an option to renew annually through June 30, 2014. However, there are no signature dates and the review has no evidence to confirmation that the agreement is active.

The agency has an internal policy on Interagency Agreements and Outreach. The review included assessing interagency agreements and outreach efforts.

1.06: Disaster Planning

Satisfactory Compliance

The program has a written Emergency Preparedness/Disaster and Emergency Plan to address the requirements as listed in indicator 1.06 Disaster Planning. A review of internal documents included the Florida Network Letter of Approval of the agency Disaster Plan and the Universal Agreement.

The current disaster plan is reviewed and updated on an annual basis. The agency's plan has procedures for disasters such as hurricane, fire, flooding, hostages, chemical spills, terrorist, etc.

The plan states when and where to evacuate with directions to evacuation locations. There are several supply lists to ensure there are enough items for youth and staff when evacuating. The supplies are checked monthly at a minimum. The supplies are in several locations and must be gathered by staff prior to evacuation. There is a process to notify staff and the Florida Network. The agency participates in the Universal Agreement Emergency Disaster Shelter. The agency plan includes a list of supplies for anyone sheltering with Anchorage, including staff families and staff members that are not on duty.

The agency posts maps/egress plans in the dormitory areas and at specific exit points throughout the youth shelter. The program participates in the Universal Agreement for Emergency Disaster Shelter with other Florida Network Member Agencies.

Standard 2: Intervention and Case Management

Overview

The Anchorage Children's Home of Bay County is contracted to provide both shelter and non-residential services for youth and their families in Bay, Calhoun, Gulf, Holmes, Jackson and Washington Counties. Youth and families receive help in a non-residential setting through the Children in Need of Services / Families in Need of Services (CINS/FINS) Non-Residential Program. This program serves youth that meet status offender eligibility status that includes runaways, truants, ungovernable and lockout youth. Trained non-residential counselors provide individual and family counseling services to youth ages 7 to 17 at sites throughout the aforementioned service region through flexible daytime and early evening hours.

Also included in the non-residential service offering through the agency are Case Staffing Committee services where parents may file a Seven-Day Letter which is a formal document to request their child's case be brought to the attention of a judge.

As is the case for all full-service CINS/FINS Providers, the agency provides centralized intake and screening twenty-four hours per day, seven days per week for status offenders that include runaways, truants, ungovernable and lockout youth. Trained staff members are available to determine the needs of the family and youth. Residential services, including individual youth, family and group services. Case management and substance abuse prevention education are also offered on an as needed basis. Aftercare planning includes referring youth to community resources, on-going counseling and educational assistance on an as needed basis.

At the time of this review, according to agency's organizational chart lists Joel Booth, Program Administrator as in charge and oversees both the Residential and Non-Residential programs. Specifically, Cynthia Hoskins, Clinical Supervisor oversees all Clinical and Counseling services for the agency. At the time of this review, she oversees three (3) AFC Counselors and two (2) Residential Counselors. Counselors are responsible for providing case management services and linking youth and families to various community services. Outpatient services or the non-residential program is responsible for coordinating the Case Staffing Committee, a statutorily-mandated committee that develops a treatment plan for habitual truancy, lockout, ungovernable, and runaway youth when all other services have been exhausted or upon request from the parents/guardians. This component of the agency also recommends the filing CINS Petitions with the court on and as needed basis.

2.01: Screening and Intake

Satisfactory Compliance

A screening and intake review included an onsite review of randomly selected number of open and closed files from the last 6 months. A total of Six (6) open residential and three non-residential (1 open and 2 closed) files were reviewed for this standard for a total of nine (9) files. Eight (8) of the 9 files have documentation that the eligibility screening was completed within seven (7) days. Nine (9) youth files have documentation that the youth and parent received available service options, rights and responsibilities, and grievance procedures. Eight (8) of the 9 youth files have documentation that parents received the parent brochure and possible actions occurring through involvement with CINS/FINS.

2.02: Psychosocial Assessment

Satisfactory Compliance

A review of the agency's policy and procedures for psychological assessments were conducted and was found to be inclusive of all components required by Indicator 2.02.

Three (3) non-residential (1 open and 2 closed) files and six (6) open residential files were reviewed for this standard. Six of the residential files have documentation the psychosocial assessment was initiated within 72 hours. Three (3) of the non-residential files have documentation the psychosocial was completed within 2 to 3 face-to-face contacts. All files have documentation the psychosocial assessment was completed by Bachelor's level staff and include a supervisor review signature. Eight (8) files have documentation on the psychosocial assessment. There was no elevated risk of suicide documented.

All agency staff members completing assessments and reviews have a bachelor's or higher level certification. The reviewer for this indicator confirmed that all staff members exceed the minimum educational certification requirements in order to execute and complete assessments.

2.03: Case/Service Plan

Satisfactory Compliance

A review of the agency's policy for case/service planning was conducted and was found to be inclusive of all components required by Standard 2.03. The agency has a comprehensive policy and procedure for initial service plans that addresses all requirements of the indicator. A case service plan is developed with each client in both residential and non-residential files.

A total of four (4) residential files and 4 non-residential files were reviewed for this indicator. All eight (8) client files contained complete Service Plans with all of the required information (e.g. identified needs, goals, assignments, target dates, signatures, and service descriptions.) Each of the 8 files showed that information from the screening, intake, psychosocial assessment, and other assessments used by the Case Managers had been utilized in developing the Service Plan.

All Service Plans were developed and initiated on the same day the psychosocial assessment was completed. The only exception noted for this standard was the actual review of Service Plans. Specifically, 2 of the 4 non-residential files showed evidence that several of the 30/60/90-day Service Plan reviews were late. In each instance, they were late by only several days.

2.04: Case Management and Service Delivery

Satisfactory Compliance

A review of the agency's policy and procedures for case management and service delivery was conducted and was found to be inclusive of all components required by Standard 2.04.

A review of eight (8) files (4 residential and 4 non-residential) showed that each youth had an assigned Case Manager. Each file also contained documentation in the Progress Notes that showed frequent communication between the Case Manager, the family, and a variety of referral sources or other involved agencies.

Each file reviewed contained documentation in the Progress Notes that showed evidence of Case Managers providing support, recommending additional services/activities, and noting progress

made toward Service Plan goals. Of the 4 closed files (2 residential, 2 non-residential) reviewed, all 4 contained a clear discharge plan signed by the youth and parent/guardian, with a summary of goals and any necessary referrals.

2.05: Counseling Services

Satisfactory Compliance

A review of the agency's policy and procedures for Counseling Services was conducted to determine adherence to all by Standard 2.05. Agency policies are in place to address all aspects of this indicator, including the development of assessments, case plans, case plan reviews, case management, confidentiality, progress notes, quality improvement and internal review.

A review of eight (8) files (4 residential and 4 non-residential) showed that each youth was provided with individual, group, and/or family counseling. Counseling services were documented in either the Progress Notes or on a Group Log (used to document the date, topic, and a client's participation in group counseling.) Each youth had their own individual case file which was clearly marked %confidential.+

Evidence of Counseling Services provided were clearly documented in seven (7) of the 8 files. In one (1) residential file, the youth had received individual counseling, just not at the frequency indicated in the Service Plan.

Each residential file reviewed showed that youth were receiving group counseling at least 5 times per week with a variety of topics being covered including: hygiene, social skills, Yoga, social interactions, etc.

Non-residential services were provided at Anchorage's main facility, on school grounds, and in-home, depending on the need of the client and his/her family. Each file contained evidence of regular clinical review with feedback on the client's progress and any necessary changes/additions to the Service Plan.

2.06: Adjudication/Petition Process

Satisfactory Compliance

A review of the agency's policy and procedures for the adjudication/petition process was conducted and was found to be inclusive of all components required by Standard 2.06.

The agency provided two (2) examples for review to assess their adherence to the requirements for this indicator. Both client files reviewed contained documentation showing that the Case Staffing Committees (CSC) were requested in writing. Each CSC was convened within 7 days of the initial written request and each CSC meeting had all required parties in attendance. One client's CSC meetings were attended by additional participants at the request of the family, including the youth's counselor and the family's youth pastor.

Both files showed that CSC meetings resulted in a written CSC staffing report that detailed which services/activities were recommended by the CSC. The youth, the youth's parent/guardian, and all other members of the CSC signed the CSC staffing report. All of the CSC staffing reports were generated and provided to CSC participants on the day of the CSC staffing. Neither of the 2 files resulted in a CINS petition being filed on that particular youth.

Standard 3: Shelter Care/Health Services

Overview

The Anchorage Children's Home of Bay County CINS/FINS is licensed by the Florida Department of Children and Families (DCF) for twenty (2) beds and it primarily serves youth from Bay, Calhoun, Gulf, Holmes, Jackson and Washington Counties. The shelter also provides service to youth referred to them from the Department of Children and Families through a separate contractual agreement.

At the time of this onsite Quality Improvement Review, there are a total of fourteen (14) youth admitted to the youth shelter. Of the 14 youth in the shelter, seven (7) are CINS/FINS youth. The residential program is designed under one (1) large one-story shelter building that houses both male and female clients. The residential facility includes a very large common area or day room. The common area/dayroom divides the sleeping areas of female and male residents. Each sleeping area is gender specific and contains individual rooms with two-three individual beds in each sleeping room. Each bedroom contains its own bathroom. The building also contains a large industrial kitchen, separate cafeteria, computer and reading areas, laundry room, Youth Specialist work station and several administrative offices. At the time of this onsite Quality Improvement review, the residential shelter was found to be in good condition and the furnishings in good order. At the time of this review, all resident bed rooms, bath rooms and common areas were clean and free from hazards. Following classification, each youth is assigned an individual bed, bed coverings and pillows. In addition, the youth have access to a host of recreational games, open green space, volley ball court, basketball court and a teen activity center. This youth shelter is not designated by the Florida Network of Youth and Family Services to provide staff secure services.

There are a total of nineteen (19) Residential staff members (full-time, part-time and on-call) assigned to perform residential duties. This number of residential staff members includes one (1) Program Administrator, 1 Clinical Supervisor, 1 Shelter Manager, 1 Assistant Shelter Manager, thirteen (13) Youth Specialists, two (2) Residential Case Managers, 1 Life Skills Coordinator, 2 Maintenance staff and 1 Food Manager. The Youth Specialists are responsible for completing all applicable admission paperwork, orientating youth to the shelter, and providing necessary supervision and programming to all residents. Youth Specialists also assist in the delivery of self-administration of prescribed and over-the-counter medications and administer first aid when needed. The Life Skills Coordinator provides a broad range of practical training to each resident.

The program has disaster plans, knife-for-life, wire cutters, and first aid kits are located in the main area near the youth work station in the facility. In addition, first aid kits are located in each transportation vehicle.

The program has access to one (1) licensed staff person on staff. The agency's Residential Counseling staff members include two (2) Residential Case Managers. An interview with the program administrator indicated that outpatient and shelter mental health services are not connected and that they operate separately.

Medical services are confined to medication administration and minor injuries. If the youth needs any medical services beyond those limits it is the responsibility of the youth's parent or guardian. Over-the-counter medications are inventoried weekly by the assistant shelter manager.

The shelter has a behavior management system that is based on the number of points a youth can earn each day. The maximum points that a youth can be awarded each day are 10,000. The maximum number of points a youth can lose per day is 48,000. The number of points a youth can earn or lose is difficult because there is not a list of behaviors and the number of awarded points. Assessment of points is totally subjective. The youth has to have all or their points in order to have access to extra privileges, which include video games, use of the computer, be able to call people not listed on the approved contact list, and snack food out of the vending machine. There are two positions that reflect exceptional behavior. They are Resident of the Day (ROD) and Resident of the Week (ROW). These awards are for youth who have made all of their daily points and have shown a leadership role with the other youth.

3.01: Shelter Care Requirements

Satisfactory Compliance

A review of the agency's policy and procedures for screening and intake was conducted and was found to be inclusive of all components required by Indicator 3.01. A total of eight (8) clients were reviewed to assess the agency's adherence to the 24 hour Orientation, Rights and Responsibilities, Grievance, Bed Check and Use of Force. The agency is not designated as a Staff Secure placement facility. The agency has a specific/individual policy on each of the aforementioned shelter care requirement areas.

A review of eight (8) residential client files revealed that all contained a comprehensive orientation at intake. All files have documentation that indicates youth receive and acknowledge their available rights and service options. The orientation process is also explained in the youth handbook. There is a grievance process that covers four (4) phases to include verbal consultation, referral to the Shelter Manager, the Program Administrator, and finally a response by the Executive Director.

The grievance process was posted in the main room in the shelter, as well as the client handbook. An interview with a current resident in the youth shelter found that he was unaware of the grievance process until it was explained to him. On-line survey data from 4 additional youth indicated 4 response yes responses on each survey when asked "Do you know about the Grievance Process?"

A review of the shelter logbook found the required fifteen (15) minute bed checks were being conducted at ten (10) minute intervals. A review of agency Logbook was conducted. Because the 10 minute bed checks were logged in the logbook and not highlighted they were difficult to find. During the program review, the review team recommended that the agency highlight all overnight bed checks documented in the logbook by staff members.

A review of the Hide House policy and procedures found that the program they use a "hands off" policy for the possible use of force. At no time are the youth physically restrained. Hide House is not designated by the Florida Network to provide Staff Secure services.

3.02: Healthcare Admission Screening

Satisfactory Compliance

A review of the agency's policy and procedures for screening and intake was conducted and was found to be inclusive of all components required by Indicator 3.02. This policy addresses healthcare screening practices for all youth entering shelter care. An Admissions Checklist/Physical Health Screening form is completed at the time of intake into the shelter. This

form includes a screening section that inquires about the youth's following areas: observable injury, illness or health issue, any current medical, dental or health conditions, recent hospital visits, recent treatment or medication for mental health disorder, current medications, allergies, and dietary concerns.

Eight (8) youth files were reviewed for completion of the health screening upon admission to the shelter. A review of the healthcare screening found an assessment for youth with current medical conditions, to include: current medications, any existing chronic or acute medical conditions, allergies, recent injury, and the presents of any pain or physical distress, any evidence of illness, tattoos, or difficulty in moving. If a youth has any of these medical conditions in may be necessary to have the youth's parent or guardian arrange transportation or appointments to address the treatment of the medical condition. A logbook entry is made when a medical referral is made.

3.03: Suicide Prevention	Satisfactory Compliance
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The program had written policies and procedures related to ~~%Mental Health, Substance Abuse and Suicide Risk Screening+~~ and ~~%Suicide Assessment+~~. If a youth presents with suicidal ideation, self-harm, or plan to end their life, they referred to the licensed mental health counselor for assessment of the appropriateness of a referral to a Baker Act receiving facility. All youth are screened at intake for the possibility of self-harm or harm to others. The Hidele House policy for suicide prevention follows the Florida Network Policy and Procedures for a CINS/FINS program. Youth found to be at risk for suicide either the admission process or through observation are assessed to determine potential for suicide.

An interview with the Shelter Supervisor and Program Administrator indicated that they currently are structured to handle youth that are actively suicidal. If a youth is found to be at risk for suicide they are assessed by the license mental health professional within twenty-four (24) hours. If the determination of risk for suicide is made on the weekend the youth will be assessed within seventy-two (72) hours. The youth is directed to sign a Safety agreement to contact staff if they feel that they might hurt themselves. After a youth is released from the Baker Act receiving facility and they are release to their parent. The shelter is again contacted and another assessment is conducted prior to them entering the shelter. Upon the youth's return to the shelter, they are placed on one-to-one supervision. The level of elevated supervision is not removed until the youth can meet with the licensed mental health professional and is found to be stable.

3.04: Medications	Failed Compliance
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The program had written policies and procedures related to ~~%Medications+~~. A review of the agency's policy and procedures for Medications were conducted and found to address all of the requirements for this indicator. The program has procedures for the administration, storage, access, inventory and disposal of medications.

A tour of the staff office found a large clear plastic board that lists all shelter residents. This board acts as part of the shelter's general alert system and specifically identifies youth that are youth currently taking medications. There is no identification of the medication each of the youth are taking just the dosage and the time of day the youth is to take their medication. An interview with one (1) of the direct care staff indicated that they first look at the large board to identify the youth

who is scheduled to take a medication and the prescribed dosage. The staff then checks with the individual medication administration record for the identification of the medication the youth is supposed to be taking and lastly checks the medication and dosage on the container. Although this system requires three (3) checks for administering the correct medication and dosage, it has not helped in the prevention of six (6) instances of missed or adjusted dosages by staff. Although the agency was aware that there incidents of missed medications, documentation reviewed onsite indicated that the agency still continued to experience instances of missed medications and incorrect inventories of medications. Further, there was evidence that medication errors were discussed in the February, 22, 2012 staff meeting. However, the agency was not able to provide any evidence of a formal write-up of the specific staff members that committed medication errors, nor any documented evidence of a formal intervention or training that would demonstrate internal agency oversight and an immediate follow-up response to remediate the medication error issue.

All of the supervisors are trained in assistance in the delivery of medications to all youth that are prescribed medications. In one (1) file there was no documentation of an inventory of the medications that was in the possession of the youth when admitted. In one (1) file the amount of the medication that was documented on the medication log was incorrect.

All medications are stored behind two (2) locks. The shelter followed the program's policy in the separation of different medications. Although there is a working refrigerator during the time of the review there were no medications stored there. The cabinets were divided into three (3) selves for current medications, refills, and medications to be disposed. Interview with the shelter director indicated that medications that are left at the shelter after the youth have left are disposed of in the garbage with two (2) witnesses. The medications are crushed and mixed with coffee grounds.

3.05: Medical/Mental Health Alert Process

Satisfactory Compliance

The program has a written procedure for sharing critical information with staff regarding any information concerning a youth's medical condition, allergies, side effects of medications, or any information regarding a youth's treatment.

The shelter uses a color-coded system to identify youth with either a mental health, behavioral, or a medical condition that needs to be monitored. A Yellow dot indicated that the youth has an allergy or a medical condition. A Red dot indicates that the youth has a mental health or behavior issues and a green dot indicates the youth is at risk for running away. The majority of youth with a red dot were at risk for suicide. There is a large clear plastic board in the staff station that identifies all of the youth by provider (Emergency Services, Department of Children and Families or Department of Juvenile Justice) and on an alert status.

3.06: Episodic/Emergency Care

Satisfactory Compliance

The program had written procedures for Episodic and Emergency Care. The program had written procedures for the provision of episodic and emergency care. All staff members are required to be certified in first aid and CPR/AED.

An interview with the program administrator indicated there has not been a youth that required off site medical treatment in the last six (6) months. However, there is a program policy and procedures to follow in the event that a youth would need to be taken off site for emergency

Medical treatment. A review of the internal and DJJ CCC incident reports indicated that there has been no use of episodic or emergency medical services within the last 6 months.

At the time of this onsite review, the shelter building contained stocked first aid kits. Each shelter is stocked with emergency suicide prevention equipment (knife-for-life and wire cutters). The vehicles utilized to transport youth contain emergency vehicle escape equipment (window punch and seatbelt cutter). Procedures include emergency response for youth with illness or accidental injury.

Overall Rating Summary	
Satisfactory Compliance:	89%
Limited Compliance:	0%
Failed Compliance:	11%