



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of CHS West Palm Beach

on 04/13/2016

CINS/FINS Rating Profile

Standard 1: Management Accountability

1.01 Background Screening	Satisfactory
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Satisfactory
1.05 Analyzing and Reporting Information	Satisfactory
1.06 Client Transportation	Limited
1.07 Outreach Services	No rating

Percent of indicators rated Satisfactory: 83.33%
Percent of indicators rated Limited: 16.67%
Percent of indicators rated Failed: 0.00%

Standard 2: Intervention and Case Management

2.01 Screening and Intake	Limited
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/Petition Process	Satisfactory
2.07 Youth Records	Limited

Percent of indicators rated Satisfactory: 71.43%
Percent of indicators rated Limited: 28.57%
Percent of indicators rated Failed: 0.00%

Standard 3: Shelter Care

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

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

Standard 4: Mental Health/Health Services

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

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

Overall Rating Summary

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

Rating Definitions

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

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

Review Team

Members

Marcia Tavares, Lead Reviewer, Consultant - Forefront LLC

Sharon Coplin, Government Operations Consultant I, Department of Juvenile Justice

Terry DeCerchio, Director, Florida Network of Youth and Family Services

Marybeth Dick, Counselor, Youth and Family Alternatives



William Mann, Co-CEO, Florida Keys Children's Shelter

Kathryn Morris, Program Director, Mount Bethel Human Services Corporation

Persons Interviewed

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

Documents Reviewed

- | | | |
|---|--|--|
| <input type="checkbox"/> Accreditation Reports | <input checked="" type="checkbox"/> Fire Prevention Plan | <input checked="" type="checkbox"/> Vehicle Inspection Reports |
| <input checked="" type="checkbox"/> Affidavit of Good Moral Character | <input checked="" type="checkbox"/> Grievance Process/Records | <input checked="" type="checkbox"/> Visitation Logs |
| <input checked="" type="checkbox"/> CCC Reports | <input type="checkbox"/> Key Control Log | <input checked="" type="checkbox"/> Youth Handbook |
| <input type="checkbox"/> Confinement Reports | <input checked="" type="checkbox"/> Logbooks | 3 Health Records |
| <input checked="" type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 2 MH/SA Records |
| <input type="checkbox"/> Contract Monitoring Reports | <input type="checkbox"/> PAR Reports | 11 Personnel Records |
| <input type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 9 Training Records/CORE |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 9 Youth Records (Closed) |
| <input type="checkbox"/> Escape Notification/Logs | <input type="checkbox"/> Sick Call Logs | 6 Youth Records (Open) |
| <input type="checkbox"/> Exposure Control Plan | <input checked="" type="checkbox"/> Supplemental Contracts | 1 Other |
| <input checked="" type="checkbox"/> Fire Drill Log | <input checked="" type="checkbox"/> Table of Organization | |
| <input checked="" type="checkbox"/> Fire Inspection Report | <input type="checkbox"/> Telephone Logs | |

Surveys

- 3 Youth 3 Direct Care Staff 3 Other

Observations During Review

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

Comments

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

[Rating Narrative](#)

Strengths and Innovative Approaches

Rating Narrative

Children's Home Society (CHS) is a statewide agency that employs more than 2,000 employees who are located in 15 divisions throughout the state. Since 1982, CHS of Florida has continuously maintained accreditation through the Council on Accreditation. The agency is headquartered in Winter Park, Florida and serves over 100,000 kids and family members each year.

Children's Home Society of Florida, 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 also houses the agency's administrative offices. 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.

The program continues to enhance 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. Activities include: theatre improvisation, theater writing, soccer, and potting. The program also offers additional recreation activities such as: drug prevention; music; yoga; broadcasting; sewing; art; and a tennis clinic. The shelter facility utilizes space to support these activities and has 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 become incentives for youth to earn points in the Behavior Management System and exchange the points for items in the store.

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 50 points that can be used to obtain items from the point store when the youth participates in tutoring.

The program also continues to leverage its relationship with the local schools and participates in meetings hosted by the school guidance counselors. The meetings are held separately for elementary, middle, and high school guidance counselors and increases knowledge of the CINS/FINS program as well as facilitate the referral process.

During the current FY, the agency received approval of funding from Lost Tree Village for a new van which will allow the program to replace its 2002 GMC van.

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, 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 and twelve (12) Youth Care Workers (YCW). The program is operated around three ten-hour shifts that provide two hours overlap for shift exchange. The shift times are: 6 a.m. to 4 p.m., 2 p.m. to 12 a.m., and 10 p.m. to 8 a.m.

The agency's Clinical Supervisor is a licensed mental health professional who oversees the agency's counseling services. The clinical component of the program includes four (4) fulltime counseling positions that are designated as Residential/Non-Residential Counselors (3 Non-residential and 1 Residential). The program also utilized the services of fifteen (15) 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 two (2) fulltime YCW and one (1) Residential Counselor position vacant in the program. 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 8/1/15, was reviewed. A total of eleven employee files and fifteen volunteer/intern files were reviewed. All of the employees were background screened prior to hire date and e-verified. The provider completed the annual Affidavit of Good Moral Character and submitted it to the Department of Juvenile Justice Background Screening Unit. There was no staff eligible for the 5 year rescreen during the review period.

Exception

It was difficult to determine the start dates for some volunteers; however, all had completed background screenings.

1.02 Provision of an Abuse Free Environment

Satisfactory Limited Failed

Rating Narrative

Provision of an Abuse Free Environment Policy and procedure was reviewed. The policy and procedures was last updated 8/1/15. The program provides a Grievance box with forms in the common area located next to the staff workstation. The Grievance box was opened by staff during the QI visit and was observed to be empty.

Two grievances were submitted in the last six months regarding no computer access and youth being told to stay in room for 30 minutes. Both were resolved at the Program Supervisor level. No employee discipline for abuse/excessive use of force was found in last 6 months.

Three youth and three staff were interviewed. All of the youth reported that they felt safe, treated with respect, and were fed well. Staff and youth were knowledgeable about what to do and where to go should they need to report abuse and/or file a grievance. Abuse reporting was evident in the provider's incident reporting database.

No exceptions.

1.03 Incident Reporting

Satisfactory Limited Failed

Rating Narrative

Risk Management and Incident Reporting Policy and Procedures were reviewed. The policy and procedure was last updated 8/1/15.

A review of the program's internal incidents and CCC reports was conducted. The agency had eight CCC reports in last six months. Three of the eight CCC reports were not documented on an internal incident form or on CCC/DCF Incident Reporting Log. All were reported within the two-hour time frame. Follow-up communication is completed as requested.

The program's Logbook was reviewed for documentation of incidents. All incidents were found in the log book with the exception of 12/13/15, Facility Keys Missing.

Exception

Three of the eight incidents reported to the CCC were not documented on an internal incident report form or on CCC/DCF Incident Reporting Log (12/20/15 Medication Error, 12/13/15 Facility Keys Missing, and 2/4/15 Contraband). The incident on 12/13/15, Facility Keys Missing, was not entered into logbook.

1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

The agency has a current policy and procedures (CHS/7105), updated 8/1/2015, to ensure all direct care staff is appropriately trained to meet the needs of youth served. The agency's policy and procedure complies with the minimum 80 hours of training during their first year of employment and 40 hours of job related training annually each full year thereafter. The training topics included in the policies and procedures include trainings to be completed in the first 90 days of hire and additional in service trainings thereafter.

The program maintains individual training files for staff in a red binder that includes an all-inclusive training plan and log that lists mandatory and recommended trainings along with due dates and hours completed. Training files are maintained by the program supervisor. Additional trainings and in-service hours were also visible on the training log for each file reviewed.

Three (3) of the six (6) files reviewed were for staff in their first year of employment. All three staff exceeded the 80 mandatory training hours required. The three staff completed the majority of mandatory topics with the exception Signs and Symptoms of Mental Health and Substance and one did not complete the Professionalism training. Signs and Symptoms of Mental Health and Substance is reviewed for a quarter hour during orientation but a comprehensive review of the topic is not provided thereafter.

Three of six files reviewed were for in-service staff employed for more than one year. One of the three staff is on target for completing the required annual 40 hours. Two of the staff had not completed Fire Safety and none had completed Suicide Prevention to date; all three had sufficient time during the current training year to complete the missing trainings.

Exception

One of the mandatory trainings required, Professional Ethics, and six (6) of the recommended training topics were not included in the provider's policies and procedures under the respective required and recommended trainings sections.

Three first year staff did not complete Signs and Symptoms of Mental Health and Substance training and one staff did not complete Professionalism during the first year of hire.

Two of the three in-service staff are not on target for completing the required 40 hours of training. One staff completed 20 hours but should have completed 33 hours to date. The second staff has completed 24.75, 5.25 hours short of the prorated hours to be completed.

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 clinical staff as directed by the program supervisor conducts quarterly case record reviews. Upon completion of each record review, the QM Specialist aggregates the results and provides a copy of the aggregated report to the Executive Director and Quality Management Division Evaluation to the program supervisor to discuss themes, trends, and any areas of concern, during data analysis meetings quarterly but the committee meets more frequently. 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.

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

The program's Safety Committee, represented by the Shelter Manager and non-residential staff, 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 by program supervisors and reported to the QMS on a monthly basis via the Program Performance Report.

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. A copy of the most recent Consumer Satisfaction Survey Result for the 1st period of FY 2015-2016 was reviewed.

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, incidents/accidents, satisfaction survey results, outcome data, and Netmis data reports. Strengths, weaknesses, and goals are reviewed and documented in the minutes. Copies are provided to the Youth Care Workers and Counselors.

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. 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 2015-2016 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 appropriate Program Manager and followed up for completion by the DMS. A review of the Netmis Quality check report for the period 1/1/2016-4/14/2016 was conducted showing minimal missing data that will be addressed this month.

The agency has not yet implemented the use of the Pyxis Med-Station and therefore does not have any Knowledge Portal reports to review.

No exceptions noted.

1.06 Client Transportation

Satisfactory

Limited

Failed

Rating Narrative

The provider has a Client Transportation policy (CHS/7115), updated 8/19/2015, that addresses transportation of youth. The policy and procedures outline the agency's protocol regarding definition of 3rd party passenger, requirement for approval by Program Manager in the absence of a 3rd party, consideration of the client's history before approving a single client transport, documentation of the transport on a log, communication with the Program Manager when unforeseen circumstances occur including the use of an open line.

In reviewing the policies and procedures, information about the agency's protocol for approval of agency drivers, criteria for approval, maintenance of valid driver's license, and insurance coverage for staff was not included. The P&P also did not include name or initials of staff as a required documentation on the transportation log; however, in practice, the logs do include this information. Per the Director of Programs, all staff hired pass the driver's license check and would be approved to transport youth. If during the course of employment an employee receives a negative driver's license check, the employee's approval would be rescinded. In addition, the agency's policies and procedures require staff transporting youth to call the program manager or designee upon arrival and departure and every 15 minutes should the travel time take longer than 30 minutes. This practice was not evident in a few of the records reviewed where the departure and return times while transporting youth exceeded 30 minutes.

The agency has two vans that are used to transport youth and staff are not allowed to use their own vehicles. A review of the program's transportation log for the past six months was conducted. The provider implemented the use of a revised Van Mileage/Tracking log on April 6, 2016 that includes the supervisor's approval. Two staff interviewed indicated the supervisor's signature is documented after the transport is completed. The new log contains all of the information required to be documented on the log; however, the previous log was missing the number of youth transported making it difficult to ascertain when single client transports occurred.

On three occasions reviewed in the past three months, staff conducted single client transports. There was not documentation maintained on the log or in the logbook to demonstrate that a program supervisor was aware of the single transport and consented accordingly.

Exceptions

The program does not maintain a list of approved drivers.

In reviewing the policies and procedures, information about the agency's protocol for approval of agency drivers, criteria for approval, maintenance of valid driver's license, and insurance coverage for staff was not included.

The P&P does not include "name or initials" of staff as a required documentation on the transportation log.

A few of the records reviewed where the departure and return times while transporting youth exceeded 30 minutes does not document staff calling the program manager or designee upon arrival and departure and every 15 minutes as required by the provider's P&P.

On three occasions reviewed in the past three months, staff conducted single client transports. There was not documentation maintained on the log or in the logbook to demonstrate that a program supervisor was aware of the single transport and consented accordingly.

1.07 Outreach Services

Satisfactory

Limited

Failed

Rating Narrative

The provider has a policy (CHS 7500) in regards to outreach staff providing emergency items and Safe Place information. The agency has 2 full time employees in outreach positions that are grant funded. The outreach staff document their hours in their program and the Data Administrator documents it in the NetMis system as well. The two employees conduct presentations to the community at parks, schools and other community functions. There has been 40 outreach events entered since 12/3/2015. The provider also has a policy CHS 7104 for interagency agreements and outreach. Interagency agreements are maintained in a binder for both residential and non-residential services. It was neatly organized.

Due to changes in employment, different employees have attended the DJJ board and council meeting. There is a binder labeled "Community Needs Assessments" that holds papers from each meeting, including agendas and sign in forms. There is an email documenting September's Board meeting invitation. In the binder are agendas from November and December 2015 DJJ meetings. There are agendas in the binder that are not documented in NetMis as outreach.

No exceptions

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). The program takes care of the youths' basic needs 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.

Six (6) youth files were reviewed, five (5) Closed or Inactive files and one (1) Open or Active file. Three (3) of the files for the youth received Residential Services and three (3) of the files received Non-Residential Services.

2.01 Screening and Intake

Satisfactory Limited Failed

Rating Narrative

There is a written policy that addresses a referral process. Policy CHS/ 7209 addresses 24 Hour Access to Services and in the procedure all referrals are mentioned as being documented and then sent to clinical staff who then refer for screening.

Upon review of the current procedure, 83% of the files reviewed do not indicate when the referral, or what the referral process is in place to be able to accurately measure this timeframe. The current practice for program referrals is inconsistent with the policy and procedures. Two (2) staff and one (1) youth in the residential program were interviewed for assisted perspective in the measurement and review of this standard. The first interview was with the Clinical Supervisor. She expressed the incoming referral process as being two different things. She revealed that the incoming school referrals for last year was over 400 and that it was "physically impossible" to screen all of the referrals coming from the school.

In interviewing a counselor in the Non-Residential program, it was that the process of prescreening families for ongoing psychiatric issues, or cases that would require "monitoring" were categorized as ineligible for services. Confidentiality is addressed at their staff meeting that takes place mid-month, with direct one-on-one supervision taking place weekly. High risks cases or issues that arise are addressed right away with the Clinical Supervisor. The case termination process does not involve a letter being mailed or provided to the families and staff has not been directed to include termination or follow-up information in the case file notes or standalone file. Satisfaction surveys are mailed and the Data Management Supervisor then generates a report.

Six (6) youth files were reviewed, five (5) Closed or Inactive files and one (1) Open or Active file. Three (3) of the files for the youth received Residential Services and three (3) of the files received Non-Residential Services. 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. This policy further identifies that the CINS/FINS Parent Handbook is provided during intake. This Handbook was updated in October 2015, and then named the Consumer Handbook. The Handbook provides the required materials for Standard 2.0. All six files reviewed indicated this process was in line with the procedures of the agency based on the policy.

Exceptions

There is no official "Referral Form" or notation of an initial referral date, referring person in file, case note, or on screening form. The "Student Concern Form" (a form sent by the School District) for the 2 that were found in the files reviewed, the date of referral on the form was 34 to 35 days from submission to Screening. One was 17 days from Screening to Intake with no case note documentation identifying a reason for the time lapse. Regarding the 164 Student Concern Forms provided to this reviewer that had not been responded to by program staff, this process could be tailored to have screening completed based on the program standard requirements, by Interns or other cleared and approved program staff so that the forms are screened and responded to in a timely manner.

On the form that is signed indicating "Receipt of Consumer Handbook", (indicates the Parent and Child received the Available Service Options, Rights & Responsibilities, and Parent/Guardian Brochure), the signature block provides the option of either the Parent or the Child to sign and does not require both signatures.

Some forms had no signature; "Refused" was noted in lieu of a parent's signature for some forms, and some where a parent had signed but all had no consistent documentation of refusal. One form did not have a Supervisors signature. Staff signatures are missing on some forms and there was no Supervisor's signature on the Behavior/Point sheets.

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. Upon review of the six files, 83% were completed within the required 72 hours of program admission as mandated by the standards. All six files were completed within the required time for completion by a Bachelors or Masters level staff with a supervisors review upon completion. All six files included Needs Assessments completed with a risk assessment for suicide indicators. Regarding the file

reviewed with one assessment that identified elevated risk, the protocol in the agency's policy and procedures were followed in identifying appropriate more intensive assessment be conducted for this youth.

The program's current practice is in line with the policy and procedures set forth for the agency and meet the standards required by the Florida Network.

Exception

For one Needs Assessment reviewed, it was completed outside of the 24-hour time required (Residential Youth client).

2.03 Case/Service Plan

Satisfactory

Limited

Failed

Rating Narrative

There is a written policy CHS/7202 and CHS/7208 that address the procedures for Service Plans. Based on the review of the files and the practices of the agency, 83% of Service Plans were completed within the standard's required timeframe of within 7 days of the completion of the Psychosocial Assessment. The Service Plans all contained prioritized goals, type, frequency and location. The persons responsible for completing each goal with target dates were included in the Service Plans. However, all of the six files reviewed were missing some of the actual completion dates as noted in the Exceptions for this Standard.

The Service Plans all had the youths' signature, counselor's signatures, supervisor's signature, but only 33% had a parent's signature. All six Service Plans reviewed had appropriate corresponding dates for service initiation but only 33% were reviewed or revised with the parent having signed off during the timeframe designated by the Standard.

Based on the Quality Improvement Youth Survey that was completed, the information gathered relating to this standard was reflected positively by the youth. The youth was able to identify their goals for services and reflected positively about their experience.

Exception

On the Individualized Service Plans, only some had actual completion dates. Some had the Parent/Guardians signature only on the initial Plan signature sheet. The header on one Plan indicated a different client than the file was actually servicing (*Corrected on site). When a Parents signature was missing there was no indication of refusal to sign the form.

2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

Rating Narrative

The program has policies related to case management and referrals to outside agencies, recommending and pursuing judicial intervention in selected cases, and youth discharge.

Three nonresidential youth files were reviewed. All files had coordinated service plans implemented and a plethora of 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 has many outside agencies with which to refer youth and families. The program makes multiple referrals via a form entitled, "Referral for Concurrent Services," and tracks them at least monthly on their service plan and referral checklist as well as in their progress notes. The program provided case monitoring and review of case staffing in the file that was applicable. The program also provides follow-up services after discharge.

Five residential youth files were reviewed. Similarly, all files had coordinated service plans implemented, a plethora of progress notes that reflected the counselors monitored youth and family's progress in services, provided support for families, and monitored out-of-home placement. Similarly, the program has many outside agencies with which to refer youth and families and makes multiple referrals and tracks them at least monthly on their service plan. There are written policies for Case Management and Service Delivery. Policy CHS/7203 provides the 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 support. Policy CHS/7204 and CHS/7206 provide the procedures for additional referrals for services to the family of the youth. Upon review of the files, 100% of all youth and files reflected that these standards were met. Monitoring of out-of-home placement was not applicable for the files reviewed, but no policy or procedure was found reflecting this process. Policy CHS/7203 provides the procedures for case staffing, but none of the files reviewed required this practice.

There is no Policy or Procedure for the accompaniment of youth and/or family to court hearings or appointments was found. Upon review of the files, only one file indicated court hearing attendance and/or involvement and the case note reflected that the counselor followed up, but did not attend.

No Policy or Procedure for CINS Petition case monitoring and/or the review of court orders was found. However, none of the files reviewed were applicable.

Exceptions

Policy CHS/7207 identifies the procedure for Youth Discharge and details the discharge process but does not include that case termination will be reflected in the case notes. The practices for the reviewed files showed that 4 files did not have documentation, 1 did have termination documented in the case note, and one case file was still open.

There was no Policy and Procedure for follow-up at 30 and 60 days after discharge. Upon review of the current practice, there is no documentation in the client files indicating completion of follow-ups and the documentation is being kept in binders in a staff office rather than in the client file as well as documenting this type of action in the case notes.

There was no case termination or follow up information in the file or case notes for closed files. One case had a child attending Juvenile Court, it was documented that the Counselor followed

up but did not attend the hearing with the Client.

2.05 Counseling Services

Satisfactory

Limited

Failed

Rating Narrative

There is no a written policy or procedure for Counseling Services. Review of the six files indicated that 33% did not receive counseling services in accordance with the standards for Service Plans. The Case Notes did not indicate reasoning and the external service referrals did not either. Regarding the residential counseling and group services, 100% of the residential files reviewed showed compliance with this standard. 100% of the files reviewed for the youth indicated that their presenting problems were identified in the needs assessment, service plan and in the service plan reviews (for those that had review completed).

Not all case notes maintained for all counseling services provided documented the youth's progress.

Policy CHS/7208 addresses the procedure for on-going internal process that ensures clinical review of case records and staff performance. The current practice is being followed, but best practice would be the follow the standards in reviewing client files and records to ensure service implementation and delivery is in substantial compliance.

Exception

There is no a written policy or procedure for Counseling Services. The current process does not encompass all of the required services reflected as reviewed and Case Notes were not completely indicative of external client services, referral outcomes, and progress for this section.

2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

Rating Narrative

There is a policy CHS 7205 that meets the requirements of the indicator. One closed file was reviewed. The progress note indicated on 1/22/2016 that the parent left a voicemail for counselor asking for a case staffing. The counselor documented several voicemails left for the parent regarding case staffing information. The case staffing was held on 2/18/2016. One open file was reviewed. Progress notes indicate the parent requested the case staffing, it was not held within the standard 7 days. Parents and committee members were notified several weeks before the case staffing. The files had the letters mailed out to the parties and the tracking codes for each letter mailed. The files had copies of the case staffing, documented in notes as well. The case staffing is scheduled around the schedule of the family. The case staffing is held in different locations, as best to suit the family.

Exception

The case staffing was not held within the 7 days when the parent initiated.

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

There is a written policy CHS/7111 that aligns with the indicator based on file review and review of the agency's procedures and practices. It was observed that all records reviewed were marked "confidential" and transported in locked, opaque containers also marked confidential.

This Policy and Procedure also addresses how records are maintained and the levels of security required for files marked confidential. The current practice is not being followed 100% of the time and details are noted in the exception portion for this standard.

Youth records are centrally housed in a file room, in file cabinets (all labeled Confidential), behind a double-locking door that sits in a corridor that locks.

Exceptions

"Closed/Inactive" youth files were observed in three (3) stacks under a Med Cart (not in a locked cabinet) in a locked office in the Residential wing of the facility. Youth Residential Active file binders were observed not in a locked cabinet, but behind a locked door only. Other clients records were observed in other clients' files (note that Staff changed on-site).

Follow-ups are kept in binders in the office of the Data Management Supervisor. During the day, the 30, 60 and 180 Day follow-up binders are kept on the front desk in the main entry area. These are records that should be kept in line with the Youth Records standard.

All records are not maintained in a neat orderly manner.

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 23, 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 Environment

Satisfactory Limited Failed

Rating Narrative

The agency has a written policy and procedures that address all of the key elements of this indicator regarding maintaining a safe and clean shelter environment. The policies were last reviewed on 8/1/15. An inspection of the shelter environment was conducted during our tour of the facility. In general, the facility was clean and well maintained. There were no signs of any insect infestation and the agency had a routine pest control service on 2/29/16. The agency keeps cleaning supplies in a locked closet; there is a weekly inventory as well as a perpetual inventory with sign out/in information. MSDS records were available for all cleaning supplies. The agency has a security camera system with 15 cameras that backs up video in excess of 30 days. Each staff is issued their own shelter keys.

The facility was free from any observable physical property damage and there was no graffiti or hazards. In the shelter hallways, the closets for hygiene products, chemical inventory, recreation equipment, clothing donations were observed and were found to be very organized. The kitchen and dining area were also inspected during the review and the refrigerator was clean and pantry area organized. The agency's last inspection by the State of Florida Department County Health Department was conducted on 10/22/2015 and resulted in a satisfactory inspection with two comments, one for a knob missing from a drawer in room #5 and the other was for a light bulb missing in the kitchen, both were corrected. The agency also has a knife for life located in the staff office and two first aid kits in the shelter (Kitchen and Staff office).

On the outside of the facility, there is a large area for recreation with a basketball court, a tennis court, and a racquet ball area which is being used as a storage area at the moment. The grounds are spacious and the landscape was well maintained, there were a few items of debris in the outside grounds that appeared to have been recently discarded by youth.

The shelter is licensed by DCF as a 10 bed facility. The current license expires 1/23/2017. The agency has posted client recreation activities, menus (which were signed by registered Dietician), grievance forms, and a grievance box. The agency also has the abuse hotline number posted for clients which all four youth interviewed were aware of, as well as several informational posters and flyers. The DJJ incident reporting number was not observed among the postings.

Also, during the review, the agency vehicles were observed and were very clean and had working seat belts. The vans had first aid kits, fire extinguishers, seat belt cutter tool, and current registration and insurance. Monthly vehicle checks are completed by the residential shift leader.

The agency has a policy and procedures that include a comprehensive safety and emergency disaster preparedness plan updated April of 2015. The emergency response plan includes all forms of emergencies, special considerations for residential program, hurricane preparedness/emergency kit inventory/ bomb threat and checklist. Fire drills and episodic drills are conducted on at least a monthly basis and with the exception of February on each shift every month. The drill logs were all well documented. Daily Programming schedules were posted and accessible to staff and youth. They included time for youth to complete homework, quiet time to read and physical activity.

3.02 Program Orientation

Satisfactory Limited Failed

Rating Narrative

The agency has a written policy and procedure 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 comprehensive new client orientation process that consists of 23 specific areas documented on the Client Orientation check List.

A review of three residential program orientation files indicates that all residents receive a detailed orientation during intake process. Of these files, the documentation indicates that all clients

receive information on the program rules, client rights, the behavior management system, and grievance process which is explained by CHS staff. The clients all sign and initial receiving the client handbook and above mentioned information; however, in one case, although documentation of the client receiving the hand book was noted, the youth did not sign the acknowledgement form. The agency provides a checklist, which also includes staff initial and signature, of the procedures taken place during the intake process. Clients also receive a Safe Harbor Shelter handbook and Parents receives a Consumer handbook which explains the program services and service options.

Exception

The clients all sign and initial receiving the client handbook and above mentioned information; however, receipt of the handbook was acknowledged in one of the three cases reviewed.

3.03 Youth Room Assignment

Satisfactory
 Limited
 Failed

Rating Narrative

The agency has a detailed policy and procedures that include all components that meet the general requirements of youth room assignment. The program documents the client's room assignment on the CINS/FINS Intake Form during the intake process.

Three residential files were reviewed and two files had clients receiving general classification and room assignment while being admitted in the shelter; however, in one case the room and bed assignment was not documented in the file. All files included age, gender, height, weight, and build 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, and substance abuse. 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.

Exception

Three residential files were reviewed and two files had clients receiving general classification and room assignment while being admitted in the shelter but one of the case files did not document the room and bed assignment in the file.

3.04 Log Books

Satisfactory
 Limited
 Failed

Rating Narrative

The agency has a written policy and procedure that addresses 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 timeframe from December 1, 2015 through February 17, 2016. Communication among staff from shift to shift was well documented in the log book along with important information such as safety and security issues which are highlighted. The log book indicates that the staff is signing in and signing out on each shift. Supervisors provide information and any recommendations for staff in red. A supervisor documents reviews and initials each log book page. Errors were struck with a single line noted as void and initialed.

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.

Exceptions

Staff do document reviewing the log book however this was not done consistently, for instance on 12/9/15 two staff came in during the morning shift both documented they were on shift but only one documented reviewing the log book, and in the afternoon both staff noted they had come on duty but neither documented review of log book for at least the last two shifts. This deficiency was noted in a supervisor review on 12/12/2015 and improvement was noted.

It was observed that staff is not consistent in documenting the name/initials of clients who are being counted during the resident counts or when youth are leaving the residential unit to go to school such as on 2/1/2016; however, they are documenting the number of youth.

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 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.

In the review of three residential files, it was confirmed that staff does explain the behavioral modification system during program orientation and 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 earned up to 119 points a week. New intakes remain on orientation level until they demonstrate knowledge of the youth handbook, then they are able to start accumulating points. CHS Safe Harbor shelter has three levels in the BMS system: Orientation and Level 1 through Level 3. CHS Safe Harbor staff determines how many points a client receives based on the level of compliance with following rules and completing tasks. Client daily points are posted for clients to view and follow. Clients can request to move 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 each week to receive a BMS reward in the reward closet. In the closet there were items such as candy, accessories for girls, hygiene products, jewelry, and other supplies. BMS consequences for clients not following rules and poor behavior will result in not participating in the next scheduled outing, 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. Client point sheets are completed daily on each shift by staff and are on a weekly sheet.

BMS staff training was completed for all new hires. Room restrictions or isolation is not used. Only staff impose consequences and youth do not discipline youth; group discipline is not used. Consequences of the following are never used as discipline: regular meals and snacks, clothing, sleep, physical health services or mental health services, educational services, exercise, correspondence privileges, and contact with parents or guardians, attorney of record, juvenile probation officer or clergy. Both Supervisory training files reviewed showed they trained in the use and monitoring of the BMS.

3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

Rating Narrative

There is policy, CHS 7114, ensuring staff to youth ratio. The schedule book has weekly schedules (Thursday through Wednesday). The shifts are 8 hours with variations of 6am-2pm/7am-3pm, 2pm-10pm/3pm-11pm, 10pm-6am/11pm-7am. The staff schedules have blank fields during weekly schedule. The census has been below 6 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 worker's names and cell phone numbers posted in the staff room.

There has not been a female youth at the shelter since March 18, 2016. When there are two males working midnight shift and a female youth comes in, Staff stated the female can stay in the female group home (located in same building) where there is 24 hour staff. The agency is in the process of hiring 2 females for the 2 job vacancies. The shelter is fully staffed with male youth care workers. There are midnight shifts where there was only 1 worker present and ratio was below the requirements of 12.

There is a policy CHS 7306 for beds checks that meets the standards. On 3/17-3/18/2016 night shift, the bed checks were not completed within 15 minutes. Staff documented every 30 minutes a bed check was completed in the log. There was only one male staff working the night shift. The male staff completed at 11:24pm (3/17) and then laid on the futon with a blanket at 11:25pm. The next time the staff left the futon was at 2:55am and completed a bed check. The worker then laid back on the futon and left the futon at 3:45am and completed a bed check. The worker went back to futon at 3:55am and did not leave the futon till 4:08 am. The worker then went back to the futon till 5:24am, where the worker was seen putting the blanket away. At 5:34am the worker appeared to write in the log book. The log book was not touched from 11:24pm till 5:34am. The log book indicated that youth seen every 30 minutes. The same worker worked on 3/28/16. The worker was only staff on duty as of 3:30am (2 male youth at shelter). A bed check was completed at 4:05am and 4:36am. A female worker came on duty and completed the next bed check at 5:40am. On the night of 4/5, two staff were working, bed checks were completed, although not at exactly 15 minutes. The log book indicated it was completed every 15 minutes.

A CCC reported was called in during the QI review by the Reviewer on 4/14/16 with falsification of the log book records by staff on 3/17-3/18/16 and 3/28/16. CCC accepted the report, number 2016-02224.

Exceptions

The bed checks written in the log book do not reflect the actual time of the checks on both 3/17-3/18/16, 3/28/16 and 4/5/16. As described above, on 3/17-3/18/16, the staff did not complete a bed check from 11:24pm till 2:55am. The next bed checks were completed 3:45am, 4:08am, and 5:40am. The same male staff was the only staff on shift starting at 3:30am. It was documented in the log book the youth was seen every 30 minutes. The same worker worked on 3/28/16 and falsification of logbook entries was also observed.

On 4/5 the bed checks were completed but not within the exact 15 minutes as per the standard. The log book indicated every 15 minutes.

3.07 Special Populations

Satisfactory

Limited

Failed

Rating Narrative

There is a policy CHS 7307 for Staff Secure. Even though the shelter has not had any staff secure in the last year, the policy does state the youth will have 3 to 5 counseling sessions a week.

Two closed Probation Respite files were reviewed. The youth stayed less than 30 days. One youth was discharged due to arrest and the other to his mother. The youth was released by the Court to Safe Harbor in both cases. One open probation respite was reviewed. Youth is to stay until court date, noted in the notes during intake. Counseling needs are met. Approval letters were not found in file but were accessible from the Director of Programs.

There were no Domestic Violence Respite, Domestic Minor Sex Trafficking (DMST), or Staff Secure files to review.

Exception

There is no agency policy for probation respite or DMST population.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

CHS Safe Harbor has specific procedures related to the admission, interviewing and room assignment of youth admitted into the program. Upon admission, YCW staff will interview youth and complete the intake. An initial intake assessment occurs to determine the most appropriate room assignment given the youth's needs and issues, the current population at the facility, physical space available, and staff's assessment of the youth's ability to function effectively within program rules and expectations.

Staff conducting the initial interview and assessment considers the youth's physical characteristics, maturity level, history (including gang or criminal involvement), potential for aggression, and apparent emotional or mental health issues. Based on this information, the youth is assigned a room which can change after further assessment. Room assignment is documented on page 2 of the CINS/FINS Intake Assessment form.

Staff on duty at the time of admission immediately identifies youth who are admitted with special needs and risks, such as risk of suicide, mental health, substance abuse, physical health, or security risk factors, etc. The Program Manager, Counselor and/or the DPO is notified immediately if risks and/alerts are present and recommendations regarding placement and supervision are provided to the direct care staff. This information is documented on the alert board that is mounted in the medication room, on a youth alert form, and in the youth files using a color coding system. Youth admitted to the shelter with prescribed or over the counter medication will surrender those medication to staff during admission.

At the time of the annual review there was not a licensed registered nurse (RN) or licensed practical nurse (LPN) on staff or on-site. Per the DPO, there are two potential candidates, awaiting background screening results, for the approved Nurse position. Upon approval, the Nurse will work 2 hours in the morning (6-8am) and 2 hours in the evening. The program is not currently utilizing the Pyxis Med-Station system which was installed during the summer of 2015; therefore youth admitted to the shelter on/with medications, receive medication via administration by non-licensed staff.

During the tour of the facility, medications were observed to be stored in a locked room in a double locked medication cabinet. Topical and/or injectable medications are stored separately from oral medication. Refrigeration is available for medication requiring cool storage. The program has a list of staff who are authorized to distribute medication and the designated staff is identified for each shift. Medication records for each youth are maintained in a binder that is stored in the locked medication cart in a locked room.

The program has policies and procedures in place relating to the healthcare, mental health and substance abuse needs for the youth entering the shelter. The health/mental health related policies and procedures developed and implemented by the program are in compliance with the Florida Network CINS/FINS Manual. However, there are discrepancies/deficiencies with the program staff adhering to the medical/mental health and substance abuse policy and procedures, as well as the program management team following up with staff's adherence to the processes in place.

4.01 Healthcare Admission Screening

Satisfactory Limited Failed

Rating Narrative

The program has a policy and procedures in place to ensure the provision of a physical health screening for each youth admitted to the program. The program performs a preliminary physical health screening for each youth at the time of admission to the shelter. The screening includes questions and observations for the following topics; current medications, existing medical conditions, allergies, recent/current injuries and/or illnesses, existing pain, and/or physical distress, observations for evidence of illness, injury, physical distress, difficulty moving, and scars, tattoos or other skin markings. A body chart is completed on each youth during admission documenting the intake findings. The program has written policy and procedures regarding healthcare admission screenings.

A review of three active youth files documented the programs adherence to the policy and procedures.

No exceptions noted.

4.02 Suicide Prevention

Satisfactory Limited Failed

Rating Narrative

The program has a policy and procedures for mental health, substance abuse, and suicide risk screening and additional policy for suicide assessment. During the intake process staff reviews the youth's past and current mental health, including suicidal history. The program also has a comprehensive master plan for access to mental health and substance abuse services. This plan includes processes on suicide prevention, and suicide risk assessments/screenings. The master plan also includes a client/youth safety agreement which must be signed by the youth, parent, and Safe Harbor staff. The program's written plan clearly delineates staff positions, duties, and supervisory roles.

A review of the medical alert binder book found neither of the current youth in the program or during the review period had a suicide alert. Therefore, there are no suicide prevention/treatment processes to observe for documented practices.

No exceptions noted.

4.03 Medications

Satisfactory

Limited

Failed

Rating Narrative

A review of the program's written policy and procedure regarding medication found the policy to indicate the program has a comprehensive system in place for medication management. The policy includes all aspects of medications, including receipt and storage, inventories, distribution, documentation, and disposal. The policy and procedure states that when a registered nurse is on-site, the nurse will conduct all medication related processes and procedures. In addition, the nurse will train all non-licensed staff on medication related processes and procedures in accordance to the Department of Juvenile Justice (DJJ) Rule. The policy further states all youth will receive medications as ordered. During the on-site review, the program did not have a licensed nurse on-site for administering/distributing medications. Therefore, the shift leaders, program supervisors, program manager, and director of operations or designee distribute medications.

The program has eleven identified staff who are authorized to distribute medications. Documentation of training for eight staff on the list of staff authorized to distribute medication was provided, via copies of certificates of participation which reads: for training on DJJ Medication Management, documentation and delivery, to include admission, verification and discharge processes. Additional certification for Epi-pen training was provided. The remaining three staff authorized to distribute medication training was verified in Standard One.

The medication distribution record (MDR) which includes the youth's name, date of birth, name of medication, allergies, precautions, method of distribution, and time of distribution, and other identifying information as outlined in the DJJ Rule shall include the initials of the person distributing the medications listed on the MDR, indicating the youth received the medication as ordered. The MDR list the distribution time as one hour before to one hour after the time indicated on the medication. The initial MDR reviewed for four youth (three open files and one closed file) entering the program with medications matched the orders/medications regimen for the youth. The program is not currently utilizing the Pyxis system for medication storage, and/or distribution; however, all medications found at the program were stored in a separate room, secured and inaccessible to the youth. The program had no medications requiring refrigeration, yet there is a secured refrigerator in the locked area should the need arise for refrigeration of medications. The program reported having no sharps, or syringes on site at the time of the review. The narcotics and controlled substances were maintained in a double locked medication cart which has wheels. The medications observed in the double locked cart were labeled with the youth's name and were inside of a pharmaceutical issued container. Medications which are expired or no longer applicable is disposed of in the commode with two staff present and a medication disposal form is completed, and the supervisor must be notified; medications which are expired, discontinued or left behind by youth, is disposed of by turning the medication into a community take-back program such as Walgreen's. The pharmacist is asked to sign the medication disposal form as a second witness.

Although the program is not currently utilizing the Pyxis system, they have identified their site-specific Super User for the Med-Station.

Exceptions

The program's policy and procedures indicates the over-the-counter medications (OTC), and non- controlled medications must be inventoried weekly and by maintaining a perpetual inventory when dispensed. A review of the over-the-counter (OTC) medication log book, found discrepancies with the weekly and perpetual counts for three medications: Tylenol, Ibuprofen, and Pepto-Bismol. The Tylenol remaining count on 2/1/16 was twenty pills. On 3/1/16 the total remaining count was ten with no documentation of distributions. On 3/23/16, one pill pack (two pills inside) was distributed and the remaining count was seven. The last count for Tylenol was completed on 3/24/16 with a remaining count of six. Observation of OTC medications revealed there were only two packs (four pills) of Tylenol found in the locked medication cart. Discrepancies with the ibuprofen counts reflect: a count completed on 1/10/16 has a remaining count of eight and the next count conducted on 1/13/16 reflects one pill distributed with a remaining count of three. The next count conducted 2/1/16 reflects a count of three, and the next count completed 3/1/16 reflects a remaining count of zero. The discrepancy in the remaining count for the Pepto-Bismol indicates a remaining count of fourteen tablets on 11/30/15, and a remaining count of twelve tablets on 12/22/15, with documented distributions on 1/5/16, and 1/8/16 and again on 1/12/16 with an accurate count of nine tablets left after three tablets was dispensed. However, on 2/1/16, a count of the Pepto-Bismol tablets reflects zero, as well as the count on 3/1/16 reflecting zero. There were no explanations on the medication count sheet verifying or explaining the discrepancies for the Tylenol, Ibuprofen, nor the Pepto-Bismol.

The Florida CINS/FINS Policies and Procedures Manual in regards to medications requires documentation of shift-to-shift counts of medications. In reviewing the program's policy-CHS/7405 and CHS/7408 (effective date: 7/01/15) there is no mention of shift-to-shift medication counts. However, the program's policies do reference the Florida Network CINS/FINS Policies and Procedures Manual. A review of the program's log: Shift Change Medication Count Log, the form does not indicate which medications are being counted, the remaining counts for the counted medications, or any other identifying information related to the medications. The shift change medication count log only includes the month, three columns labeled first shift, second shift and third shift. In the first column there are seventeen rows with the words: date, third shift and first shift; the second column has the same number of rows with the words date, first shift and second shift, the third column has seventeen rows with a space for date and second and third shift. The log sheets for January thru April 2016, are all sporadically completed, but not on each shift for each day.

The medication records requires the full printed name, signature, and title of each staff member who initials a dosage of medication, and the full printed name, and signature of the youth receiving medications. A review of four (three open and one closed) youth medication distribution records (MDR) found the documents to include a cover sheet-Safe Harbor Shelter-List of Prescribed Medications, which includes: the youth's name, date of birth, allergies, and admission date at the top of the sheet; the middle of the sheet has the medication name, dosage and instructions and the distribution times; the bottom of the sheet has identification of initials, where the staff initials the sheet, print their full names and then their signatures, however this is done prior to the date which medications are distributed; as there are initials on the actual MDR on the date and time of medication distribution which are not included on the list of prescribed medications cover sheet. Also, there is no place for the youth's signature on either document-neither the MDR nor the list of prescribed medication sheet. There were also discrepancies in the administered times for the medication. One youth's medications are to be administered at 9PM, on 3/26/16. The medication was administered at 7:08pm; on 3/27/16 the medication was administered at 11:15pm with a note explaining the medication was not given by previous shift. The person administering the medication at 11:15pm did not initial the MDR and neither did the youth.

4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

Rating Narrative

The program has a medical and mental health alert process to ensure information concerning a youth's medical condition, allergies, common side effects of prescribed medications, foods and medications which are contraindicated, or other pertinent treatment information is communicated to staff. The program utilizes a color coded General Alerts sheet for Medical, Mental Health, Substance Abuse and Behavior Issues. If an alert is noted, two copies of the sheet is made and dispersed as follows: the original copy of the document is maintained in the file, and the second copy is placed in the medical alert binder. The program also utilizes a general alert board, located in the medication storage room. The alert board is color coded to reflect the youth's various alerts and is used as a quick reference for staff to identify youth, and their particular alerts without having to pull the file. Precautions and common side effects for the prescribed medications are located on the youth's medication distribution record (MDR). The provider's policy states, staff members are instructed on how to identify and respond to the need for emergency care and treatment as a result of medical, mental health or substance abuse problems. A review of the medical alert binder found each youth in the binder having a color coded general alert sheet completed. The alert sheet includes the youth's name, a date, how the alert information was obtained, whether the youth has a medical condition, food allergy/restriction, substance abuse issues, mental health issues, behavior issues, and/or a runaway issue. The general alert sheet provides a space to specify the medical condition, substance abuse issues, mental health issues, behavior issues and runaway issues, and the second page provides information on food alerts. The color coding on the alert board in the medication storage room and those found on the general alert sheets in the alert binder and the youth's file all match. Staff are provided sufficient information/instructions to recognize/respond to the need for emergency care for medical/mental health problems monthly through episodic/mental health drills. Staff are required to take fourteen hours of training in NAPPI, and seven hours of NAPPI training annually as well as CPR and First Aid.

No exceptions noted.

4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy and procedure relating to episodic/emergency care, which includes clear details as to where the knife-for-life, and first aid kits are to be maintained. The policy indicates staff must conduct episodic emergency drills on each shift at least quarterly. This practice by the program was verified by another reviewer during the annual review. It was reported the program conducts the medical/emergency drills monthly and the only month without documentation of a drill was February 2016. However, since the drills are required quarterly and the program does them monthly, the program is in compliance with the required number of drills. The program maintains an Episodic/Medical Care log book which documented three youth requiring episodic/emergency care within the last six months. Two youth were Baker Acted: one youth was BA on three separate occasions and one youth required transport to the local emergency room. The program completed an internal incident report for each of the three youth, documenting actions taken, persons notified, persons involved, type of incident, date of incident, date reported and date entered into the program's data system. In each of the episodic/emergency events, the youth's parents were notified.

No exceptions noted.