Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Anchorage

on 11/30/2016

CINS/FINS Rating Profile

Standard 1: Management Accountability	
1.01 Background Screening of Employees/Volunteers	Satisfactory
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Limited
1.05 Analyzing and Reporting Information	Satisfactory
1.06 Client Transportation	Limited
1.07 Outreach Services	Satisfactory

Percent of indicators rated Satisfactory:71.43%
Percent of indicators rated Limited:28.57%
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	Satisfactory
3.07 Special Populations	Satisfactory
3.08 Video Surveillance System	Satisfactory

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

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

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

Overall Rating Summary

Percent of indicators rated Satisfactory:92.59%
Percent of indicators rated Limited:7.41%
Percent of indicators rated Failed:0.00%

Rating Definitions

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

Satisfactory Compliance	Non-systemic exceptions that do not result in reduced or substandard service delivery; or exceptions with corrective action already applied and demonstrated.
Limited Compliance	Exceptions to the requirements of the indicator that result in the interruption of service delivery, and typically require oversight by management to address the issues systemically.
Failed Compliance	The absence of a component(s) essential to the requirements of the indicator that typically requires immediate follow-up and response to remediate the issue and ensure service delivery.
Not Applicable	Does not apply.

Review Team

Members

Ashley Davies, Lead Reviewer and Consultant, Forefront LLC

Tracy Bryant, Systems Coordinator, Hillsborough County

Rachel Greene, Clinical Director, CCYS

Catherine St-Vil, Consultant, Forefront LLC

Patrick McKinstry, Regional Monitor, DJJ

Persons Interviewed

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

2 Case Managers
1 Program Supervisors
1 Health Care Staff

0 Maintenance Personnel
0 Food Service Personnel

1 Clinical Staff
0 Other

Documents Reviewed

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

5 # Health Records
5 # MH/SA Records
3 # Personnel Records
10 # Training Records
5 # Youth Records (Closed)
5 # Youth Records (Open)
3 # Other

Surveys

3 Youth 5 Direct Care Staff

Observations During Review

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

Comments

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

Strengths and Innovative Approaches

Rating Narrative

Since the last on-site Quality Improvement Review the agency has had a complete turnover in shelter management. There is a new Shelter Manager and the position of Assistant Shelter Manager has been eliminated and replaced with three Lead Youth Specialists. These three Leads were not in place yet and still in the transition phase.

There has also been a complete turnover in non-residential staff since the last on-site review. There are four Non-Residential Counselors currently in place and a fifth one expected to start soon after the on-site review.

Improvements have been made to the shelter since the last review including a completely renovated intake office.

Standard 1: Management Accountability

Overview

Narrative

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

The agency employs a licensed clinical director, counseling, direct care, fiscal, nursing, administrative and facility support staff members. The agency provides residential and non-residential services through its direct care and residential and non-residential counseling staff. The agency maintains several on-going community partnerships, conducts outreach activities and hosts local community-based organizations to provide services to the youth and families it serves.

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

1.01 Background Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a written policy and procedure; "Background Screening" (ACH-ADM-HR-009), which addresses all the key elements for this indicator. This policy and procedure was last reviewed and signed by the Executive Director and Board of Directors on July 14, 2016.

The program's procedure requires all potential employees; interns and volunteers, who provide direct service to children or who oversee direct service personnel are screened in accordance with Chapters 409, 435, and 985 of the Florida Statues.

Seven staff personnel files were reviewed for initial background screening prior to being hired by the program. All seven staff had an initial background screening completed prior to the staff's date of hire. Each of the seven background screenings were completed through the Department of Juvenile Justice Background Screening Unit (BSU). The program did not have any volunteers hired during the six month period being reviewed. One staff personnel file was eligible and reviewed for five year rescreening. The one staff had a background rescreening completed prior to their anniversary date of hire.

A review of the Annual Affidavit of Compliance with Level 2 Screening found it was completed on January 7, 2016. In addition, the program completed an Affidavit of Compliance for Florida Statute 435.05(3), on September 13, 2016.

There were no exceptions noted for this indicator.

1.02 Provision of an Abuse Free Environment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a written policy and procedure; “Code of Ethics” (ACH-HH-PM-002), which addresses the key elements for this indicator. This policy and procedure was last reviewed and signed by the Executive Director and Board of Directors on May 2, 2016. The program also has a written policy and procedure; “Abuse/Neglect Reporting” (ACH-CS-SD-018), which addresses the key elements for this indicator. In addition, the program outlines the code of conduct, professionalism, and ethical practices to be modeled by staff within the employee handbook, which each employee receives upon date of hire.

The program’s procedure requires all employees to work together in an effort to accomplish the program's mission. This procedure requires professional, respectful, and ethical interaction with all youth, co-workers, and supervisors. Employees must ensure they demonstrate compassion to the youth they serve and maintain appropriate professional relationships with them. In addition, each employee of the program is a mandatory reporter for any suspected abuse or neglect of any child, disabled adult, or elderly person under Florida Statute 415.504.

The program has postings of the Florida Abuse Hotline. The program maintains two separate three ring binders which record attempts made to contact the Florida Abuse Hotline of any suspected child abuse. One binder is specifically utilized for those calls which meet reporting requirements under Florida Administrative Code 63F-11 Central Communications Center (CCC). The second binder captures all other incidents pertaining to daily operations; i.e. youth runaways, etc. which may or may not rise to the level of contacting the CCC and or Florida Abuse Hotline. Upon hire to the program, each employee receives an employee handbook and signs acknowledgment for receipt of the handbook, code of ethics, and professional code of ethics statement. These documents are maintained in each employee’s personnel file and kept on-site. A review of six staff training files revealed five staff have received child abuse reporting training. The remaining one staff is a new hire and is still within their 120 day training time frame to complete this required training.

The program had only two occurrences of disciplinary action as a result of staff conduct unbecoming and violation of program policies and procedures. The program administration demonstrates taking immediate action in both of these incidents to address misconduct by staff towards youth.

The program had seven grievances submitted by youth spanning the six month review period. All seven grievances were addressed by staff timely and it appears each grievance was resolved. Each grievance was written by the youth with an identified situation or problem. The grievances had a written staff response and a youth signature; which identified a resolution to the initial problem submitted by the youth. The program has a grievance box located on the living unit of the program. Youth have unimpeded access to complete and submit a grievance as needed. The grievance box is checked daily and efforts are made to address youth grievances timely.

There were no exceptions noted for this indicator.

1.03 Incident Reporting

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Hidle House does have an incident reporting policy. In fact, there are two policies that cover the instructions for when an incident occurs. They are titled “Unusual Incidents” and “DJJ/Families First District One Incident Reporting.” They were both last reviewed on May 2, 2016 by the Executive Director and a staff from the Board of Directors.

The procedures for incident reporting include the involved staff member notifying the appropriate supervisor of the actual event as soon as possible. Every staff member with direct knowledge of the incident must then complete an Unusual Incident Report (individually) as quickly as possible after the incident is resolved and prior to leaving work for the day. Each report is to be completed individually without any input from any other person. Once the report is completed, it is immediately submitted to the appropriate manager for review and any further action if necessary.

In the case of a reportable incident to DJJ, the program supervisor will contact the on-site case manager or on-call case manager/counselor to make contact with the DJJ Central Communications Center (CCC) and then complete the DJJ Incident/Complaint Report Form. The CCC is to be notified as soon as possible but no later than two hours after the incident, or within two hours of the affected facility, office or program learning of the incident. Documented on the back of the DJJ Incident/Compliant Report Form is any pertinent information received from the Hotline operator.

The policy and procedures do meet the required mandates of this indicator.

After reviewing the last six months of incidents (two incidents) through the DJJ report and the Hidle House Unusual Incident Report Log Book, it is noted that the program does notify the CCC within two hours of the incident or two hours of becoming aware of the incident. After reviewing the program's Unusual Incident Report Log, there is evidence that the program clearly identifies the people involved, the actual incident and supervisory review/follow-up. All incidents are signed by the Program Administrator.

However, there is one incident (missed medication) that does not note any supervisory review or follow-up. The program was not able to produce any evidence of email correspondence with DJJ or program log book entry that staff was re-trained on medication distribution or any type of follow-up with the staff involved. However, the program administrator did state their practice for a missed medication incident is to immediately contact a supervisor and the CCC. Follow-up action would require follow-up with the CCC (contains contacting the pharmacy) and re-training of the staff member involved.

At the end of the second day of the review, the Program Administrator provided the writer a written follow-up documentation process for incident reporting. This includes the step-by-step procedure after the incident contacting the CCC.

1. The Shelter Manager and/or the Program Administrator will discuss the incident directly with the staff member(s) involved.

2. Management staff will follow agency requirements for administrative action if warranted; verbal or written conference statement.

3. If the incident does not require administrative action then the Shelter Manager and/or the Program Administrator will document the follow up with the staff as a training. If the incident involves medication/medical then the Nurse will also be part of the meeting. The form will be turned into the PQI/Training Director.

4. If the incident involves a call to the CCC; then the Shelter Manager and/or the Program Administrator will keep a copy of all the correspondence and attach them to the incident report.

Exception:

There is one incident (missed medication) that does not note any supervisory review or follow-up. The program was not able to produce any evidence of email correspondence with DJJ or program log book entry that staff was re-trained on medication distribution or any type of follow-up with the staff involved.

1.04 Training Requirements

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

Hidle House does have a policy (entitled Professional Development) to ensure the professional development of all hired personnel. The policy was last reviewed by the Executive Director and a member of the Board of Directors on May 2, 2016. The program has a training plan that serves as policy as well.

The procedure is for each team member within the first year of employment must have 80 hours of training and at least 40 hours every following year. The agency provides training opportunities through on-site orientation, training sessions in conjunction with staff meetings, formal in-service trainings and off-site training. It is the shelter manager and program administrator that schedule team members for training. The program's training is scheduled to be conducted every other month for a full week.

There were ten employee files (seven first years and three annual) reviewed for training requirements. The program maintains an individual training file for each staff which includes: an annual employee training hours tracking form, and related documentation such as certificates.

Of the seven first year staff members reviewed none documented training in Information Security Awareness. One staff member exceeded the required hours but did not document training in Serving LGBTQ youth. One staff member only had 35.25 hours and was missing the required training on Serving LGBTQ youth. One staff member had 35.5 hours with many months remaining to complete the rest. However, had passed the 120 days to complete the required training of Managing Aggressive Behavior, Signs and Symptoms of Mental Health and Substance Abuse, Behavior Management, Title IV-E Procedures, Fire Safety Equipment, In-Service Component, Ethics, and Serving LGBTQ Youth. Another staff had 24.5 hours with almost a year left to complete all training and a couple of months to complete the required training within 120 days. Another staff member had 15.5 hours and has a couple of weeks to complete the required 120 day training requirements. Another staff had 31.5 hours and has about a month to complete the trainings required in the first 120 days. The last staff member for first year training requirements had 34 hours and had till the first day of the review to complete the required trainings in the first 120 days. Trainings that were still needed were Managing Aggressive Behavior, CINS/FINS Core, Title IV-E Procedures, Fire Safety Equipment, CPR, First Aid, In-Service Component, Confidentiality, PREA and Serving LGBTQ Youth.

Of the three annual staff members, one staff had completed 42.5 hours with all required annual trainings documented. The second staff had completed 54 hours but had one more required training to complete: PREA. The last time this staff took the training was on 10/2/14 and hasn't been trained in PREA since, but still has a couple of weeks to complete the training according to the hire date. The third staff member had 48 hours and has completed all the required trainings.

The program does have documentation of non-licensed mental health clinical staff person’s training in assessment of suicide risk designated for clinical staff personnel. It includes the date and signature of the licensed mental health professional supervisor, however does not note their license number.

Exceptions:

The policy does not note the required training's needed for the initial 120 days of hire.

Information Security Awareness is not part of the agency's training requirements, therefore no personnel has been trained in it.

One staff member exceeded the required hours for first year training but did not document training in Serving LGBTQ youth.

One staff member only had 35.25 of the required 80 hours and was missing the required training on Serving LGBTQ youth.

One staff member had 35.5 hours with many months remaining to complete the rest. However, had passed the 120 days to complete the required training of Managing Aggressive Behavior, Signs and Symptoms of Mental Health and Substance Abuse, Behavior Management, Title IV-E Procedures, Fire Safety Equipment, In-Service Component, Ethics, and Serving LGBTQ Youth.

One staff member had 34 hours and had till the first day of the review to complete the required trainings in the first 120 days. Trainings that were still needed were Managing Aggressive Behavior, CINS/FINS Core,

Title IV-E Procedures, Fire Safety Equipment, CPR, First Aid, In-Service Component, Confidentiality, PREA and Serving LGBTQ Youth.

The program's documentation of non-licensed mental health clinical staff person's training in assessment of suicide risk does not note the licensed mental health professional supervisor's license number.

1.05 Analyzing and Reporting Information

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has an Analyzing and Reporting Information policy that meets the general requirements of this indicator.

Interview with the Hidle House Performance Quality Improvement/Training Director and observations of documents found evidence of quarterly case records reports and peer reviews, quarterly incident, accidents, and grievances reports, monthly NetMIS data reports, and an annual report that contains documentation of non-residential and residential (shelter) outcome data. There are Performance and Quality Improvement reports (II & III) that documents activities at both the Anchorage Children's Home and Hidle House to include all outcome data generated from both programs. This included both residential and non-residential programs that is also used in the monthly Senior Management Report.

There was documentation of CINS/FINS Client Satisfaction Surveys for both non-res and all Anchorage Children's Home that are compiled into a single annual report. There is a quarterly review of medication practices generated from the monthly Pyxis Med-Station report developed by the Hidle House nurse. There are quarterly staff meetings at Hidle House to present findings from the previous three months activities at the program.

There were no exceptions to this indicator.

1.06 Client Transportation

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

The Hidle House program does have a transportation policy that was last revised on April 15, 2016 by the Executive Director and a member of the Board of Directors.

Written program procedures include-

The staff provides transportation for: group and individual outings, emergency needs, off-site appointments, routine medical/mental health/dental care, and other needs.

Approved agency drivers are agency staff approved by administrative personnel (by way of approved DJJ and driver's license check) to drive client(s) in agency or approved personal vehicle. Approved agency drivers are documented as having a valid Florida driver's license. A third party is an approved volunteer, intern, agency staff or other youth. Documentation of use of a vehicle notes destination, approximate mileage, and anticipated arrival.

As per the program administrator, the program allows only approved drivers to drive the Hidle House

vehicles. The reviewer verified through the HR personnel of four employees. Two new employees have not officially been approved yet because paperwork through the DMV has yet to come back. They are not currently driving. And the other two employees did have their checks approved. As per the Financial Director, agency drivers are covered under the company's liability insurance policy.

The program does not have a transportation log (program administrator states they stopped the usage of a log after the last review) but uses the program log book to note when transportation is taking place with clients. Entries in the log book does note the driver, passenger(s), date, time and location. However, entries does not take into account mileage and approval of single client transportations. Or if single client transportation is given, it does not explain if client's history, evaluation, or recent behavior is considered before transporting. After interview with the shelter manager, it was determined there is a lack of practice of gaining approval before single client transports. It is important to note that the shelter manager moved into that position recently and has been working to put together a transportation log and a working procedure for single client transports.

At the end of the QI review, the Program Administrator produced a vehicle transportation log that will be used by drivers when transporting clients, as well as, a log that will be kept by the Shelter Manager and/or Program Administrator to keep the drivers accountable. This will help with documenting the details of every trip, including approving single client transports.

Exception:

Entries in the log book does note the driver, passenger(s), date, time and location. However, entries does not take into account mileage and approval of single client transportations. Or if single client transportation is given, it does not explain if client's history, evaluation, or recent behavior is considered before transporting. After interview with the shelter manager, it was determined there is a lack of practice of gaining approval before single client transports.

1.07 Outreach Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program does have a policy in reference to outreach services in the layout of an outreach plan. The plan is entitled "2016-2017 Public Awareness and Targeted Outreach Plan."

The program's effort into reaching the community and at-risk youth and families' population is by: participating in the Juvenile Justice Council Meeting for each county; contacting and explaining services to all middle schools and high schools in the service area, these contacts will be made not less than monthly; and contacting and explaining services to local law enforcement agencies, state attorneys, DCF, DJJ, or other agencies not less than once a month.

The program has a plethora of memorandum of understandings and written agreements with many organizations and entities in the community. The program maintains a cooperative agreements log that is divided into four different categories: SafePlace Agreements, Community Activity Agreements, Cooperative Service Agreements and Other Agreements. Examples of community partnerships include Bay County Chamber of Commerce, Boys and Girls Club of Bay County, Calhoun County Children's Coalition, National Association of Professional Fundraisers and Teen Court of Bay County.

Anchorage Home also participates in public presentations as a means of outreach. As this reviewer was entering the building on this review, one of the staff members that welcomed this writer in mentioned they were on their way out to do a presentation at one of the local colleges.

Anchorage also does participate in the Circuit 14 Advisory Board meetings. Evidence of their attendance on October 12, July 13 and April 13 was provided. The Juvenile Justice Council meetings are also staffed by a representative from the Anchorage team. The Executive Director, the Program Administrator and/or the non-residential staff members attends these events quarterly. Evidence by way of meeting agendas

was provided. (March and June 2016 was provided. The one scheduled for November was cancelled.)

In addition, the Program Administrator attends case staffing at the Bay Regional Juvenile Detention Center weekly. This allows him to stay abreast with the previous or potential clients and stay connected with the juvenile justice system.

Senior management also plan outreach and volunteer events for the program. Evidence of their November 2016 senior management report was provided.

There are no exceptions for this indicator.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

Anchorage Children's Home Residential and Non-Residential programs offer CINS/FINS services to youth and their families in Bay, Gulf, Calhoun, Jackson, and Washington County. Currently, the agency has a Licensed Mental Health Counselor who serves as the Clinical Supervisor and provides oversight for both Residential and Non-Residential services. The agency also has four Non-Residential ("AFC") counselors and three Residential Case Managers ("RCM"). Currently a fifth Non-Residential Counselor has been hired but has not come on board yet.

The agency has a well staffed team including a Clinical Supervisor, Residential Shelter Manager, Program Administrator, four Non-Residential Counselors, and three Residential Case Managers. Two Non-Residential Counselors have offices off site while the other three, as well as, the three Residential Case Managers have offices on-site, or within the primary agency location. All three Residential Case Managers have Bachelors degrees as well as two of the Non-Residential Counselors. One Non-Residential Counselor has a Master's degree. Both the Residential Shelter Manager and Program Administrator have MSWs, while the Clinical Supervisor is a Licensed Mental Health Counselor.

The residential cases are reviewed as a team, with the Residential Shelter Manager and RCMs, twice a week. During this meeting staff discuss youth behavior, youth progress and discharge planning. The Program Administrator and Clinical Supervisor occasionally join the weekly meetings depending on the census and risk level of youth in the program. Clinical staffing meetings are held once a month with the Program Administrator, Clinical Supervisor, RCMs, and Youth Specialists.

The Non-Residential cases are also staffed as a team once a week and include the Clinical Supervisor and all four Non-Residential Counselors. During staffing meetings, youth progress and case plans are reviewed as well as any relevant clinical concerns including mental health needs and suicide assessments.

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

2.01 Screening and Intake

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Anchorage Children's Home has a policy in place to address centralized screening and intake. The policy is located within the agency's "Client Services and Outreach" policy and procedure manual. Referrals for services are accepted 24 hours a day, seven days a week. Screenings for eligibility are attempted with all youth and families referred for services. Centralized intake services are also available to youth and their families 24 hours a day, 7 days a week.

During normal business hours, referrals are received by support staff who then direct the referral to a counselor. The counselor then attempts to reach the family referred to complete a screening and determine eligibility for services. If a counselor is not available at the time of the referral, then the on-call counselor/case manager will attempt to complete the screening. "Walk-ins", or any youth or family that arrives on site without an appointment are met by a counselor/case manager who completes eligibility screening with the family.

An on-call schedule is in place to ensure youth and families have access to 24/7 intake services. If an intake occurs within regular business hours the intake is completed by a counselor or case manager on site. After-hour intakes are completed by the on-call staff or a trained youth specialist.

There were five residential case files (two closed and three open) reviewed for this indicator. All reviewed files met the minimum requirements for this indicator with the exception of one closed file not containing the CINS Voluntary Placement Agreement which contains documentation of the parent/guardian receiving the Parent/Guardian Brochure and CINS/FINS brochure.

There were five non-residential case files (three closed and two open) also reviewed for this indicator. All reviewed files met the minimum requirements for this indicator.

In addition, two residential staff and one non-residential staff were interviewed and articulated the screening and intake practice utilized by each program.

Exception:

One closed residential file was missing the CINS voluntary placement agreement where documentation of guardian receiving Parent/Guardian Brochure and education regarding CINS/FINS services would be found.

2.02 Needs Assessment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Anchorage Children's Home has general policies and procedures for both residential and non-residential services and additional policies and procedures for each component (res and non-res program) separately. Needs assessment policies and procedures are covered in both the general policies and procedures and the individual policies and procedures. General policies and procedures require needs assessment for all youth.

For residential services, a Needs Assessment must be initiated within 24 hours of admission. The Needs Assessment is typically completed at the time of intake by the RCM. However, if a youth specialist completes the intake then the Needs Assessment will be completed within 72 hours by an RCM.

For non-residential services, the assigned counselor completes the Needs Assessment with the youth and family within 72 hours of admission into services. Most often this occurs during the intake process.

There were five residential case files (two closed and three open) reviewed for this indicator. All reviewed files met the minimum requirements for this indicator.

There were five non-residential case files (three closed and two open) also reviewed for this indicator. All reviewed files met the minimum requirements for this indicator.

In all files reviewed, the Needs Assessment was completed at intake.

In addition two residential staff and one non-residential staff were interviewed and articulated the process of initiating and completing a Needs Assessment.

There were no exceptions for this indicator.

2.03 Case/Service Plan

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a specific policy in place that addresses case/service planning. The policy states that case plan is initiated at the start of services and updated as necessary based on progress made by the youth

and family. The case plan provides a summary of the presenting issues, goals to be addressed as well as strategies/objectives for meeting those goals. In addition the case plan is created with input from the youth as well as the parent/guardian.

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

There were five residential case files (two closed and three open) reviewed for this indicator. All reviewed files met the minimum requirements for this indicator with the exception of one closed file. The file did not have documented completion dates on Case Plan or noted in the discharge summary. The same Case Plan was missing Parent/Guardian signature and had no documentation of refusal.

There were five non-residential case files (three closed and two open) also reviewed for this indicator. All reviewed files met the minimum requirements for this indicator.

In all files reviewed the case plan was completed at intake.

In addition two residential staff and one non-residential staff were interviewed and articulated the practice of completing and updating a case plan.

Exception:

One closed residential file did not have documented completion dates on Case Plan or noted in discharge summary. The same Case Plan was missing Parent/Guardian signature and had no documentation of refusal.

2.04 Case Management and Service Delivery

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has multiple separate policies outlining case management and service delivery. The case management policy states that through advocacy and case management, staff will assist families and youth who have a variety of needs. It references external referrals will be made to address needs that are not provided by Anchorage.

In procedure, case management services are provided to every referred client. At intake, a case manager is assigned to the client. For non-residential cases, the counselor also provides case management services. These services are documented in progress notes in individual client files.

There were five residential case files (two closed and three open) reviewed for this indicator. All reviewed files met the minimum requirements for this indicator.

There were five non-residential case files (three closed and two open) also reviewed for this indicator. All reviewed files met the minimum requirements for this indicator.

In addition two residential staff and one non-residential staff were interviewed and articulated the practice of providing case management services including referrals and monitoring court progress.

There were no exceptions for this indicator.

2.05 Counseling Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place addressing counseling services. It states that residential services will

focus on crisis/adjustment issues. In addition, if youth in services are seeing a provider through another agency then they will continue to see that provider. Youth in services will have access to group, individual and family counseling.

Residential Case Managers meet with each youth individually one time per week. Crisis counseling is provided as needed. Group counseling is offered five times per week.

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

There were five residential case files (two closed and three open) reviewed for this indicator. All reviewed files met the minimum requirements for this indicator. However, the files and the group log reviewed did not have documentation of group counseling being consistently provided at least five times a week. During the month of October there were eighteen groups documented and during the month of November there were twelve groups documented.

There were five non-residential case files (three closed and two open) also reviewed for this indicator. All reviewed files met the minimum requirements for this indicator.

Exception:

The residential files and the group log reviewed did not have documentation of group counseling being consistently provided at least five times a week. During the month of October there were eighteen groups documented and during the month of November there were twelve groups documented.

2.06 Adjudication/Petitiion Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a clear policy in place which states that youth who have previously demonstrated behavioral symptoms which meet the criteria for chronic running away, habitual truancy, etc, will be referred to a case staffing committee.

The procedure in place outlines that if the case staffing committee recommends a CINS petition for a youth, a case manager will be assigned to the case and is expected to prepare the documents necessary for the DJJ attorney to file a CINS petition in court. The documents will be completed within 21 days of the case staffing and forwarded to the Clinical Supervisor. The case manager attends court hearing and serves as the Anchorage representative. The case is reviewed every 30 days with a staffing team and at least quarterly with the entire case staffing committee.

There were three files reviewed. All files met the requirements of the indicator.

There were no exceptions for this indicator.

2.07 Youth Records

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a clear policy regarding youth records stating that all files are confidential in nature and will be maintained in a secure setting.

All client records are stamped confidential and kept within a locked filing cabinet inside a locked office. When files are taken off of agency property they are transported within a locked, opaque container that is marked confidential.

There were thirteen files reviewed for this indicator and all files met the minimum standards for this indicator. File room locations were directly observed and found to meet the standards of this indicator.

In addition two non-residential counselors were interviewed regarding the process for transporting youth files. Both counselors were able to articulate the policy and showed reviewer the locked, opaque boxes used for transport of files.

There were no exceptions for this indicator.

Standard 3: Shelter Care

Overview

Rating Narrative

The ACH program provides residential CINS/FINS services at its Hidle House youth shelter that is located in city limits area of Panama City, Florida. The shelter facility is located in the rear of the property. The shelter contains two side entries for shelter and for counseling services respectively. The ACH residential program has adequate staffing and maintains a licensed residential shelter with a maximum of twenty beds in the shelter.

The facility is equipped with a large day room with split level sleeping rooms on each side. In addition, there are additional day or activity rooms with more split level rooms. The agency has excellent community support and hosts several local groups to visit and spend time with the residents during their shelter stay.

3.01 Shelter Envonment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has written policies and procedures addressing overall maintenance, shelter operations, and inspections for shelter environment which meet the intent for this indicator. In addition, the program has a site specific daily activity schedule which also addresses youth participation within the shelter.

The program has maintenance staff which provide upkeep of structural issues as they may arise. Maintenance address issues when identified by employees via a work order process. Youth maintain individual living areas through daily cleaning, which are inspected daily by staff.

The program had a Fire Inspection completed on May 20, 2016; no identified issues. In addition, the program had an annual Department of Health (DOH) inspection on December 28, 2015. All previous violations were corrected and an overall result of satisfactory was given for the inspection.

Observations of furnishing located throughout the program revealed property is in good repair. The program appears to be free from any insect infestation. This reviewer interviewed two youth concerning any observance of insects within the program. Both youth responded no they have not seen any insects. The program's grounds and landscaping are well maintained. Walk through of youth bathrooms revealed each room has a functioning shower, toilet, and sink. There were no observable instances of graffiti on walls, doors, or windows.

Each youth has their own individual bed with a mattress, pillow, sufficient linens, and a blanket. Lighting was observed throughout the program. Lighting appears to be adequate for tasks performed. Youth have an area which they can utilize to lock personal belongings when requested.

A review of both the program's activity and daily schedule identifies youth are engaged in meaningful and structured activities seven days a week. The program's activity and daily schedules are posted in areas accessible for youth to view. Youth are provided with a minimum of one hour physical activity daily. Daily programming for youth includes opportunities for youth to participate in faith-based activities. Additionally, there are non-punitive activities offered for those youth who choose not to participate in faith-based type activities.

The program has a designated area which youth can utilize to relax, read books, or just get away to calm down if necessary. The area is aesthetically pleasing; meeting the interest of those youth utilizing the space. The area is outfitted with several chairs, lights, books, colorful rugs, and two large bean bags--appropriate for youth housed at the shelter.

There were no exceptions noted for this indicator.

3.02 Program Orientation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has written policies and procedures which address all the key elements for this indicator. In addition, the program has a site specific client handbook which identifies and addresses program orientation and youth expectations.

Upon arrival to the shelter, the youth is assigned a staff who completes an admission checklist which is utilized to ensure the entire orientation/admission transition goes smoothly. The youth is given a copy of the client handbook which assist the youth in better understanding service delivery and daily shelter operations.

There were five youth files reviewed for program orientation. All five youth files reviewed had an orientation to the program during the first twenty-four hours following admission. All five youth files contained the following: each youth was provided with a client handbook, disciplinary action, grievance procedures, emergency procedures, daily activity, abuse hotline, and contraband rules were explained or provided. All five youth files did not have any indication of requiring a suicide alert and/or notification needed. Each of the five youth signed the program orientation documentation and a parent/guardian also signed. There are emergency/egress facility layout diagrams posted throughout the program.

There were no exceptions noted for this indicator.

3.03 Youth Room Assignment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a written policy and procedure, “Room Assignment” (ACH-HH-PM-009), which addresses the key elements of this indicator. This policy and procedure was last reviewed and signed by the Executive Director and Board of Directors on May 2, 2016.

The program's residential case manager or designee assigns each incoming youth to a specific bed and storage area in an assigned room. Room assignment is based on information gathered during the intake process and is considered to assist the youth in adjusting to the program. The room/bed assignment is documented within the program's logbook. Male/female bed assignments are made to house each gender on opposite sides of the living area. Room assignments are changed as the need arises.

There were five youth files reviewed for room assignments. All five youth files reviewed had a room assignment completed upon admission to the program. Each of the five youth had room assignments

made utilizing the following criteria: Youth's history, status, exposure to trauma, age, gender, history of violence, disabilities, physical size, gang affiliation, suicide risk, sexually aggression, and gender identification. The program utilizes collateral resources/contacts and on-site observations in an effort to ascertain appropriate room assignment. In addition, when necessary, alerts are entered for youth meeting specific criteria and or have needs.

There were no exceptions noted for this indicator.

3.04 Log Books

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place that staff members document all routine information, appointments, telephone calls, youth behavior and attitudes, emergency situations, unusual incidents, the current population, whereabouts and etc.

The youth specialist documents ongoing daily activities in the daily log. The agency uses a highlighting color code to emphasize specific areas of information: yellow= medication or medical issues; pink=special attention; green=intake information, discharge, absconders/returns; and blue=staff/residents departing/returning to/from appointments, schools, etc. Entries documenting information which could impact the safety and security of the residents and/or program are highlighted in pink.

Review of the logbook indicated that the staff constantly document in the logbook throughout each shift to communicate the whereabouts and daily activities of the youth and staff-- youth appointments, incidents, bed checks, shift summary, etc. All staff initial in the logbook that they have reviewed the logbook since their last shift.

The program uses a permanently bound logbook marked "Confidential". All entries in the logbook are written legibly in ink, have dates and times of events, and recording errors are struck through appropriately. The staff highlight all important information using the color coded system.

There were no exceptions for this indicator.

3.05 Behavior Management Strategies

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy that states the "Youth Specialist" conveys the expectation of a professional who is responsible to work effectively with youth within the context of youth development. The staff is trained in the Boy's Town Model curriculum and is expected to work within the principles of youth development. Youth specialists use basic principles of behavior psychology to guide interventions that improve the motivation of the youth to make those necessary changes.

At intake, the youth are issued a point card and explained the point system. All new youth receive the same four target skills: disagreeing appropriately, accepting no, following instructions, and accepting criticism/consequences. When the youth behavior requires consequences, staff members make an effort to discuss, explain, and even explore possible consequences. Disciplinary practices are directed through implementation of the Behavior Self Management System. The focus of the self-management program is not to externally gain control over the youth but instead to assist in gaining control over his/her behavior and life through addressing the underlying issues motivating her/his behavior and/or attitudes.

The youth work on a daily point system in which they earn both positive and negative points. Once the

youth have accumulated enough points, they are able to use their points for various rewards such as: identified outings, money, gifts, etc.

Appropriate behavior interventions are applied immediately and reflect the severity of the behavior.

No youth are allowed to discipline another youth. Room restriction is never used as a form of punishment. Nor are any youth denied of their rights (i.e. meals, clothing, educational services, exercise, contact with parents, etc.).

The four target social skills are posted in the common area for continued positive reinforcement.

There is a storage room of items where the youth can use their points to purchase things.

There were no exceptions for this indicator.

3.06 Staffing and Youth Supervision

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy and procedure to address this indicator. Youth specialists provide awake supervision 24 hours per day, 7 days per week. The shelter manager's staff schedule identifies adequate coverage for all shifts while minimizing overtime and the over-utilization of youth specialists. In scheduling, equability and fairness are required. The care of the youth and needs of the program are of primary concern and therefore determinants of the program schedule. There is a female and male staff member scheduled on duty when possible.

The shelter manager develops a monthly staffing schedule by the 20th of the month for the following month. The schedule is posted in a place that is visible to staff and identifies not only the days/shifts scheduled to work but includes: trainings, meetings, days off, and days on leave or holiday. The schedule is posted in the the staff area that is visible to staff.

The staff schedule was reviewed. Observations of the day shift schedule found that there was at least one male and one female onsite during the day shift. The program is well staffed during the awake hours to cover the very active shift. A review of the last three months of overnight shift staff schedules revealed the overnight shift did not have a male staff on a majority of the night shifts. An interview with the Shelter Manager indicated that they are short staffed on males for the overnight shift. The program had a big turnover rate in the last few months.

There is a staff list in the back of the logbook that has the staff name and phone numbers in case there is a need for additional staff. The schedule is posted where it is visible for staff in the staff area. Also, the shelter manager will post a list of available shifts for staff to sign up for.

Bed checks are documented every ten minutes in the logbook.

Exception:

A review of the last three months of overnight shift staff schedules revealed the overnight shift did not have a male staff on a majority of the night shifts. An interview with the Shelter Manager indicated that they are short staffed on males for the overnight shift. The program had a big turnover rate in the last few months.

3.07 Special Populations

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy and procedure in place for staff secure shelter. Under the contract with the Florida

Network of Youth and Family Services, Anchorage Children's Home is not a provider for the Staff Secure Shelter Program. Therefore, staff secure court ordered youth will be referred to the appropriate provider agency as identified by the Florida Network.

Domestic Violence Respite (DV) services designed to assist youth that have been arrested on a domestic violence charge, are screened by the local detention centers and do not meet detention criteria and cannot immediately return home. DV is short term and designed to facilitate services and supports for safe return of the youth to his or her home.

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

Domestic Minor Sex Trafficking (DMST) services are designed to serve domestic minor sex trafficking youth approved by the Florida Network who may exhibit behaviors which require additional supervision for the safety of the youth or the program. DMST services provide a more intensive staffing and individualized service than the short-term shelter services.

For staff secure, the assigned case manager will coordinate placement of all staff secure court ordered youth with the appropriate provider agency as provided by the Florida Network of Youth and Family Services. Coordination of placement will include, but not be limited to transportation of youth, transfer of documentation related to service history and custody and communication regarding mental health, substance abuse, medical and other pertinent needs.

The agency will provide services to youth who are identified special populations including DV or Probation Respite, and DMST in accordance with the guidelines established through the Florida Network of Youth and Family Services policy and procedure manual.

The agency hasn't had any Domestic Violence, Probation Respite, DMST, or Staff Secure youth for this review period.

There were no exceptions for this indicator.

3.08 Video Surveillance System

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Anchorage has a video surveillance system that operates 24 hours a day, 7 days a week to monitor and capture activity to assure the safety of all youth, staff, and visitors. The purpose of the video surveillance system is to proactively deter any misconduct and ensure that any allegations of incidents are recognized through visual means.

The agency ensures that the video and images are secured in a designated secured network storage and access to the video surveillance system and the recordings is restricted to personnel determined by the Program Administrator. The agency has designated staff including the program administrator, program manager and assistant program manager who are trained to handle the equipment and review footage in a professional, ethical and legal manner.

The agency has cameras in the interior and exterior locations of the shelter and hallways for sleeping rooms where youth and staff congregate and where visitors enter and exit. The cameras are never placed in the bathrooms or sleeping quarters.

An interview with staff indicated that they maintain a logbook and the cameras are reviewed bi-weekly. This writer reviewed the surveillance review logbook which documented that the reviews were completed. The designated staff review a random sample of two day shifts and a random sample of three overnight shifts. No major issues or concerns were indicated in their review.

The agency recently upgraded their surveillance camera. There are approximately 26 cameras that covers the outside, common areas, kitchen/dining, entrance/exit area, intake room, etc of the facility. The camera stores videos at a minimum of 30 days. There is a practice in place for third party request which could become evidence are kept indefinitely unless otherwise directed by DJJ.

The surveillance cameras were reviewed for several overnight shift bed checks in the past month. The staff were doing the required bed checks every ten minutes and the checks were documented in the logbook.

Video surveillance warning signs are posted throughout the shelter and visible to everyone that come into the shelter.

There were no exceptions for this indicator.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The agency has a total of sixteen staff members providing residential group care related services. Of these staff members, the agency has one Program Administrator, one Shelter Manager, one Registered Nurse, three Residential Case Managers, three Lead Youth Specialists, and seven Youth Specialists. The agency has six vacant Youth Specialist positions.

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

The agency provides assistance to all youth admitted to the program that require medication. The agency provides medication distribution training to select direct care staff members. The agency has a Registered Nurse on the agency schedule for a total of twenty (20) hours per week. The RN provides all medication distribution training. All medications are stored in an automated medication cart called the CareFusion Pyxis MedStation 4000. The Pyxis machine is stored inside a secured closet in the residential service area.

The agency does provide all staff with first aid response, CPR, fire safety, emergency drills and exercises 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 in conducting the assessment phase of the suicide assessment process.

4.01 Healthcare Admission Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place for Medical Care for Routine, Acute, and Chronic Medical Conditions that was last reviewed on May 2, 2016.

A Health Screening Form is completed upon each youth's admission to the program to determine any dental, medical, or mental health needs or acute or chronic medical conditions a youth may have. Documentation at intake is required for youth diagnosed with chronic medical conditions that identify: Qualified professionals making the evaluation, specific diagnosis, current evaluation and/or follow-up information, individual functional limitations identified with the condition, and any adverse effects to the general public from exposure or possible contaminates associated with the illness. During clinical staffings any youth identified with medical concerns will be staffed to ensure all required documentation has been received and all required medical services and/or follow-up is provided in a timely manner.

There were five youth files reviewed for Healthcare Admission Screening. All five files documented the Shelter Intake Assessment Form was completed on the day of admission. The form documented a physical health screening including any chronic conditions, allergies, medications, mental health and/or substance abuse issues, and any dental concerns. The form also documents any scars, tattoos, or body piercings.

Four of the files documented the youth were on medications. The medications, as well as, the reasons for the medication were documented. None of the youth had any type of medical condition requiring a follow-

up; however, procedures are in place if needed.

In addition to the above assessment being completed, the nurse also completes a Health Screening Form. This form was found in all five files and either completed on the day of admission or the following day. This is a more in-depth screening form covering more medical conditions, current medications, any special accommodations needed, observations, and notes from the nurse.

There were no exceptions for this indicator.

4.02 Suicide Prevention

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place for Suicide Prevention and Intervention that was last reviewed on May 2, 2016.

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

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

The shelter employs three residential counselors who are supervised by the Clinical Supervisor who is a Licensed Mental Health Counselor (LMHC). There were three youth files available for review of youth who had been placed on suicide precautions. All three files documented the youth were placed on suicide precautions at intake due to issues identified during the screening process. All three youth remained on constant sight and sound supervision until assessed by a qualified professional. All youth were seen and assessed using a suicide risk assessment within twenty-four hours. All suicide risk assessments were completed by a counselor and reviewed by the LMHC. The supervision level was not changed or reduced until approved by the LMHC. All Youth were placed on an elevated supervision level upon completion of the suicide risk assessment and then placed on standard supervision after another suicide risk assessment had been completed. All three youth had ten minute observations documented the entire time they were on sight and sound supervision and thirty minute observations maintained while on elevated supervision. Any youth on suicide precautions sleep in their bedrooms and ten minute checks are maintained. All changes in supervision levels were documented in the shelter log book.

There were no exceptions for this indicator.

4.03 Medications

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy on Medication Management that was last reviewed on May 2, 2016.

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

The agency provided a list of ten staff who are trained to supervise the self-administration of medications. The Registered Nurse (RN) is listed as the Super User of the Pyxis Med-Station.

The shelter has an RN on-site Monday thru Friday from approximately 7:45am till 1:00pm. The RN will distribute any needed medications when on-site. Direct care staff distribute medications in the mornings before the RN arrives, in the evenings, and on the weekends.

The RN trains all staff on the use of the Pyxis Med-Station and the medication administration process at hire. The RN also conducts an additional refresher training for current staff members during the year.

All medication is stored in the Pyxis Med-Station, including over-the-counter (OTC) medications which are stored in the top and bottom bins of the Med-Station. Prescription medications are stored in the second and third drawers of the Med-Station. Medications are verified at admission using one of the four approved methods by the Florida Network.

The RN reported there have been no major discrepancies with the Pyxis Med-Station. There have been minor discrepancies, mainly involving staff entering the wrong number when inventorying medications. However, there have been very few of these discrepancies and they were easily fixed and cleared out within twenty-four hours. The shelter has had no discrepancies on controlled substances at all.

The RN completes a weekly inventory of all medications on-site. Trained direct care staff complete an inventory every shift of all the controlled substances. This inventory is documented on the youth's Medication Distribution Log (MDL). An inventory of the medication is completed every time it is given and a perpetual inventory is maintained.

The shelter has a system in place for refrigeration of medication if needed. However, there was no medication that required refrigeration during the time of review. There is also a separate locked cabinet where sharps are stored. All sharps are also inventoried weekly and as used. The youth must use disposable razors which are discarded on the red sharps box after use.

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

There were two youth in the shelter currently on medications. These files as well as two additional closed files were reviewed to verify the medication administration process. The youth's Medication Distribution Log (MDL) is maintained in the youth's individual file after release. For the current youth, the MDL is maintained in a binder in the staff work area. All MDLs reviewed documented the youth's name, date of birth, physician, allergies, medication the youth was taking with dosage, route, times to be given, and reason. A picture of the youth is located in front of the MDL in the Medication Log Book. Side effects of the medications are attached to the back of the MDLs. The youth also signs the MDL. All MDLs reviewed on site document that perpetual inventory counts with running balances are being maintained on each youth. All MDLs reviewed for the youth also documented that all medications were given at prescribed times. Staff also document in the shelter log book when medications are given, who they were given to, and the name dosage of medication.

There are procedures in place for medication refills when needed. The Pyxis Med-Station keeps a list of medications that are running low. Staff will review this list in the Med-Station and notify the youth's parent that a refill is needed. This is also documented in the program log book.

The shelter has had one CCC report in the last six months relating to a medication error. The error occurred on July 15, 2016 and was due to a youth not receiving a scheduled dose of an antibiotic. The pharmacy was contacted and reported there would be no side effects and to continue with the next scheduled dose.

Exception:

The shelter has had one CCC report in the last six months relating to a medication error. The error occurred on July 15, 2016 and was due to a youth not receiving a scheduled dose of an antibiotic.

4.04 Medical/Mental Health Alert Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place for Medical/Mental Health Issues Alert that was last reviewed on May 2, 2016.

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

There were three youth currently in the shelter. These three open files were reviewed for the Medical/Mental Health Alert process. The agency uses colored dots on the spine of the youth’s file to indicate applicable alerts. The alerts documented on the spine of the file corresponded with information documented on screening forms inside the file, for all three open files reviewed. There is also an alert board located inside the staff work area in the shelter that documents all youth in the shelter and any alerts or allergies they may have. All alerts documented on the youth files reviewed also corresponded with the alerts documented on the alert board.

There were two additional closed files reviewed for adherence to this indicator. The files revealed all applicable alerts were documented on the spine of the youth’s file. It was unable to be determined if these alerts were also documented on the alert board as these youth were no longer in the shelter.

There are no exceptions for this indicator.

4.05 Episodic/Emergency Care

☐ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place for Emergency Medical Care that was last reviewed on May 2, 2016.

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

The shelter has had five instance of off-site episodic emergency care since the last Quality Improvement Review. In all incidents, the youth’s parent was notified and the youth was transported to the local emergency room. The shelter maintains an Episodic Log for Emergency Medical Care that documents the incident, youth involved, and follow-up care. The incidents were also documented in the shelter log book.

The shelter has completed one emergency medical drill in the last six months. The drill was completed on November 29, 2016 and was a drill involving a youth fainting. The drill included a description of the activity, a critique, and a debriefing.

The shelter has multiple first aid kits located in the residential shelter and the transportation vans. The RN re-stocks the kits when they are used and inventories them every couple of months for expired items. The knife-for-life and wire cutters are maintained in a locked cabinet in the staff work area. It was noted upon a review of this cabinet that the lock will stick and makes it difficult to turn to unlock the cabinet. At times, it can take the staff a couple minutes messing with the lock until the cabinet will open. Staff reported this lock is going to be replaced.

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

Exception:

The knife-for-life and wire cutters are maintained in a locked cabinet in the staff work area. It was noted upon a review of this cabinet that the lock will stick and makes it difficult to turn to unlock the cabinet. At times, it can take the staff a couple minutes messing with the lock until the cabinet will open. Staff reported this lock is going to be replaced.