Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Anchorage

on 06/08/2015

CINS/FINS Rating Profile

Standard 1: Management Accountability	
1.01 Background Screening	Satisfactory
1.02 Provision of an Abuse Free Environment	Limited
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Satisfactory
1.05 Analyzing and Reporting Information	Limited

Percent of indicators rated Satisfactory:60.00%
Percent of indicators rated Limited:40.00%
Percent of indicators rated Failed:0.00%

Standard 2: Intervention and Case Management	
2.01 Screening and Intake	Satisfactory
2.02 Needs Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management and Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petitiion Process	Satisfactory
2.07 Youth Records	Satisfactory

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

Standard 3: Shelter Care	
3.01 Shelter Environment	Satisfactory
3.02 Program Orientation	Satisfactory
3.03 Youth Room Assignment	Satisfactory
3.04 Log Books	Satisfactory
3.05 Behavior Management Strategies	Satisfactory
3.06 Staffing and Youth Supervision	Limited
3.07 Special Populations	Satisfactory

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

Standard 4: Mental Health/Health Services	
4.01 Healthcare Admission Screening	Satisfactory
4.02 Suicide Prevention	Satisfactory
4.03 Medications	Limited
4.04 Medical/Mental Health Alert Process	Satisfactory
4.05 Episodic/Emergency Care	Satisfactory

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

Overall Rating Summary

Percent of indicators rated Satisfactory:83.33%
Percent of indicators rated Limited:16.67%
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 Carr, Lead Reviewer FOREFRONT/FNYFS

Terry DeCerchio, Director of CINS/FINS Contract Operations

Cheri Brandies,LMHC CEO, Arnette House, Inc.

Patrick G. Minzie, Shelter Program Manager, Capital City Youth Services, Inc.

Ken Phillips, QI Reviewer, DJJ, Office of Quality Improvement

Persons Interviewed

- [x] Program Director
- [ ] DJJ Monitor
- [ ] DHA or designee
- [ ] DMHA or designee

4 Case Managers
7 Clinical Staff
0 Food Service Personnel
0 Health Care Staff

3 Maintenance Personnel
1 Program Supervisors
6 Other

Documents Reviewed

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

7 Health Records
6 MH/SA Records
11 Personnel Records
20 Training Records/CORE
18 Youth Records (Closed)
2 Youth Records (Open)
4 Other

Surveys

3 Youth | 10 Direct Care Staff | 0 Other

Observations During Review

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

Comments

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

The agency had no Domestic Violence, Probation Respite or Staff Secure referrals during the current fiscal year to date.

Strengths and Innovative Approaches

Rating Narrative

Living areas and hall ways observed to be clean. No clutter observed or trash on floors.

Youth who were observed during the review, were engaged in some activity.

Staff and youth interaction appeared positive. No major issues observed.

Agency has large facility with spacious interior areas, including day room, resident bed rooms and recreational green field and court activities.

Youth client files are welll organized. The agency uses a file folder with tabbed sections that make searching for client information easier to locate.

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 currently has an Acting Executive Director that is overseeing the day to day service delivery components of the residential and non-residential program areas. The agency's Board of Directors appointed an Acting Director that replaced a recently terminated Executive Director and Program Administrator. The agency has recently hired a Program Administrator and is currently in the process of hiring a new Executive Director to lead the agency and its programs. The Acting Executive Director projects that a new Executive Director to be in place in the next 45-60 days.

1.01 Background Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy that includes all major provisions and content to meet the requirements of this Background Screening indicator. The agency provided documentaion for the Annual Affidavit of Compliance with Level 2 Screening Standards completed prior to January 31, 2015.

Nineteen (19) of twenty-one (21) files reviewed contrained documentation indicating that an initial background screening was completed prior to employee being hired. The remaining two (2) files were of staff that were initially hired on 1990 and 1985, and documentation were not present to verify initial screening. Five (5) of twenty-one (21) files reviewed for five year re-screening eligibility. All five (5) were re-screened.

An exception was noted for this indicator. One staff file, eligible for 5 year re-screening, was observed to be screened later than the month of the staff's original month hired.

1.02 Provision of an Abuse Free Environment

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

The agency contained a policy to address the requirements of the Abuse Free environment indicator. Policies and Procedures reviewed for Client Rights and Responsibiliities, Prohibited Behavioral Intervention, Abuse/Neglect Reporting and Discipline and Youth/Family Grievances Abuse hotline and CCC reporting phone numbers are posted throughout the building. Client grievances were reviewed. One grievance in past six months related to a staff person making derogatory comments to youth (fat and stupid) and one related to staff telling youth to shut up. All grievances responded to within 24 hours. The agency Grievance box is not labeled as "Grievance Box" and no forms were provided at the time of the initial tour of the facility. Forms were later brought out in binder. The Grievance Binder has a contents list on cover that does not include "Grievance Forms".

There are exceptions noted for this indicator. Two (2) concerning grievances: derogatory remarks made by staff to youth and staff telling youth to shut up.

Grievance box not labeled as such and no forms available. Binder with forms was provided later and put out on floor to be accessed by residents if needed. The Grievance Binder has a contents list on cover that does not include "Grievance Forms".

Three (3) staff interviewed indicated that they had observed staff using profanity when speaking to yourh. One staff interviewed observerd co-worker using threats, intimidation or humiliation when interacting with youth.

1.03 Incident Reporting

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has an active Incident Reporting policy in place that currently meets the requirements of this indicator. Both Internal and DJJ CCC accepted incident reports were reviewed for the previous six (6) months. Twelve (12) DJJ CCC accepted reports primarily medication errors and contraband recovered. Internal incidents reviewed for adherance to CCC reporting possiblity. All appropriate incidents were reported within the appropriate time frames with the exception of one incident.

A exception was noted for this indicator. A review of all DJJ CCC incidents reported in the last six (6) months indicated that a total of four (4) DJJ CCC accepted incidents did not have evidence that they had been properly closed-out. The DJJ CCC close-out process requires that the reporting agency provide a single or a series of follow up responses to satisfactorily document actions taken by the reporting agency regarding the reported incident. The agency did respond on site and provided documentation in writing that all 4 incident had been properly closed out on Day 1 of the onsite QI program review.

1.04 Training Requirements

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a training policy that includes provisions that addresses the majority of requirements of this training indicator. The agency's policy indicates that the agency's first year eighty (80) hours of training is required to be completed within the first year of employment, and forty (40) hours of training per year after the first year. A total of nineteen (19) staff member training files were reviewed to assess the adherence to this indicator. Annual training for new and on-going staff members required 80 and 40 hours respectively.

Agency has a training plan that has been submitted to the FL Network as required. The agency has an automated training records system called the Conductor. The agency current training hours maintained by the Conductor computer managment system lists a description of the Training Topic; Date of Training, Recertification of Training; Course Hours; Credit Hours; Instructor; and Required Score. Current system maintains all training certificates, cards, sign-in sheets, etc. in file by the respective month that the training cours was completed.

A review of a total of nineteen (19) staff member training record logs were completed during this onsite QI program review. Of these training records, each list topics and hours as required on an individualized Student Progress Detail report. At this time no individual training is being used to manage training achieved by each staff member.

Exceptions are noted for this indicator. The agency does not have a determined training year. Current training year designations vary from employee anniversary dates, fiscal year and annual DCF licensing dates. The current format presented challenges in terms of the agency being able to consistently verify and confirm training topics, trainings for all staff members.

The agency does not maintain an individual training file for each staff member (full, part time and or on-call/PRN). Current system maintains all documentation of completed training files listed by month. The current policy is not consistent with the Training Standard that requires an individual training file for each staff member. At the time of this onsite program review, the agency places all sign-in sheets and trainings completed by staff members in consolidated files each month. In general, all trainings completed by staff members are filed including certificates, credentials, etc. in a file organized by the month that it was completed.

1.05 Analyzing and Reporting Information

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

The agency has Analyzing and Reporting policy that meets general requirements of this indicator. The agency conducts Quarterly peer reviews. These reviews are completed for residential and nonresidential client records. Each program area is to review program performance, training, audit compliance, incidents, client satisfaction in QIC meetings quarterly. Review of meeting minutes for last six months show inconsistent review of required areas across programs. Hidle House shows no review of required areas in QIC meetings. Family Counseling services shows consistent review of all areas. No review by senior management of required areas documented.

There are exceptions noted for this indicator. Hidle House QIC shows no review of required areas going back to 2013 in meeting minutes provided. In addition, there is no documented review of performance by Senior Management in required areas going back to 2012 in meeting minutes provided.

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 program continues to maintain working partnerships with local service organizations. 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 agency has added two new non-residential counselors in the Northern County areas of the panhandle.

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. The agency has added two new non-residential counselors in the North region of the Florida panhandle. Specifically the agency opened new offices in Fiscal Year 2014-2015 in northern outlying towns of Marianna (Jackson County) and Chipley (Washington County).

2.01 Screening and Intake

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The organization has comprehensive policies and procedures addressing the elements of the indicators such as 24 hour access, time frames for screening and other related areas.

This reviewer evaluated four (4) residential files (2 open and 2 closed) and four non-residential files (3 open and 1 closed). Of the residential files one met all elements of the indicator, 2 documented that information was provided to the youth in writing but not the parents and one had most consents incomplete. I spoke with Sylvester and the reason the consents are incomplete is because the mother refuses to cooperate and a report is in to DCF. Of the non-residential files all the elements were met. (recommend putting the date on referral form in order to tell if the screening is done within 7 calendar days)

The organization has comprehensive policies and procedures addressing the elements of the indicators such 24 hour access, time frames for screening, etc.

No exceptions are noted for this indicator.

2.02 Needs Assessment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The organization has a comprehensive policy and procedure addressing the elements of the Psychosocial Assessment indicator.

I reviewed four residential files (2 open and 2 closed) and four non-residential files (3 open and 1 closed). Of the four residential files all had Psychosocial Assessment completed on day of Intake (above and beyond the 72 hour requirement) All Psychosocial Assessments are signed as required by the indicator however three of the residential files and one of the non-residential files was signed by the supervisor later than the 72 hours in the agencies policy and procedures. On one of the residential files I was unable to determine if the person who signed was credentialed. The non-residential files met all elements of the indicator. (recommendation to align agency policy and procedures with standard requirements to prevent issues with practice not meeting policy and procedure).

No exceptions are documented.

2.03 Case/Service Plan

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The organization's policy and procedure does not specify that the Case/Service Plan is completed within 7 days of the completion of the Needs Assessment.

I reviewed four residential files (2 open and 2 closed) and four non-residential files (3 open and 1 closed). Both Residential and Non-Residential plans met the elements of the indicator. The plans had individualized and prioritized goals with client and family involvement. One of the residential files reviewed did not have a case plan completed despite client being in shelter for 11 days. The reason is that the mother has been uncooperative however the client could be working on goals despite mother's lack of involvement. Progress notes indicate that the staff have been very involved with the client. Counselors reviewed plans within 30 day requirement. The agency policy and procedures state that the plan will be reviewed for residential clients within 7 days. (recommendation to align agency policy and procedures with standard requirements to prevent issues with practice not meeting policy and procedure).

No exceptions noted.

2.04 Case Management and Service Delivery

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The organization has a comprehensive policy and procedure addressing the elements of the Case Management and Service Delivery.

Four (4) Case Management files (two open and two closed) were reviewed. Three of the four files met all the elements of the indicator including time frames for notifications, members of the Case Staffing Committee, Case Monitoring, and Family Support. One file has no case plan or evidence of other required documentation due to mother's refusal to cooperate. The Case Manager continues to try to engage the mother.

There are no exceptions noted for the sample reviewed.

2.05 Counseling Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The organization has a comprehensive policy and procedure addressing the elements of the Counseling Services indicator. A total of four (4) residential files were reviewed (2 open and 2 closed) and 4 non-residential files (3 open and 1 closed). The residential and non-residential files had extensive documentation of counseling services. The progress notes were especially comprehensive giving a clear picture of the client's goals and the interventions taking place. There is evidence of ongoing clinical review. Three of the four residential files did not have documentation of group counseling 5 days/week.

2.06 Adjudication/Petitiion Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy and procedure that addresses the elements of the Adjudication/Petition Process. A review of four (4) files (two open and two closed) was conducted by the reviewer. There hasn't been any petitions filed in the past six months. In all 4 files the elements of the indicator have been met.

One file is missing some required documentation. There is evidence of the Case Manager trying to obtain the information however the mother is non-compliant.

2.07 Youth Records

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has policy and procedure addressing the elements of the Youth Records indicator. However, the policy and procedure does not specify the files be marked confidential. All files reviewed were neat and orderly which made information easily accessible. Residential and non-residential files are stored and locked in the client's respective counselor or case managers office.

Standard 3: Shelter Care

Overview

Rating Narrative

The ACH program provides residential CINS/FINS services at the Hidle House youth shelter which is located in Panama City, FL. The residential program is licensed for a maximum of twenty (20) beds in the shelter, with no more than 2 beds in each room. Each resident bedroom has its own bathroom which is shared by the youth assigned to that room. The shelter utilizes its spacious layout by having a computer room, day room, activity/game room as well as a library/reading area. They have an industrial kitchen as well as a cafeteria onsite. There is also an outdoor area next to the cafeteria that is used for outdoor snacks with seating available. The agency makes use of the video surveillance system as well as their metal detecting wand for security. They also have two doors which are set with alarms that chime whenever they are not closed. They agency has a general alert board for staff to be aware of the youth's status throughout the day. The agencies screening and intake process notifies residents of their rights and rules of the shelter. The residents are also given client handbooks at intake and shown where the abuse registry number is posted for their convenience.

The hidle house shelter is managed by a shelter manager and an assistant shelter manager. The program also has assigned residential case managers. The program offers group sessions to clients a minimum of five days a week on different topics that cover many different issues as well as life skills. The agency also makes use of a behavioral management system that is used throughout their residential programs.

The agency does have some vacancies of staff of both male and female staff members across all three (3) work shifts. The agency is currently experiencing specifically being short on male staff members on the overnight work shift. The agency's training log indicates 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 eleven (11) random agency staff members that have received medication distribution training and are authorized to verify, inventory, and distributed medication to residential clients.

3.01 Shelter Envonment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The shelter was clean, organized, and well maintained. There was no visible graffiti on the walls or furniture. Each youth has his/hers own bed with pillow, linens, and bed spreads/blankets. There is also storage space for each youth in the room as well as extra space in the shed for youth that have extra belongings. There is adequate lighting in all areas of the facility and there property is treated regularly for pest control.

All health and fire inspections are up to date. The recreation areas located in the building include a pool table, as well as an air hockey and foosball table. There is an area for youth to have snack and a television with a gaming system. There are first aid kits located at the staff station, the counselor's office, kitchen, and 3 extras in the maintenance room.

The grounds are well maintained and include a basketball court and ample space for various outdoor activities. There is a large covered porch for use by both staff and youth alike. There are posted daily youth schedules which include physical activity, faith based activities, homework time, and quiet time for reading. There is also grievance box available for youth grievances in the common area. It should be noted that although a grievance box is mounted on the wall it is not labeled and there were no grievance forms present at the time of the tour. The shelter manager was made aware and had them put out within minutes.

During the tour there was lint found above the dryers near the venting system. The maintenance manager was informed and replaced the vents before the review team left on day 1 of the onsite review. The maintenance manager was informed and replaced the vents before the review team left on day 1. It should also be noted that with the new weather windows on the building and the curtains in the youth rooms, the blinds in the youth rooms seem to be more of a hazard than helpful.

3.02 Program Orientation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There are policies and procedures in place that outline the orientation process for new youth entering the shelter. Once the counselor has completed the intake, a youth specialist is assigned to complete an agency orientation with the youth. Each youth is given a client handbook that covers program rules, youth rights, behavioral management, contraband, as well as other materials. The grievance process is explained and all other required areas are covered and documented on the admission checklist which is initialed by both the youth and staff member and placed in the youth's file. All youth are then shown where the abuse hotline number is posted.

Four residential files (2 open and 2 closed) were reviewed for this indicator. All four files contained documentation of the orientation process on the youth's intake date. The process was also explained during an interview with the assistant shelter manager.

3.03 Youth Room Assignment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There is a policy and procedure in place when collecting information that will help staff determine what room a youth will be assigned to. During the screening and intake process agency staff members gather information including age, level of maturity, perpetrator/victimization history as well as other required elements. The residential counselor/ designee would then assign all incoming youth to a room. The room assignments are listed in the log book as well as on the room assignment /supervision checklist and the client board.

Two (2) open and 2 closed files were reviewed for this indicator. Of the four (4) files reviewed all had the required elements used to make room assignments. All files had the assigned room number indicated on the checklist and all room assignments were documented in the daily log as well as the client board for open cases.

3.04 Log Books

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Agency policy and procedures state that the shelter must maintain a bound permanent daily log for communication between agency staff members, and to maintain a legal record of the daily care program operations. The program uses a 4 color coding system to alert staff of different events. Routinely documented events included youth comings and goings, appointments, youth behaviors, emergency situations, safety and/or security matters, and medical information.

Program staff members are expected to review the log book and document that they have done so. Staff members must intial and sign their names on the sign in sheet in the front of the log book, which helps indicate which staff member has reviewed it on any given day. The shelter manager and assistant shelter manager must document a weekly review of the log. This process was confirmed through the review of six (6) months of logbooks and during the interview with the assistant shelter manager.

3.05 Behavior Management Strategies

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has multiple policies in regards to Behavioral Management Strategies. The shelter uses a point system which is built on the foundation teaching social skills. During intake each youth is given four (4) target skills. The daily point system is used to give both positive and negative points which are recorded on the youth's point sheet. Positive points are earned by displaying appropriate social skills in their daily interactions. A loss of points occurs when negative behaviors are displayed. Some negative behaviors include running away, fighting, contraband, etc. Negative behaviors are addressed through corrective teaching and also verbal de-escalation.

Youth must have a minimum of 10,000 points a day in order to earn and maintain youth privileges. Privileges are earned on an all or nothing basis. These privileges include video games, mp3 use, phone calls and outings. Additional privileges such as allowance, resident of the day and resident of the week may also be earned. Extra points are banked and can be used to make purchases from the shelter "store."

Staff receives training in the following; Advancing Youth Development, Crisis Intervention/Conflict Resolution, Establishing Rapport, Point Sheets, Positive Reinforcement and Logical Consequences. The Shelter manager and assistant manager are involved daily in observing and modeling implementation of the behavioral management system.

Agency policy and procedures prohibit use of any physical restraint. The shelter program only uses verbal de-escalation techniques. Group discipline is not imposed and no youth can discipline another youth. Policy states that no disciplinary measures taken will deny a youth things such as meals, clothing, sleep, Etc.

Policy and practice was confirmed through a review of logbooks and an interview with the assistant shelter manager and staff on duty.

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. Bed checks are conducted at 10 minute intervals during sleeping hours. Bed checks are documented in the daily log. Review of logbooks for the past 6 months confirmed bed check policy.

The agency's policy notes that at least one male and one female staff will be on shift when possible. The staffing schedule reflects that there are regularly 3 staff on the first and second shifts and 2 on the overnight shift. The Youth Specialists and Residential Counselor schedules are posted in the office and visible to staff. There were times within the last 6 months were there have been no male or no female present on some shifts and no documentation stating why this occurred. After speaking with both the Shelter Manager and Assistant Shelter Manager it was determined that there hasn't been a full time overnight male since early-mid April 2015. There is no evidence or documentation in regards to the agency actively searching for a male replacement.

3.07 Special Populations

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

At the time of this onsite Quality Improvment program review, the agency had no Staff Secure, Domestice Violence of Probation Respite referrals in the last six (6) or more months.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The ACH program provides screening, counseling and mental health assessment services. The agency has a recently appointed (April 2015) Residential Shelter Manager. The Residential Shelter Manager and Assistant Shelter Manager oversese the daily operations, programming and responsibilities of the program. The AFC Counselor staff members are trained on a standard training regemine 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 for 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 select direct care staff members. The agency does provide all staff with 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. 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 recently moved the CINS/FINS program to the rear area of the building to increase its capacity to serve youth DCF referrals.

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 2014.

A health screening form is completed on each youth at the time of 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. 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. All health information is captured using the ACH Health Screening and Physical Health Screening forms. These forms captures the current Medial 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. In addition, the agency also documents family medical history in the client's psycho-social assessment. In addition, the preliminary health screening process includes obsrevation for presence of scars, tattoos, or other skin markings, as required in the standard/indicator. This information is captured in the Hidle House admission data form.

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 health/medical 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.

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 two (2) open and four (4) 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 residential program.

No exceptions are noted for this indicator.

4.02 Suicide Prevention

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a detailed policy and procedure that addresses the requirements of this indicator. This policy and procedure was reviewed

onsite and states that the six (6) Suicide Risk questions are used and if a "yes" response is documented to any of the said question, then the EIDS is used as additonal screening tool (need to make sure P & P does not refer to EIDS as Assessment). This is more than required by Florida Network of Youth and Family Services policy. Two (2) youth records were reviewed. Documentation of Elevated supervision counts being conducted every 10 minutes were verified in each residential file reviewed. Documentation reviewed onsited was completed as required and within required time frames.

No exceptions noted for the Suicide Prevention Indicator.

4.03 Medications

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

The agency has a policy on medication. The current medication policy is detailed and addresses the safe and secure storage, access, inventory, disposal and administration of medication in accordance with the FNYFS Policy Manual. The agency's Assistant Shelter Manager is primarily responsible for the agency's medication distribution process. This staff person coordinates annual training to be delivered by a Registered Nurse. In addition, this staff person acts as the lead in medication distribution retraining of on-going staff members. The agency still maintains a typed list of all staff members that are authorized to have access to secured medications, and limited access to all controlled substances. A total of eleven (11) staff members are authorized to provide medication.

The medication for all residents is still being stored in a separate closet that is inaccessible to youth. Specifically, the medication is stored in a locked closet area in the Youth Care Worker (YCW) station. The agency's prescribed and over the counter medications (OTC) are double-locked in a large 3 door wood cabinet behind. 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 maintains all over the counter medications (OTC).

All oral medications are stored separately from topical medications. The agency places all oral medications on 3 different shelves in the cabinet (Active, Inactive and Unapproved Meds/Refills). The agency places all inactive/disposal medications on the top shelf in the locked medication cabinet. All un-approved and 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 clear baggie marked with the respective youth's name. Oral and topical medications are stored in their original containers inside each baggie. The agency maintains a small refrigerator that is only used for medication storage. At the time of this onsite review, there was no medication that required refrigeration. In addition, there were no injectable medications on site.

Shift-to-shift counts are completed on all three (3) work shifts on a daily basis with two (2) staff members that include both staff of the outgoing and the incoming shifts. A perpetual inventory count is conducted and documented for controlled and prescribed medications when given. Non-controlled medication is counted on a perpetual basis when given. All over the counter (OTC) are accessed regularly and are inventoried weekly by maintaining a perpetual inventory. Agency OTC counts for November 2014 – May 20, October 2015 indicates that the majority of counts were conducted as required.

The agency utilizes a Medication Distribution Log (MDL) to capture major information related to each youth admitted to the youth shelter on a daily basis. The MDL 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 is completed by each staff member that has been trained to distributed medication.

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 three first aid kits inside the facility. The agency also utilizes a bio hazard waste disposal bin for razors and 1 for other sharps.

A total of six (6) closed residents' Medication Distribution Logs (MDL) were reviewed on site to determine accuracy and completion. The agency's MDL captures all major information related to each youth and their medication specific information. The MDL 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 MDL 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 Direct Care 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 in low supply and require a refill.

There are exceptions for this indicator. A total of six (6) medication errors were noted in the last 6 months. Of these errors, three (3) documented errors do not identify staff members responsible for the medication error is unknown. In addition, similar to last year's FY 2013-2014 QI program review, all six (6) reported DJJ CCC incidents reported in the last 6 months 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. Further, some of these medication did not contact the DJJ CCC with the required update at or around the time that they occurred.

4.04 Medical/Mental Health Alert Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policy addressing medical/mental health alert issues. The program's procedure is that all medical alert conditions are communicated through documentation in the youth file, progress notes, health screening form, daily log. Youth files are also marked with a colored dot on the outside of the binder for identification of mental health and medical alerts, as well as a history of elopement. Observations within the youth specialist office included a board with all youth names currently at the facility, and colored dots indicating these alerts beside the names of the youth.

Youth shelter manager reported that alert information is passed on to staff through review of youth files and daily log information. Six (6) of six (6) closed youth files were reviewed, and found youth to have been appropriately placed on the program's alert system based on documenation completed during initial assessment completed.

One (1) of the active youth files reviewed had a 'yellow' dot on the youth file indicating a medical alert for the youth. This did not match with the master board located in the youth specilist office, which had no alert code posted by the youth's name.

4.05 Episodic/Emergency Care

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policy that addresses procedures for facilitating the provision of emergency medical and dental care. The policy does not specifically address parental notification, though this was reported by staff as the practice. Notification of a medical or dental emergency would be given to the assigned, or on-call counselor. The counselor would then notify the parent or legal guardian. Incidents requiring emergency care are documented in the daily log. Shelter managers also maintain an Episodic log to document off-site medical emergencies for youth.

A review of six (6) youth files were completed to review for incidents involving youth requiring off-site emergency medical or dental care. Two (2) of seven (7) files contained an incident whcih met this criteria. Contacts and attempts to contact the parent or legal guardian was documented in the progress notes.

Safety equipment was found on site. A Knife-for-life and wire cutters were observed secured in the Youth Specialist Office. First aid kit/supplies were observed in the Youth Specialist office, kitchen, maintenance, and counselor offices.

Ten (10) staff training records were reviewed for emergency medical procedres such as CPR/First Aid and Blood Born Pathogen. One (1) of ten (10) staff reviewed is presently on worker comp and has been out of work an extended period of time. Eight (8) of ten (10) records contained documentation indicating that CPR/First Aid training was current.

Exceptions were noted for this indicator. Observed six (6) of ten (10) staff training records, which indicated that training for blood born pathogens were expired. Could not find documentation of training for one staff for re-certification of First-Aid.