Florida Network of Youth and Family Services Quality Improvement Program Report

Review of CHS West Palm Beach

on 12/07/2016

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	Satisfactory
1.07 Outreach Services	Satisfactory

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

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

Marcia Tavares, Lead Reviewer, Consultant - Forefront LLC

Pierre Bandoo, Shelter Manager, Crosswinds Youth Shelter

Karen Boulding, Statewide Training Director, Florida Network of Youth and Family Services

Paula Friedrich, Regional MQI Monitor, Florida Department of Juvenile Justice

Shareet Pennino, Executive Director, Lutheran Services Florida Southwest

Persons Interviewed

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

0 Case Managers
0 Program Supervisors
0 Health Care Staff

0 Maintenance Personnel
0 Food Service Personnel

1 Clinical Staff
0 Other

Documents Reviewed

- [x] 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
- [x] Exposure Control Plan
- [x] Fire Prevention Plan
- [x] Grievance Process/Records
- [x] 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
- [x] Supplemental Contracts
- [x] Vehicle Inspection Reports
- [ ] Visitation Logs
- [x] Youth Handbook

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

Surveys

3 Youth 3 Direct Care Staff

Observations During Review

- [ ] Intake
- [x] Program Activities
- [ ] Recreation
- [ ] Searches
- [x] Security Video Tapes
- [ ] Social Skill Modeling by Staff
- [x] Medication Administration
- [x] Posting of Abuse Hotline
- [x] 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

Children's Home Society (CHS) is a statewide agency with programs located in 15 divisions throughout the state. The agency's headquarters is located in Winter Park, Florida. CHS employs more than 2,000 employees. Since 1982, CHS of Florida has continuously maintained accreditation through the Council on Accreditation and is expecting their next COA accreditation site visit in February 2017.

CHS Safe Harbor Shelter is located at 3335 Forest Hills Boulevard in West Palm Beach, Florida. The shelter is licensed for 10 beds by the Department of Children and Families effective through January 2017. The shelter facility is located in the rear of a large campus that includes its administrative offices housed in a separate building. The Safe Harbor program is the agency's Children In Need of Services/Families In Need of Services (CINS/FINS) program which is sub-contracted with the Florida Network of Youth and Family Services (Florida Network) to provide temporary residential and non-residential services to youth and families in South Palm Beach County. Services are provided to male and female youth under the age of seventeen.

Since the last onsite visit, the program has continued to supplement its services to the youth in the CINS/FINS program by offering life skills training, educational, and career coaching. Additionally, the program provides structured enrichment activities for the youth through the Choices program. The Choices program is fully supported by volunteers who offer a variety of services such as: theater improvisation, theater writing, art, soccer, and potting. The program also offers additional recreation activities such as: drug prevention, music, yoga, broadcasting, sewing, and a tennis clinic. All of these services are provided onsite and the shelter also converted one of its bedrooms into an indoor game room where youth are encouraged to earn privileges to play video games. The program also converted a hallway closet into a Point Store where some of its donations are used as incentives for youth, in exchange for points earned.

During the past year, the program also implemented the Sanctuary Model of Care which is a trauma informed care approach. The Sanctuary Model rests on four "pillars": scientifically-grounded knowledge about trauma, adversity, and attachment; the Sanctuary Commitments as a values-based, interactive system; a Shared Language called "S.E.L.F.; and a set of practical instructions, the Sanctuary Toolkit, for creating and maintaining a Sanctuary culture.

The youth at CHS Safe Harbor have been able to gain valuable career skills and career development with the assistance of a Job Coach. Select youth are involved in the "Teach-A-Teen" program that provides an opportunity for youth to interact with business owners in the community who serve as mentors and provide youth with necessary employment and job skills training. The program offers tutoring bucks, valued at 50 points, which can be used to obtain items from the point store when the youth participates in tutoring.

Standard 1: Management Accountability

Overview

Narrative

CHS Safe Harbor is under the leadership of a management team that consists of an Executive Director, a Director of Program Operations, a Clinical Supervisor, a Residential Program Manager (vacant), a Data Management Supervisor, and an Administrative Secretary. In addition to the Residential Program Manager, the residential component of the program is staffed by a Residential Shift Leader, eight full time Youth Care Workers (YCW), and six relief YCWs. The program is operated around 8-hour shifts with variations of 6am-2pm/7am-3pm, 2pm-10pm/3pm-11pm, and 10pm-6am/11pm-7am.

The agency's Clinical Supervisor is a licensed mental health counselor (LMHC) who oversees the agency's counseling services. The clinical component of the program includes four (4) full time counseling positions that are designated as Residential/Non-Residential Counselors (3 Non-residential and 1 Residential). The program also utilized the services of several volunteers during the review period.

The agency has 2 full time employees in outreach positions that are grant funded. The two employees conduct presentations to the community at parks, schools and other community functions.

At the time of the onsite visit there were three vacant positions: one shelter Program Manager; one full time YCW; and one (1) Non-Residential Counselor position. Safe Harbor shelter is licensed by the Department of Children and Families for 10 beds. The current license expires 1/23/2017.

1.01 Background Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The provider's Background Screening Policy and Procedure, last updated 12/3/16, was reviewed.

CHS policy #7101 requires all staff and volunteers to complete a Level 2 Background Screening that includes good moral character documentation, employment history checks, employment screening, criminal record checks, and juvenile record checks. Additionally, per the provider's policy, personnel will be re-screened "during the fifth year of their employment" but does not indicate re-screening every five years of employment. Upon notification, the policy was updated on site on 12/7/2016.

Prior to hire, the provider also conducts a background check with the Department of Motor Vehicles and local City/County law enforcement screening.

A total of ten background screening files were reviewed for 4 staff, 1 nurse sub-contractor, and 5 volunteers. All of the new employees were background screened prior to hire date and e-verified. Similarly, all 5 volunteers were background screened with eligible results prior to their start dates. The provider completed the annual Affidavit of Good Moral Character and submitted it to the Department of Juvenile Justice Background Screening Unit via email on November 22, 2016, prior to the January 31, 2017 deadline. The provider did not have any eligible 5 -year rescreening during the review period.

Exception:

Per the provider's policy, personnel will be re-screened "during the fifth year of their employment" but does not indicate re-screening every five years of employment. Upon notification, the policy was updated on site on 12/7/2016.

1.02 Provision of an Abuse Free Environment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a current policy and procedure in place, CHS/7103 updated 4/4/2016, for the provision of an abuse free environment and Grievance policy CHS/7303, last updated 12/3/16.

Upon hire, employees receive the employee handbook and sign receipt of the Agency's Code of Conduct (Professional Conduct) which outlines the agency's policy against workplace violence and expectation regarding the provision of a safe environment. Employees are required to report all known or suspected cases of abuse and/or neglect and youth have unimpeded access to self-report. Abuse reports are maintained in the youth's file and are entered in the provider's AirsWeb incident reporting database.

The Florida Abuse Registry Hotline number, rights and responsibility, and other relevant numbers are visibly posted in the hallway on the Resident Corner board. Youth are also informed of these procedures during program orientation and the abuse hotline number is included on the orientation checklist and in the Resident Handbook. The grievance procedure is also reviewed with the youth during intake and the program has a grievance box with forms accessible to youth in the dormitory lounge adjacent to the staff desk. Per the provider's grievance policy, youth will personally handle their grievance documents unless a request for staff assistance is made by the youth.

A total of 6 abuse allegation incidents were reported and reviewed during the onsite visit for the review period; copies of the reported incidents are on file. None of the abuse allegations were institutional. There were no reported incidents of youth being deprived of basic needs or physical abuse by program staff was reported during youth surveys conducted during the review or observed during the visit.

The three youth survey indicated knowledge of the abuse hotline and location of the posting of the number in the facility. None of the youth surveyed reported being stopped from reporting abuse. The three youth surveyed also indicated that they feel safe in the program and have never heard staff threaten them or other youth.

The three staff surveyed said they have never witnessed another staff prohibit youth from calling the abuse hotline and have never heard the use of profanity in the presence of youth or have observed staff use threat or intimidation when interacting with youth. All staff agreed the working conditions have been fair and/or good at the program. All of the staff's training files reviewed documented staff training in Child Abuse Reporting.

A review of one of the two (2) grievances during the review period showed that one of the grievances included an allegation of verbal abuse against youth by staff. The Director of Programs (DPO) met with the staff to address the grievance and interviewed youth and other staff who witnessed the incident. Upon further review of the video footage, the DPO concluded that most of the allegations were unfounded but the staff was warned that any further incident will result in disciplinary action.

No exceptions to this indicator were found as of the date of the onsite QI review.

1.03 Incident Reporting

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The Risk Management and Incident Reporting policy and procedures (CHS/7102) were reviewed. The provider also has statewide directives for CHS agencies. The policy and procedures were last updated 7/27/2016.

Children's Home Society has a written risk management plan that identifies and addresses significant changes in the number/severity of incidents via the accident reporting process. Safe Harbor program staff takes immediate action to address incidents by completing incident reports and following the incident reporting process. The Central Communications Center is informed of incidents pertaining to CINS/FINS youth. Staff immediately informs their supervisor of incident/accident occurring. Supervisor reviews facts and determines whether to call the CCC within 2 hours of learning of the incident.

A review of the program's internal incidents and CCC reports was conducted. The agency had eight CCC

reports in the last six months. All of the eight incidents were documented on the internal incident system/form and on the CCC & DCF Incident Report Log. All of the CCC incidents were reported within the two hour time frame with one exception of 8/4/16 (medication given late). Follow-up communication was completed as requested.

Exception:

One non-critical medication incident that occurred on August 4, 2016 was reported to CCC on August 5, 2016 outside of the two hour requirement. The incident was documented in AIRSWEB but not in the log book completely.

1.04 Training Requirements

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

The agency has current policy and procedure CHS/7105 last updated on 7/16/2016 to ensure that all direct care staff is appropriately trained within the first year of hire to adequately meet the needs of sheltered youth.

The agency's policy and procedures are updated to comply with the first year requirements of the minimum of 80 hours of training and mandatory training completed within the first 120 days of hire. However, the policy does not correctly identify all the mandatory training for CINS/FINS contract requirements. Six (6) of the ten (10) courses identified as additional training to be completed during the first year of employment are actually mandatory courses to be completed in the first 120 days. The courses missing from the required list are: Medication Distribution (non-licensed staff); PREA; NAPPI –Crisis Intervention; CPR; First Aid; and Adolescent Development. The on-going training requirements comply with contract requirements and the mandatory course list is accurate with one omission (PREA) which should be added.

The program maintains individual training binders for staff that include a complete training plan and log. Mandatory training is listed in the training plans and includes training required internally, for CINS/FINS and DCF. Naturally there is overlap in the requirements but one course (PREA) that is mandatory for CINS/FINS is missing from that mandatory list.

Three (3) of six (6) files reviewed were for staff in their first year of employment. One (1) of the three (3) was in his 120 day period and has not completed his mandatory training yet, but has a few months left to meet compliance. The remaining two (2) staff in their first year of training have completed their 120 day time frame and are not compliant with their training requirements both in hours of training and mandatory courses.

Three (3) of six (6) files reviewed were for in-service staff employed for more than one year. All three staff are within their one (1) year training cycle; one staff member has surpassed his hours requirement and all mandatory courses except one (Suicide Prevention), the remaining two staff members are on track to complete their hours requirement. One of the two only has one mandatory course left to complete (Suicide Prevention) and the remaining staff member has the hours requirement but has four mandatory courses to complete (Suicide Prevention, NAPPI, Fire Safety and PREA).

Exceptions:

Six (6) of the mandatory courses required for completion within 120 hours of employment are not identified as mandatory in the provider's policy.

The provider's in-service mandatory training course list is accurate with one omission, PREA, which should be added.

Two (2) of the staff in their first year of employment, beyond their first 120 days of employment, are not compliant with training requirements for mandatory courses during the first 120 days and are missing approximately 42% of mandatory courses.

1.05 Analyzing and Reporting Information

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a written policy and procedures (CHS/7112), updated 8/1/2015, for analyzing and reporting data for case record reviews, incidents, accidents, grievances, customer satisfaction, outcome data, and monthly review of Netmis data reports. In addition, there is a comprehensive CHS Quality Management Plan for the current FY 2016 that describes the agency's philosophy, Quality Management Structure, CQI strategies, strategic planning, management/operational plans, program results/outcomes, monitoring and evaluation of performance, data collection, and communicating results.

The program has a designated Quality Management Manager (QMM) who is responsible for the implementation and oversight of its CQI program in Palm Beach, Inter-coastal, and Southwest Florida. In practice, the program's CQI program includes many activities that are conducted by all staff to ensure all aspects of analyzing and reporting data are consistently implemented and documented.

The program's non-residential clinical staff as directed by the program supervisor, along with QM for the residential files, conducts quarterly case record reviews. Upon completion of each record review, the QM Specialist aggregates the results and provides a copy of the aggregated Quality Management Division Evaluation report with corresponding graphs to the DPO, Program Managers as well as the Executive Director. Themes, trends, and areas of concerns are discussed monthly during team meetings and data analysis meetings. Program supervisors discuss the aggregated data with direct support staff to ensure appropriate areas are addressed and responded to in a timely manner. The QMS also follows up at a later date to spot check specific files to verify completion of the corrective actions.

The program's Safety Committee is facilitated by the QM Specialist and includes participation of the designated shelter staff (RSL) and non-residential staff. The committee is responsible for reviewing incidents and accidents, performing safety checks and fire drills and making recommendations to management on a monthly basis. Each program and site has a representative who sits on the Safety Committee. The safety committee meets on the third Thursday of each month and if unable to attend, can appear by phone. The QMS facilitates the call and meeting minutes from each meeting are produced and provided to committee members (including the QMS), Program Managers, and the Executive Director (ED). The Division Safety Committee Coordinator discusses safety concerns and suggestions with the ED monthly and follows up with the QMS as needed. The QMS will follow up with the ED and program supervisors as needed to ensure division safety. Consumer grievances are submitted to program supervisors and reviewed weekly by the QM Specialist.

Consumer surveys are administered twice a year during the second and fourth quarters. The QMS addresses consumer surveying via email and at management team meetings and notifies the program supervisors of the outcome of the surveys. The surveys are aggregated by the QMS and provided to supervisors, DPO, and ED.

The provider also has a Data Analysis Committee comprised of the Director of Program Operations (DPO), Program Manager, Clinical Supervisor, QMM, QMS, and Data Specialist that meets monthly to review findings of the peer reviews, grievances, incidents/accidents, satisfaction survey results, outcome data, and Netmis data reports. Strengths, weaknesses, and goals are reviewed and documented in the minutes and discussed by QM at team meetings.

Outcome data is reviewed monthly, quarterly, and annually. Monthly and quarterly data is entered into the agency's Division Quality Performance Report (DQPR) into the following areas: program performance, program team minutes, safety, record review, consumer satisfaction, and outcomes.

A review of peer record reviews for the 4th quarter FY 15-16 and 1st FY 16-17 was conducted. The residential program completed 27 peer record reviews resulting in a 92% compliance rate. During the same period, the non-residential program completed peer record reviews for 37 files with a 99% compliance rate. Detailed reports of the case record reviews include: ratings of the review, significant findings, data analysis, and report summary/recommendations.

Monthly meeting minutes for the period June-November 2016 were provided demonstrating Safety Committee meetings held to discuss trends and patterns in incidents, accidents, safety inspections, and fire drills. The Safety Committee conducts monthly analysis of the data and submits the necessary recommendations to the ED for approval. Grievances are reported to the QMS on a monthly basis via the Program Performance Report and are discussed at the monthly Data analysis meetings when applicable.

A copy of the most recent Consumer Satisfaction Survey Result for the 2nd period of FY 2015-2016 was reviewed. Survey results are compiled for the shelter and non-residential clients separately.

The outcomes data incorporates all of the contract, Netmis, and program outcomes required by the Florida Network and DJJ QI. A copy of the Florida Network Agency FY 2016-2017 Contract and Benchmarks was reviewed on site.

Netmis data is reviewed on a monthly basis by the Data Management Supervisor (DMS). Discrepancies and deficiencies are communicated verbally to the Administrative Secretary to correct. A review of the Netmis Quality check report for the period 4/15/16-12/6/16 was conducted showing minimal missing data.

Monthly minutes were up to date with documentation of QM aggregated data being discussed with detailed action plans of any needed areas of improvements or changes needed from analysis.

No exceptions to this indicator were found as of the date of the onsite QI review.

1.06 Client Transportation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The Client Transportation Policy CHS/7116 was last updated 10/12/2016 and addresses the transportation of youth. The policy and procedure outlines the safe transportation process for the direct care staff and clients in their care, as well as striving to follow best practices.

The policy outlines protocols regarding requirements and usage of a 3rd party passenger; prior approvals required for single client transport; approval of agency drivers; and the maintenance of current list of approved drivers. Current procedure requires the use of the updated vehicle travel log that requires staff initials and approving supervisor initials for single client transport.

A review of the agency‘s transportation logs showed use of a travel log that documents initials of the driver, date and time, mileage, purpose of travel/location, number of passengers (beginning and ending), use of open line if needed and approving supervisor’s initials for single client transports. Client transports are also logged in the client log. Additionally, copies of reminders of the transportation policy requirements are entered in the client log to reinforce the practices for staff. There is a current approved agency driver’s list maintained and monitored periodically utilizing DMV Motor Vehicle Reports.

No exceptions to this indicator were found as of the date of the onsite QI review.

1.07 Outreach Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The provider has a policy (CHS 7104) that establishes outreach activities, written agreements, and informal linkages with community based service providers targeting at risk youth.

The agency outreach positions are grant funded. The outreach staff documents their meetings/events in the Netmis system as well as maintaining agendas from activities conducted. Outreach employees conduct presentations to the community at parks, schools and other community functions.

There have been 75 outreach events entered since 04/06/2016. During September-October 2016, the grant funding for outreach staff was lost. Due to changes in employment, different employees have attended the DJJ board and council meeting. Agendas and sign-in forms are maintained in a binder.

No exceptions to this indicator were found as of the date of the onsite QI review.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

CHS Safe Harbor is contracted with the Florida Network of Youth and Families to provide both shelter and non-residential CINS/FINS services for youth and their families in West Palm Beach, Florida. The program provides centralized intake and screening twenty-four hours per day, seven days per week, and every day of the year. Trained staff are available to determine the immediate needs of the family and youth. Each youth at the program receives an initial eligibility screening, CINS/FINS Intake Assessment, a needs assessment, and a service plan. The counseling component consists of a total of four (4) counseling positions and a LMHC supervisor. The counselors are responsible for completing assessments, developing case plans, providing case management services, and linking youth and families to community services. Additionally, case management, individual, family, and group counseling services, substance abuse prevention education, and referrals to local community agencies are provided as needed.

The shelter program provides critical temporary shelter care services to youth meeting the criteria for CINS/FINS, DV and Probation Respite, Staff Secure as well as Domestic Minor Sex Trafficking (DMST). During the review period, the program did not serve any youth meeting the criteria for staff secure or DMST.

The program meets the needs of the youth while in care with the ultimate goal of reunification with their families. The facility has ten beds available for both male and female youth in the CINS/FINS program and twenty-four hour awake supervision is provided for youth residing in the shelter.

As needed, CHS Safe Harbor coordinates the Case Staffing Committee, a statutorily-mandated committee that develops a treatment plan for habitual truancy, lockout, ungovernable, and runaway youth when all other services have been exhausted or upon request from the parents/guardians. The Case Staffing Committee can also recommend the filing of a CINS Petition with the court. Non-residential counseling services are provided by qualified Master's level staff who are under the supervision of a licensed Clinical Supervisor. Case file reviews revealed that the counselors monitor the youth's and family's progress in services, provided support for the families, and monitored out-of-home placement as applicable. Additionally, the program has many outside agencies with which to refer youth and families and makes multiple referrals to meet the needs of the families it serves.

2.01 Screening and Intake

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a screening and intake policy, CHS/7201, that meets and exceeds Indicator 2.01. The policy was last updated 7/6/2016.

There is a written policy for Screenings and Intakes. Policy CHS/7201 states that initial screening is completed within 7 calendar days of referral to the program and documented on the CINS/FINS Netmis screening form. This policy further states that the CINS/FINS Consumer Handbook is provided to parents during intake. The Consumer handbook includes: 1) available service options, 2) rights and responsibilities, and 3) grievance procedures.

Six files were reviewed for three non-residential cases (1 open, 2 closed) and three residential cases (1 open, 2 closed). Agency CHS/7201 was followed for all six files. Screenings and intakes were done accordingly. All documents were signed by designated staff. The screening was completed within 7 calendar days in all 6 files reviewed. Similarly, all six files demonstrated youth/parent received a copy of the consumer handbook, providing information regarding available service options, rights and responsibilities, and grievance procedures. Possible actions occurring through involvement with CINS/FINS is provided via the Florida Network CINS/FINS parent booklet.

No exceptions to this indicator were found as of the date of the onsite QI review.

2.02 Needs Assessment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There is a written Policy, CHS/7201, which provides the procedures addressing the Needs Assessment which the agency completes for each incoming youth receiving services. The policy was last updated 7/6/2016.

The procedure details the process staff follows for the completion of needs assessments. All needs assessments are to be initiated within the required time frames. All needs assessments include a suicide risk screening section.

Six files were reviewed for three non-residential cases (1 open, 2 closed) and three residential cases (1 open, 2 closed). The needs assessments were completed in all six files within the required time for completion by a Bachelors or Masters level staff with a supervisor's review upon completion. All six files included Needs Assessments completed with a risk assessment for suicide indicators. One case was referred for an assessment of suicide risk and additional direct supervision. It was reviewed by a clinician as required. All policies were adhered to with requirements pertaining to Needs assessments and suicide assessments.

No exceptions to this indicator were found as of the date of the onsite QI review.

2.03 Case/Service Plan

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There are written policies CHS/7202 (Service Plans) and CHS/7203 (Service Plan Implementation, Review, and Revision) that address the procedures for Service Plans. Both policies were updated on 7/6/2016 and 8/1/2015, respectively.

The provider's policy requires Service Plans to be completed within 7 days of the completion of the Needs Assessment. The Service Plan forms all contained goals, type, frequency and location of services. The persons responsible for completing each goal with target dates were also included in the Service Plans.

Six files were reviewed for three non-residential cases (1 open, 2 closed) and three residential cases (1 open, 2 closed). The six Service Plans reviewed included: individual goals; service type, frequency, and location; persons responsibility; target and completion dates; plan initiation date; and signatures of the youth, parent/guardian, counselor and supervisor.

Service plan 30 and 60 day reviews were done and documented; however, they lacked details with regard to actual services the youth and family are receiving and the progress for each goal.

Exception:

Service plan reviews lacked details with regard to actual services the youth and family are receiving and the progress toward achieving each goal.

2.04 Case Management and Service Delivery

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

CHS Safe Harbor has several policies and procedures that address case management and service delivery

standards: CHS/7111, CHS/7204, and CHS/7206-7207. All of the policies were last updated on 8/1/2015 with the exception of CHS/7206 (updated 7/6/2016).

The program has many collaborative community agencies with which to refer youth and families and makes referrals accordingly and tracks them on their service plan. The written policies for Case Management and Service Delivery provides procedures for counselor assignment, external referral establishment and assessment of ongoing family needs, coordination for service implementation, progress monitoring, referrals for case staffing and referrals for additional services when appropriate. Policy CHS/7204 provides the procedures for family involvement and referrals for services.

Six files were reviewed for three non-residential cases (1 open, 2 closed) and three residential cases (1 open, 2 closed). All but one file had coordinated service plans implemented and corresponding progress notes which reflected that the counselors monitored the youth and family's progress in services and provided support for families as well as monitored out-of-home placement, as applicable. The program makes referrals using a referral form, "Referral for Concurrent Services." The program also provides follow-up services after discharge.

One of the open cases presents with significant emotional issues, for example, anxiety, sadness, hopelessness, peer issues, relationship problems, parental divorce, depression, and school related issues. The youth also met the criteria for a suicide risk assessment but was determined at that time to not pose an imminent danger. The needs assessment was thorough and the service plan was done on time and targeted the areas of need for the youth and family. However, there was no follow up with referrals for the family. For example, the counselor did not document any discussions with parent regarding setting up critical services for this youth. In addition progress notes speak of youth having ADHD. This reviewer did not find any documentation in the record of a diagnosis, evaluation, or medication for ADHD, this was the first instance of reviewing the record of an ADHD diagnosis and medication and no other notations.

The record reflects a referral and communication for the mother to obtain a psychiatric evaluation for the youth. There was no documented follow up regarding this referral in documentation or staffing.

Exception:

One of the six files reviewed reflects a referral and communication for the parent to obtain a psychiatric evaluation for the youth. There was no documented follow-up regarding this referral in documentation or staffing or any documentation in the record of a diagnosis, evaluation, or medication for ADHD.

2.05 Counseling Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

CHS policy CHS/7208, "CINS/FINS Services", ensures the provision of an array of services but does not identify an actual policy to provide counseling services. The policy was last updated 8/1/2015.

Policy CHS/7208 addresses the development of a service plan, review of the service plan, follow-up monitoring of progress made, and revised service plans as a result of the case staffing and/or adjudication.

Case notes were relative to the youth needs. However did not provide much detail in terms of progress or service activity. Counseling services were provided as needed to all youth reviewed. Needs assessments and case plan reviews were held timely and addressed the youth and family needs.

Five of 5 applicable case files received counseling services in accordance with the case/service plan. Group counseling was observed in the files of two applicable residential cases. The program provides a variety of group sessions at least 5 times per week.

Exception:

While other CHS policies refer to counseling services, there is no actual written policy and procedure for

"counseling services".

2.06 Adjudication/Petitiion Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

CHS has a policy that addresses Case Staffing and Adjudication. CHS/7206 effective 1/1/03 was last updated on 8/1/15. The policy addresses all the requirements of indicator 2.06.

CHS will hold a case staffing review for those cases documented as having insufficient progress or at the request of a parent/guardian. All of the requirements of the indicator are addressed in the policy and procedures.

It appears the provider's schedule for case staffing is fluid and they are scheduled as needed.

One closed file was reviewed. Progress notes indicate the parent requested the case staffing; however, it was not held within the required 7 days. Requests can be formal (written) or informal (verbally) request. This case appeared to be a written request because the progress note suggests the mother requested a case staffing at intake and that request was documented. It however does not give any reason why the staffing was held that far past the required time frame.

The mother, father and youth were contacted by mail as well as by phone message as recorded in progress notes. It did not appear that notice of the case staffing meeting was sent to committee members within 5 days of the date of the staffing. Other than the family, only one reminder letter was sent out which appeared to be to someone in Palm Beach Sheriff's Office (PBSO). There was no contact with a required school representative.

Exceptions:

Standard 2.06 states when a parent requests a staffing, the case staffing is held within 7 working days of the request. The request date inferred was 7/8/2016 during intake; however, the case staffing was held on 7/21/16, which exceeds the time required.

The required committee member from the local school district was not present and no notice or contact was noted in the record. The provider stated they lost the school liason about one year ago. Other optional committee members were not present nor noticed in record.

The program does not appear to have a standing committee with local school district member as required.

2.07 Youth Records

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There is a written policy CHS/7111 that aligns with the indicator that was last updated 8/1/2015.

The policy and procedure addresses how records are maintained and the levels of security required for files marked confidential. It was observed that all records reviewed were marked "confidential" and transported in locked, opaque containers also marked confidential.

All open non-residential youth records are stored in locked file cabinets in locked offices. Staff have keys to their offices as well as their file cabinets. All records are transported via a zipped binder that each counselor owns. Each binder is locked. Closed cases are maintained in a locked storage room inside locked cabinets.

Active/open residential records are maintained on a metal cart behind a locked door only, adjacent to the residential hallway, and not in a locked cabinet.

All records reviewed were labeled confidential. All records are maintained in a neat orderly manner.

No exceptions to this indicator were found as of the date of the onsite QI review.

Standard 3: Shelter Care

Overview

Rating Narrative

CHS Safe Harbor Shelter program provides temporary residential shelter care for male and female youth identified to be at-risk. The program has adequate space for all indoor and outdoor activities and is equipped with one dormitory for youth of both genders. The dormitories, kitchen, restrooms and common areas were observed to be clean during the visit. Each bedroom is furnished with two beds with separate pillows and bed covering and a closet for youth belongings. Youth have access to a large yard with tennis and basketball courts for outdoor activities.

All youth who are admitted to the program receive a copy of the Consumer Handbook and an orientation to the facility. During the admission's process, each youth receives a new CINS/FINS intake screening to identify any medical, mental health, and/or substance abuse condition and this information is provided to the assigned clinical staff. The program provides individual, group, and family counseling, as needed. Group sessions are scheduled at least five times per week. The program also has a Comprehensive Master Plan for Access to Mental Health and Substance Abuse Services in place. Interagency Agreements have been established for the provision of health education, leadership development, and substance abuse, mental health, and medical services.

The shelter is designated by the Florida Network to provide staff secure services but has not admitted a Staff Secure youth since the last onsite visit. The Department of Children and Families has licensed Safe Harbor as a Child Caring Agency, with the current license for ten (10) beds, effective until January 15, 2017.

Counseling services to youth in the Residential program are provided by a Master's level Counselor under the supervision of a licensed Mental Health Supervisor. College Interns are also utilized by the program to assist with delivery of services.

3.01 Shelter Envonment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has written policies and procedures, CHS/7302 and CHS/7311 that address all of the key elements of this indicator regarding maintaining a safe, clean and neat shelter environment. The policies were last reviewed on 9/15/16 and 9/16/16, respectively.

CHS/7302, Shelter Environment, requires the building to be inspected weekly by the Supervisor or Data Management staff and Facility Operations or designee, to check for cleanliness, disrepair, or any evidence of hazardous or unsafe conditions. The inspections include verification of current health and fire inspections as well as valid inspections of the fire safety equipment. Needed repairs must be requested within 24 hours and documented on the Maintenance Request form. Completed repairs are maintained in a log accessible to staff responsible for maintenance.

During the tour of the facility, an inspection of the shelter environment was conducted. The facility appeared to be clean overall, neat, and well maintained.

All health and fire safety inspections are current as of 11/3/16 when the Department of Health completed the last health inspection and the Fire Department completed the Annual Fire Safety inspection on 9/27/16. Three out of the 3 violations were corrected on site with no further findings.

All furnishings appear to be in good repair. The program is free of insect infestation and no findings of droppings were observed while touring the facility. Two invoices reviewed for 2/29/16 and 11/30/16 reflect routine general pest control completed.

All youth dorms are in compliance with agency policy. Beds are labeled with A and B. Linen is cleaned weekly and youth are able to wash linen upon request. All 5 youth dorm bathrooms and public restrooms

observed were well maintained and functional. In the shelter hallways, the closets for hygiene products, chemical inventory, recreation equipment, clothing donations, point store, storage room, school supply room were observed and were found to be well maintained and secured. There is adequate lighting throughout facility. Youth have a safe lockable place to keep personal belongings (locked closet or in program manager's office). The locked storage is well organized with clear bins assigned to each youth 1-10.

Youth are engaged in meaningful, structured activities seven days a week during awake hours. Some of the activities include but not limited to: improvisation, sewing, painting, writing, fitness, green market, community service, large muscle activity (LMA) and exercise, bible study, yoga, and career development/job applications. Idle time is minimal. The daily schedule reflects at least one hour of physical activity is provided daily and notated in the logbook on each occurrence listed as fitness or LMA.

Daily programming includes opportunities for youth to complete homework and access books in the facility library that have been approved by the agency. Youth are allowed to read in their rooms. The library of books is kept in the day room but majority are stored in the counselor's office. Daily programming schedule is publicly posted in two areas (dining area large dry erase board/words of motivation and resident board daily schedule) accessible to both staff and youth.

Youth are provided the opportunity weekly to participate in faith-based activities. Non-punitive structured activities such as reading, journaling, tutoring, board game and counseling are offered to youth as an alternative to youth who do not choose to participate in faith-based activities.

Exception:

Facility overall was free of graffiti on property but room #2 and #5 had minor graffiti on the wall and shelf; staff was able to remove immediately once mentioned.

3.02 Program Orientation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has written policies and procedures, CHS/7313 (Program Orientation) and CHS/7301 (Classification) that address all of the key elements of this indicator. The policies were last reviewed on 8/1/15.

Youth admitted to the shelter go through a new client orientation process consisting of 23 specific areas, encompassing all of the required documented on the Client Orientation check List.

All three charts reviewed had acknowledgement from the youth of receiving a handbook. Of these files, the documentation indicates 2 out of the 3 clients received information on the program rules, client rights, the behavior management system, and grievance process which is explained by CHS staff. One chart is missing initials from staff and youth regarding disciplinary action, grievance procedure and abuse hotline number but it is a new intake and has been in the shelter for less than 24 hours.

Clients also receive a Safe Harbor Shelter handbook and parents receive a Consumer handbook which explains the program services and service options. However, 2 out the 3 charts did not contain signatures from guardian for acknowledgement of receipt of the CHS consumer handbook.

Exception:

Two of the three charts reviewed did not contain signatures from guardian for acknowledgement of receipt of the CHS consumer handbook.

3.03 Youth Room Assignment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a detailed policy and procedures, CHS/7301, for classification of youth to ensure the most appropriate sleeping room assignment. The policies were last reviewed on 8/1/15.

CHS/7301 addresses the majority of components required by the indicator with the exception of the identification of youth susceptible to victimization. In addition, the provider's CHS/7301 policy does not address the implementation of the program's alert system when youth is admitted with special needs and risks as required by indicator 3.03.

A process is in place that includes an initial classification of the youth's room assignment on the CINS/FINS Intake Form during admission for safety and security concerns. The agency also has a practice of utilizing a color coded alert system to notify staff of youth with special needs and/or risks. The agency has a five bedroom shelter with a total of 10 beds that are available for youth.

Three residential files were reviewed and all files had clients receiving general classification and room assignment while being admitted in the shelter. In addition, all files included age, gender, height, weight, and physical size of client. For classification, all client history is gathered for criminal offenses/delinquency, assault or aggressive behavior, gang involvement, sexual assault, chronic runner, mental health, substance abuse and initial collateral contacts.

Exception:

CHS/7301 policy does not include identification of youth susceptible to victimization and does not address the implementation of the program's alert system when youth is admitted with special needs and risks as required by indicator 3.03.

3.04 Log Books

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure, CHS/7109, that address all of the key elements of this indicator. The policies were last reviewed on 8/1/15.

Safe Harbor Shelter maintains a permanent, bound logbook that records all routine information, emergency situations and incidents pertinent to shelter activities. The agency requires all staff to utilize the log book for the purposes of signing in and signing out.

A log book was reviewed during the time-frame from February 18, 2016 through August 3, 2016. Effective communication among staff from shift to shift was well documented in the log book along with vital information such as security or safety of program and the welfare of the youth are highlighted for quick reference. The log book reflects staff review the logbook of the previous two shifts and that the staff is signing in and signing out on each shift. Supervisors use red ink to provide information and any recommendations for staff. In addition, a supervisor documents reviews and initials each page of the logbook.

All entries are brief and legibly written in only ink and no use of white-out was observed.

CCC incidents that were called in as well as responses from CCC were documented in the log book. Staff also documents when client arrives in shelter and when there are discharges.

Exception:

Not all recording errors were documented properly and were struck with a single line noted as void and initialed. Instead there were a lot of overwriting and exclusion of the word “void” and/or staff initials.

3.05 Behavior Management Strategies

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a detailed written description of the Behavioral Management System (BMS) and it is explained to youth at program orientation. The policy, CHS/7305, was last reviewed on 8/1/15.

The agency has implemented policies and procedures regarding its BMS that will encourage accountability and provide positive reinforcement for compliance with the program’s rules and expectations. CHS Safe Harbor shelter is a hands-off facility.

In the review of three residential files, it was confirmed that staff does explain the (BMS) during program orientation and acknowledgement of resident handbook. In addition, staff documents the behavioral notes on a daily basis.

During the interview with the Director of Program Operations, the (BMS) procedure that is in place was described. Clients can earn up to 38 points daily, totaling a maximum of 266 points a week. Points are documented on a weekly worksheet. New intakes remain on orientation level until they show knowledge of the client handbook, including an interpretation of the poem on page 2, then they are able to start accumulating points.

CHS Safe Harbor shelter has three levels in the BMS system: Level 1 (orientation) through Level 3 increasing more daily rewards and goals. CHS Safe Harbor staff determines how many points a client receives based on the level of compliance with following rules and completing tasks totaling no more than 2 points for each interaction goal. Client daily points are posted for clients to view and follow. Clients can request to advance to level 2 or 3 by writing a paragraph stating why they deserve to be on those levels. Staff can also recommend a client be promoted a level.

Clients are able to cash out their points at the point store to receive a BMS reward in the reward closet. In the closet there were items such as sweets/snacks, hygiene products and other supplies. BMS consequences for clients not following rules and noncompliance behavior will result in freeze of particular privileges, but client points are never taken away. Youth can have their level “frozen” by staff as a consequence for the shift and are not able to earn points or advance levels unless they discuss the situation with staff and are able to come to terms to unfreeze the level.

No exceptions to this indicator were found as of the date of the onsite QI review.

3.06 Staffing and Youth Supervision

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure, CHS/7306, that addresses all of the key elements of this indicator. The policies were last reviewed on 9/15/16.

Policy CHS 7306 ensures adequate staffing is provided for the safety and security of youth and staff. The policy is consistent with the requirement for 1:6 and 1:12 staff to youth ratio during awake and sleep hours, respectively. The staff schedule book has weekly schedules (Thursday through Wednesday) each week. The policy also establishes the staffing of at least one staff on duty the same gender as the youth as well as procedures for conducting bed checks during sleep hours.

The program has 8-hour shifts with variations of 6am-2pm/7am-3pm, 2pm-10pm/3pm-11pm, and 10pm-6am/11pm-7am. The staff schedules have blank fields during weekly schedule. The census has been below 7 when there was 1 staff. The schedule book is located in the Program Manager's office. The current and future schedule is posted in the staff room for everyone to see. There is a list of all youth care workers' names and cell phone numbers posted in the staff room and Safe harbor Weekly Schedules binder.

A random selection of overnight checks with one staff on duty was conducted on the following dates: 10/27/16, 10/22/16, and 11/3/16. The video review of overnight checks with one staff on duty aligned with the 15 minute checks documented in the logbook.

Exception:

There are ten findings on the following dates: 9/29/16, 10/1/16, 10/2/16, 10/22/16, 10/23/16, 10/27/16, 10/29/16, 10/30/16, 11/3/16, and 11/14/16 for 11pm-6am overnight shift where there was only 1 female worker present (supervising mix gender youth) instead of two (2) present, representing each gender.

3.07 Special Populations

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There are two policies pertaining to special populations: 1) CHS 7307 for Staff Secure that describes the higher level of security for staff secure youth and strategies in place to reduce runaway incidents; and, 2) CHS 7316 Domestic Violence and Probation Respite which outlines the procedures for both respite programs. However, there is no agency policy for Domestic Minor Sex Trafficking (DMST) population.

The provider has one bed for staff secure services. When there is a staff secure youth at the facility, the difference in staffing will be documented and clinical services are enhanced by having multiple service plan goals. Domestic Violence Respite referrals are obtained from the JAC Center/Detention Center. Youth will be admitted as a DV Respite client for 14 days and the service plan will have goals that will reduce violence in the home. Probation Respite referrals come from DJJ Probation and are submitted through the Florida Network Probation Respite Referrolator. Youth must be on Probation with Adjudication withheld.

In the last six months there were two DV Respite cases; one client was discharged and was enrolled in anger management courses and individual family therapy and the other client left after approximately six days to move out of state and live with an aunt. The case files were organized and complete. In the same six month period there were two Probation Respite cases and both youth became psychiatric placements. There were no Domestic Minor Sex Trafficking or staff secure placements during this time period.

Exception:

There is no agency policy for DMST population.

3.08 Video Surveillance System

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure, CHS/7117, that addresses all but one of the key elements of this indicator. The policy does not require the video system to enable facial recognition. The policies were last reviewed on 9/15/16.

CHS Safe Harbor shelter has a video surveillance system that is operable 24 hours a day, 7 days a week. The video surveillance system is equipped with 11 cameras that backs up video in excess of 60 days. In addition, the cameras can operate during a power outage due to support of generators.

All 11 cameras were visible to the public. At the front entrance of the facility, a sign is posted informing visitors of the surveillance system in place. All 11 cameras were positioned in the common areas and none were placed in youth dorms or facility restrooms.

The Director of Program Operations provided a list of designated personnel who can access the video surveillance system. On the back side of the agency logbook the Director of Program Operations logged random dates within the minimum of once every 14 days of review of random sample of overnights.

Exception:

CHS Safe Harbor shelter video surveillance system is unable to capture and retain video images that include facial recognition or offsite capability for designated personnel. Video surveillance did not include cameras with view of the parking lot, backyard, and front yard.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

Children's Home Society Safe Harbor shelter has written policy and procedures related to the admission, interviewing and room assignment of youth admitted into the program. Upon admission, program staff completes the intake via an individual interview with the youth. An initial intake assessment is completed to determine the most appropriate room assignment in relation to the youth's needs and issues, the current population of the facility, the physical space available, and staff's assessment of each youth's ability to function effectively within program rules and expectations. When making youth room assignment, consideration is given to each youth's physical characteristics, maturity level, history (including gang or criminal involvement), propensity towards aggression, and apparent emotional or mental health issues.

Staff receiving the youth at the time of admission notifies the program manager, counselor and/or director of program operations of any youth admitted with special needs, mental health issues, substance abuse issues, medical needs or security risk factors as well as those at risk of suicide.

At the time of this annual review the part-time licensed registered nurse (RN) had been on leave for more than two weeks; however, when onsite the contracted RN works 20 hours/week.

The program began utilization of the Pyxis Med-Station system in August 2016 and it is stored in the locked medical room adjacent to the staff work station on the facility dormitory. Topical and injectable medications are stored separately from oral medications. A locked refrigerator is maintained in the medical room for the sole purpose of storing medication requiring refrigeration. Medication distribution records for each youth are maintained in a binder which is stored in a locked medication cabinet in the locked medical room. Sharps are maintained in the drawer of a locked cart which is stored in a locked hallway adjacent to the medical room.

4.01 Healthcare Admission Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program maintains policy and procedure number CHS/7401 to address healthcare admission screenings. The policy was last revised on August 1, 2015 and was approved by the director of program operations.

The program's procedure requires staff to complete an intake assessment with the youth during the admission process to review with the youth his/her past and current medical and mental health history, inclusive of current medications, allergic reactions to medication and allergies, existing acute and chronic medical conditions, recent injuries or illnesses, the presence of pain or other physical distress, and observation for any evidence of illness, injury, physical distress, or difficulty moving.

Youth admitted with chronic conditions are to receive ongoing medical care via referrals to appropriate medical facilities. Follow-up is required for any youth with asthma, a recent head injury, hemophilia, seizures or blackouts, a heart condition, tuberculosis, diabetes, or pregnancy. The program's policy and procedures require parents of children with chronic medical conditions receive necessary treatment to ensure their medical needs are met. However if the parent is unwilling, staff are to ensure the youth receives necessary treatment. The program has four local hospital options at which youth may receive medical care.

Three of three reviewed youth records included a preliminary physical health screening for each youth which was documented on the CINS/FINS intake form. None of the reviewed files were applicable for required follow-up medical care.

Exceptions:

The completed body chart for one youth failed to document a scar on the youth's back which was reported and documented on the CINS/FINS intake form as is required by policy.

Page 2 of the CINS/FINS intake form for another youth who was admitted to the program while on medication was left blank in regards to observable injury, current medical conditions, recent hospitalizations, and current treatment or medication for mental health disorders.

4.02 Suicide Prevention

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program maintains policy and procedure numbers CHS/7403 and CHS/7402 to address suicide assessment, risk screening and prevention. The policy was last updated on August 1, 2015 and approved by the director of program operations.

The program's policies reference the program's written comprehensive master plan, which addresses elements of suicide assessment, precautions and prevention. The suicide risk screening is completed as part of the intake process with additional assessment as warranted. Potentially suicidal youth are placed under constant one-to-one supervision until a clinical assessment of suicide is conducted or the youth is removed from the program. A client safety Agreement is completed whenever a safety risk is stated, observed, or indicated, and is signed by both the youth and staff.

The assessment of suicide risk is conducted by a licensed mental health professional or a non-licensed mental health clinical staff person working under the supervision of a licensed mental health professional. The plan details notification procedures of the director of program operations and on-call management staff, outside authorities and the parent/guardian. The program's referral system for youth at high risk of suicide includes law enforcement or licensed professionals qualified for off-site mental health services related to suicide prevention/response.

Three youth files were reviewed and each documented the youth were screened for suicide risk during the initial intake and screening process utilizing the CINS/FINS intake form. Documentation evidenced two of the three youth were placed on the standard level of supervision based upon the results of the suicide risk assessment. There was one file applicable for CINS youth with an assessment of suicide risk completed during the review period. Per the program's practice, the one youth was placed on sight-and-sound supervision due to acknowledging current or regular worry despite having responded negatively to the seven risk assessment questions on the intake form. The youth was maintained on sight-and-sound supervision until assessed by a non-licensed professional under the supervision of a licensed professional. Staff documented both youth's behavior every 10 minutes on the precautionary observation log sheets.

Exception:

The CINS/FINS Intake form for one youth was left blank in the sections used to indicate the applicability of suicide assessment information, the date and time and person completing the assessment, and the supervision recommendation despite the youth being placed on sight-and-sound supervision.

4.03 Medications

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

The program maintains policy and procedure number CHS/7405 to address medication distribution and storage. The policy was last updated on September 1, 2016 and approved by the director of program operations.

The program's written procedures require the program to:

· Verify and document the verification of prescription medication with the pharmacy.

· Store all medications, including controlled medications, in the Pyxis med-station which should be inaccessible to youth.

· The program must have a minimum of two super users for the med-station.

· Store oral medications separately from injectable and topical medications.

· Maintain a perpetual inventory for OTC medication which must be inventoried at least weekly.

· Store controlled medication in the med-station inventory with perpetual inventories maintained when dispensed.

· Narcotics and controlled substances are also to be inventoried weekly.

· Utilize a secured refrigerator only for the storage of medication with storage temperature requirements.

· Allow only staff designated with user permissions to have access to secured medication and allow only limited access to controlled substances.

· Controlled substances must be perpetually inventoried with running balances when dispensed as well as counted daily with witnessed shift-to-shift counts.

· Secure syringes and sharps with documented weekly inventory counts.

· Utilize the Medication Distribution Log form to document distribution of medication by all staff.

· Have the registered nurse conduct all medication related processes and procedures when the nurse is on site.

· Conduct a review of medication management practices at least monthly via the knowledge portal or med-station reports.

The agency verifies youth medications via telephone contact with the pharmacy. All medications are stored within the Pyxis med-station and the med station is stored in a locked medical office which is inaccessible to youth. The program has three super users for the med-station consisting of the director of program operations, quality management manager, and quality management specialist. Oral medications are stored separately from both injectable and topical medications within the Pyxis med-station. The program maintains a secured refrigerator which is used only for the storage of medication. The program maintains the refrigerator at a maximum of 40° to ensure adherence with storage temperature requirements.

When on duty, the nurse conducts medication pass. Controlled substances are perpetually inventoried by the electric Pyxis med station as well as documented via witnessed shift-to-shift inventory counts. A perpetual inventory is maintained for OTC medication via a hand written log and in the Pyxis med-station. Individual Medication Distribution Log forms are maintained to document distribution of OTC medication by all staff to each youth.

Network instructions for dispensing medication from the med-cart are for the user to Login, at main menu select [remove] button, and then select the name of client to be given medication. However, the program has determined that the med-cart will not allow them to dispense liquid medications, in that the cart will not release the drawer for the liquid when it is accessed by selecting [REMOVE] because the cart consistently displays the message that it is not time to dispense the liquid medication, even when it is accessed at, or after, the time ordered for the medication. The program has worked around the system by selecting [INVENTORY] in order to access the cart for delivery of the medication and staff document dispensing the medication on the hand written medication administration log. This issue was reported to the Florida Network's Project Manager of Research and Operations, who referred the program to a panhandle based shelter which experienced the same issue with liquid medications in the cart. The panhandle based shelter provided the solution of working around the cart by selecting [INVENTORY] rather than [REMOVE].

Exceptions:

Interviewed staff reported four designated super users; however, one of the staff was included as a regular user on the Pyxis med station list of users and super users.

Registered nurse is listed as an authorized staff for medication delivery; however, he is not included on the list of Pyxis med station users. The program updated the list of Pyxis users and super users during this review to add the nurse to the list as a super user.

Only staff designated with user permissions has access to the Pyxis med-station and limited access to controlled substances is maintained via a required electronic staff witness log in to the station. However, three staff were included as regular users of the Pyxis med-station but were not included on the listing of staff authorized to deliver medication. A print out of the user summary for April 1, 2016 through December 7, 2016 supported that none of the three staff ever accessed the Pyxis med-station during that time period. The program's list of Pyxis users and super users during this review was updated to remove those three staff from the list.

Syringes and sharps are to be secured and documented in a weekly inventory. Staff reported that no razors had been on site since March 2016; however, inspection of the secure storage cabinet for sharps evidenced the presence of 23 disposable razors. A perpetual razor log was stored with the razors in the secure cabinet. The last entry in the perpetual razor log made on October 27, 2016 documented the presence of 25 razors; however, an inventory count conducted solely for the purpose of this review demonstrated only 23 razors were on hand on this date. The razor log also revealed multiple instances of corrections made by over-writing and scratching out. The razor log indicated two instances during the review period which did not document the number of razors dispensed nor the balance of razors remaining after they were dispensed. Lastly, although the log called for documentation of the time the razors were disposed, there were six instances since the last review which failed to document the disposal of the razor with that section of the form left blank. The Program conducted a search of the youth rooms but were unable to locate the two missing razors. The program neglected to search the sharps disposal containers, which were inspected by this writer and the director of programs and found to be empty. The program does not maintain any records of sharps disposal. The CCC was contacted by this reviewer to report the missing razors and the incident was assigned CCC #201606705 reported at 12:11 p.m. to CCC operator Adrian. The program revised their razor inventory log and placed it into implementation during this review, effective December 8, 2016.

The Razor Weekly Inventory log, also stored in the same binder with the perpetual razor log, documented only one weekly inventory (October 21, 2016) during the entire 6 month review period.

OTC medications are to be inventoried weekly; however, no weekly inventory of OTC medication was conducted the week of October 9-15. The program staff provided documentation of an email dated October 10, 2016 with the Florida Network's project manager of research and operations to explain the program's misunderstanding that weekly counts of OTC medication were no longer required and therefore they did not complete weekly counts.

The FNYFS Medication Management and distribution Policy requires all medications in MS4000 to be inventoried by a Registered Nurse (RN), or Super User, if RN is not available within seven days from the last inventory. Reviewed documentation revealed that the program did not consistently inventory medications within seven days from the last inventory, with some conducted at 8 days from the last

inventory.

Staff explained the program's practice is for staff to physically count OTC medication after dispensing a dosage to a youth and enter the actual count into the perpetual inventory. However, documentation of the October, November and December perpetual inventories for the OTC medication Aleve, demonstrated that one staff dispensed 2 tablets of Aleve on December 1, 2016 and did not physically count the medication to arrive at a total remaining of the medication. Rather the staff subtracted the two tablets he dispensed from the number indicated on the last entry of the October perpetual inventory and recorded the difference on the October perpetual inventory form.

4.04 Medical/Mental Health Alert Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program maintains policy and procedure number CHS/7406 to address medical and mental health alert processes. The policy was last updated on August 1, 2015 and last approved by the director of program operations.

Information concerning a youth's medical condition, allergies, common side effects of prescribed medications, food and medication contraindication is to be effectively communicated to all staff through an alert system utilizing a general alert sheet as part of the intake packet with a second copy to be maintained in a medical alert binder. A color-coded general alert board is to be maintained in the medication storage room. The system is to identify youth with needs relating to medical conditions, allergies, common side effects of prescribed medications, foods and medications that are contraindicated, and other pertinent treatment information. Common side effects sheets are to be attached to the medication distribution record clients or prescribed medication. Staff are to be trained on how to recognize and respond to emergency care and treatment as a result of identified medical or mental health problems.

The program maintains an alert system which utilizes color coded dots posted to an alert board in the locked sharps hallway and contained within each youth's file. The color coding utilizes red to identify mental health/suicide risk, blue for medical conditions, dark green for food allergies, yellow for behavioral issues, orange for substance abuse issues, green for DJJ involved/court ordered youth, and coral for youth with runaway behaviors.

Three reviewed youth files included a general alert form which indicated who provided the alert information, and identified applicable to each applicable type of medical condition, food allergies or restrictions, and substance abuse, mental health or behavioral issue. Precautions and common side effects for prescribed medications were attached to the medication distribution record of the applicable client. Staff training and monthly medical/mental health drills included recognition and response to emergency care needs for medical and mental health problems.

Exception:

The program's policy and procedures require a copy of the general alert sheet for each youth to be placed in a medical alert binder; however, the program was not maintaining a separate medical alert binder at the time of this review. The general alert sheets were maintained within each youth's individual residential file.

4.05 Episodic/Emergency Care

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program maintains policy and procedure number CHS/7407 to address episodic and emergency care.

The policy was last reviewed on August 1, 2015 and last approved by the director of program operations.

The program's written procedure for emergency medical and dental care requires the program to maintain a knife for life, wire cutters, and first aid kit on the residential unit. Episodic emergency drills must be conducted on each shift at least quarterly to focus on varying emergency situations to include detailed debriefing, critiques, and corrective action/follow-up if necessary. All instances of first-aid and emergency care must be documented on a running episodic or first aid/emergency care log to provide information essential for the identification of need for additional resources and/or clinical trends.

Parents/guardians are to be notified of all episodic and emergency care. All instances of youth requiring transfer off-site due to emergency situations are to be critiqued by the program supervisor and the critiques are to be shared with the director of program operations. The program maintains written division emergency response plan to address emergency medical care procedures.

The program had two instances in which youth required episodic/emergency care within the last six months requiring off-site emergency medical care and both were documented in the episodic/emergency care log. The two applicable closed files were reviewed and an internal incident report for each documented actions taken, persons notified, persons involved, the date, type and description of the incident, the date reported, and the date entered into the program status system.

One of the two instances was applicable for the requirement of parental/guardian notification and documentation evidenced the notification by telephone to both the mother and grandmother. Documentation in the second file indicated parental notification was not made due to the existence of a no contact order. Each file contained copies of hospital discharge instructions and follow-up care recommendations. A knife-for-life and wire cutters were maintained in a wall-mounted box on the medical room. The facility maintained four first-aid kits; one at the staff station on the dormitory, one in the medical office, and one in each of two program vehicles.

No exceptions to this indicator were found as of the date of the onsite QI review.