



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of SM ACT Behavioral Health Center

on 10/01/2014

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

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

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

Standard 2: Intervention and Case Management

2.01 Screening and Intake	Satisfactory
2.02 Needs Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management and Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petition 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 4: Mental Health/Health Services

4.01 Healthcare Admission Screening	Satisfactory
4.02 Suicide Prevention	Limited
4.03 Medications	Satisfactory
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:95.83%
Percent of indicators rated Limited:4.17%
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

Ashley Davies, Lead Reviewer and Consultant, Forefront LLC

Susan Spinella, Vice President of Quality Assurance, YCC

Al McCray, Shelter Director, Boys Town of Central Florida



Raylene Coe, Street Outreach Coordinator, Crosswinds Youth Services

Persons Interviewed

- | | | |
|--|--------------------------|-------------------------|
| <input checked="" type="checkbox"/> Program Director | 2 Case Managers | 0 Maintenance Personnel |
| <input type="checkbox"/> DJJ Monitor | 1 Clinical Staff | 3 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 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 | 5 Health Records |
| <input checked="" type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 5 MH/SA Records |
| <input type="checkbox"/> Contract Monitoring Reports | <input type="checkbox"/> PAR Reports | 3 Personnel Records |
| <input type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 6 Training Records/CORE |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 4 Youth Records (Closed) |
| <input type="checkbox"/> Escape Notification/Logs | <input type="checkbox"/> Sick Call Logs | 4 Youth Records (Open) |
| <input type="checkbox"/> Exposure Control Plan | <input type="checkbox"/> Supplemental Contracts | 0 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

- | | | |
|---------|---------------------|---------|
| 8 Youth | 3 Direct Care Staff | 0 Other |
|---------|---------------------|---------|

Observations During Review

- | | | |
|---|--|--|
| <input type="checkbox"/> Admissions | <input checked="" type="checkbox"/> Posting of Abuse Hotline | <input checked="" type="checkbox"/> Staff Supervision of Youth |
| <input type="checkbox"/> Confinement | <input checked="" type="checkbox"/> Program Activities | <input checked="" 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"/> Transition/Exit Conferences |
| <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"/> Sick Call | <input type="checkbox"/> Use of Mechanical Restraints |
| <input checked="" type="checkbox"/> Medical Clinic | <input checked="" type="checkbox"/> Social Skill Modeling by Staff | <input type="checkbox"/> Youth Movement and Counts |
| <input checked="" 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

During this review the staff was very cooperative, friendly, and available to answer all questions. The staff of the program were very welcoming and willing to answer all questions and provide guidance with documentation when requested. All LSF-NW staff were extremely professional and cooperative throughout the entire on-site QI program review.

The shelter recently found out they will receive the Basic Center Grant this year, they lost it last year. They plan to use the grant to hire additional therapists and a case manager for the weekends.

Standard 1: Management Accountability

Overview

Narrative

Stewart Marchman ACT Behavioral Healthcare serves as the local service provider of Child in Need of Services and Families in Need of Services (CINS/FINS) in the Seventh Judicial Circuit that includes Flagler and Volusia Counties. The SMA Company provides both residential and non-residential Services. The SMA Company is a current local service provider under contract with the Florida Network of Youth and Family Services to provide CINS/FINS services. This contract serves youth that are considered status offenders, homeless and lockout youth. These services include entry level of intervention and treatment for youth and families that are at risk for legal complications such as chronic runaway, lockout from the home or repeated school truancy.

The SMA company operates the B.E.A.C.H. (Bringing Enrichment And Children Home) temporary youth shelter. The agency has a capacity of twenty (20) beds. A total of ten (10) beds are designated for youth that meet the eligibility requirements of CINS/FINS services. The SMA Company has been a Safe Place member and continues to be an official Project Safe Place site.

The management team consists of A Director of Adolescent Services, an Assistant Program Director, two Residential Shift Managers, three CINS/FINS Service Managers, one Counselor, seven Youth Specialists, and an Administrative Assistant. The Program Director reports to the Vice-President of Residential/Crisis Services, who oversees all juvenile services provided by the Stewart-Marchman ACT Behavioral Services.

Training is provided through a combination of live in person instructor led courses, web-based training topics, and various approved off-campus seminars. The program has a Human Resource Director who oversees all background screenings, as well as other personnel issues. The program provides family, mental health, substance abuse, and behavior management services. The program has current operations and program policies and procedures. Further, the agency also conducts outreach services through partnerships with local community stakeholders and various system partners.

1.01 Background Screening

Satisfactory Limited Failed

Rating Narrative

Background screening files were reviewed for two new employees and one long-time employee who has been with agency for 15 years. All background screening documentation was received by agency prior to date of hire, and the 5-year screening for the long-term employee was completed 4 weeks prior to due date.

Annual affidavit for agency was completed, notarized, and sent to DJJ on January 3, 2014.

1.02 Provision of an Abuse Free Environment

Satisfactory Limited Failed

Rating Narrative

Blank grievance forms are prominently displayed in the common areas so that clients can easily access and complete forms if necessary. There are posters indicating abuse reporting protocols and hotline numbers as well as anti-bullying posters, all in the common areas where clients eat, sleep, and participate in activities. Grievance procedures are well documented in Policy and Procedures Manual.

Only one actual grievance was completed during this reporting period. It was a minimal complaint, where client was in an area that was restricted to staff only, and client complained about level being dropped due to this behavior. Client reported he was satisfied with outcome.

There were eight youth surveyed, four youth reported they know the number to the abuse hotline and four youth reported they did not. All eight youth reported they have never called the abuse hotline or been stopped from calling the hotline. Six of the youth surveyed reported staff are

respectful when talking with the youth and two youth reported they are not. None of the youth have heard staff use inappropriate language and all eight youth feel safe in the shelter.

There were three staff surveyed. All three staff reported youth are able to call the abuse hotline and they have not heard another staff member deny a youth access to call. None of the staff have heard another staff member use inappropriate language, threats, or intimidation when interacting with the youth.

1.03 Incident Reporting

Satisfactory Limited Failed

Rating Narrative

All incident reports for the past reporting year were reviewed and all were documented appropriately within CCC regulations, to include reporting them within the two-hour time frame. The incidents fell within the range of usual occurrences in these settings. There were calls to the abuse registry (pertaining to family occurrences, not shelter occurrences), minor physical injuries or illnesses, and self-harm ideations documented. There were also two incident reports pertaining to medication errors, both involved missed dosages of medication. Incident reports were documented in binders for CCC incidents and for general occurrences.

1.04 Training Requirements

Satisfactory Limited Failed

Rating Narrative

Training was documented comprehensively in a binder which indicated for each staff member the total number of hours for reporting period, in addition to each training course by topic. Sign-in sheets with the staff name highlighted were also available in binder, as well as, actual certificates of each course taken. No first year hires were reviewed, because the new staff were hired too recently to have completed the required first year courses. Six ongoing staff training records were reviewed. All of the six had exceeded the number of required annual training hours. Both online and classroom training are utilized with effective results. A broad range of applicable training topics are available to staff.

All staff whose training files were reviewed had exceeded required number of hours. There were three staff members who did not appear to have taken a Fire Safety course during past reporting year. All staff is current in their CPR and First Aid courses, as they are valid for a two-year period in many cases.

1.05 Analyzing and Reporting Information

Satisfactory Limited Failed

Rating Narrative

There are several ways in which reporting and analyzing information is handled at SM Act. One mechanism is that managers complete audits of residential client files and then discuss at monthly Risk Management/Safety Meetings. In addition, bi-weekly management meetings are held. Both of these are venues in which incident/occurrence report trends or issues pertaining to risk are discussed and resolutions proposed. There is also a Performance Improvement Committee (PIC) which meets monthly and covers topics such as data reporting, compliance with training requirements, performance measures and outcomes, client and family satisfaction survey results, clinical compliance, and utilization review. Additionally, the Shift Manager of the third (night) shift completes ongoing reviews of residential files at discharge. Clinical compliance and compliance to DJJ/CINS/FINS standards are taken very seriously. Records of Performance Improvement Committee Meetings, Risk Management Meetings, and peer and management audit reports are kept in the form of meeting minutes, and have been reviewed by this writer. Improvement in all processes is tracked in these minutes, and any concerns are noted and addressed. NetMIS reporting is reviewed monthly for quality and to ensure that all discharged clients have also been closed out in NetMIS.

SM ACT is current in its CARF accreditation, and much of the data tracked is part of the maintenance of accreditation process.



Standard 2: Intervention and Case Management

Overview

Rating Narrative

Stewart Marchman ACT Behavioral Healthcare (SMA) provides an array of services including Centralized Intake and Non-Residential Counseling services. The non-residential staff members include a Licensed Clinical Beach House Counselor, and three (3) CINS/FINS Service Managers. Non-residential services are provided to program participants and their families. These non-residential services are delivered through the agency's non-residential component and are provided twenty-four hours a day, seven days a week.

After intake, the program's Bachelor's or Master's level staff completes a needs assessment on each youth within 72 hours of admission or, completes such an assessment within two to three face-to-face contacts for youth receiving non-residential services. These assessments are reviewed and signed by a supervisor and, if there is a suicide risk component of the assessment required, it is further reviewed by a licensed clinical supervisor or written by licensed clinical staff. Within seven (7) working days after the completion of the assessment, the program develops a case/service plan with the youth and family.

Each youth is assigned a counselor/case manager who will follow the youth's progress on the case/service plan to ensure the delivery of services either directly or through referral. Case/service plans are reviewed by the counselor/case manager and parent/guardian (as available) every 30 days for the first 3 months, and every six months thereafter, for progress in achieving goals and for making necessary revisions to the case/service plan, if indicated. Youth and families receive individual, family and group counseling services, as set forth in their case/service plan, from program staff who document coordination between problems presented, and the youth's psychosocial assessment, case/service plan and reviews thereof, case management and follow-ups. Individual case files are maintained in accordance with confidentiality laws and notes kept chronologically in order to track progress. The program also has an established internal process to ensure clinical review of case records, case management, and staff performance.

2.01 Screening and Intake

Satisfactory Limited Failed

Rating Narrative

The program has a policy in place which establishes centralized intake services 24 hours a day, seven days a week. This serves to screen for eligibility, provides immediate crisis counseling, information and referral(s). Youth referred to the program are screened for eligibility within seven (7) calendar days from referral by a program staff member using a Florida Network NETMIS screening form. Upon intake, youth and parents/guardians receive documentation of the available service options, their respective rights and responsibilities, possible actions that could result from involvement with CINS/FINS service and the program's grievance procedures.

After reviewing eight (8) case files, which represented two open residential files, two closed residential files, two open non-residential files and two closed non-residential files, this reviewer found that the program is meeting the requirements of this standard.

The two open residential files were in tabbed binders, which aided the reviewer in identifying the forms used by the program to accomplish eligibility screenings. The two open non-residential files were in multi-section folders, which were indexed; however, the closed files were generally loose in a single pocket file. This reviewer notes that the two closed non-residential file folders were not stamped or labeled "confidential". This reviewer found that the program uses multiple forms to verify/ensure provision of written materials pertaining to the availability of service options, rights and responsibilities of both youth and parents/guardians, possible actions occurring through involvement with CINS/FINS services and grievance procedures. These verification documents were found in all of the files reviewed and, in one residential file, staff appropriately noted that the youth's parent/guardian signature was not obtained due to the youth voluntarily admitting himself.

2.02 Needs Assessment

Satisfactory Limited Failed

Rating Narrative

The program has a policy in place that requires an assessment of relevant social, emotional, educational, health, employment and family histories of each youth served by the program. The policy requires such a psychosocial assessment to be initiated within 72 hours of admission, for residential clients and for non-residential clients the assessment must be initiated on the first face-to-face visit and completed by the third face-to-face visit/session. The program's policy stipulates that the assessment is on-going throughout the duration of services and indicates that referrals for more intensive assessments or evaluations will be made when indicated by this assessment.

After reviewing eight (8) case files, which represented two open residential files, two closed residential files, two open non-residential files and two closed non-residential files, this reviewer found that the program is meeting the requirements of this standard. The program completed bio-psychosocial assessments timely (for non-residential clients it was done on the same day of intake), The program's records indicate that the assessments are performed by properly credentialed staff (Bachelor's or Master's level staff) and are reviewed and signed by a program supervisor.

2.03 Case/Service Plan

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy that establishes a procedure for planning delivery of services to the youth in its shelter (residential) and to those not in its shelter (non-residential). The policy specifies that a formal service plan be established between the case/service manager, the child and family (as applicable) within seven (7) working days of completion of the child's assessment. According to the program's policy, the Service Plan ties together all assessments, plans, goals, services, resources, and supports needed or desired by the individual and the family. The policy provides for development of the Service Plan with "full participation of the youth and family" and requires documentation for any exceptions. Furthermore, the policy requires each Service Plan to include:

1. Specific Needs of the youth and family
2. Time frames for completion
3. Responsibilities of the youth/family to complete goals
4. Program's responsibilities to assist youth and family in completing goals
5. Measurable objectives that address identified problems or needs
6. Services and treatment to be provided (type, frequency, location and accountable service provider/staff)

According to the program's policy, youth and family indicate their agreement to participate in the service plan by signing the plan.

After reviewing eight (8) case files, which represented two open residential files, two closed residential files, two open non-residential files and two closed non-residential files, this reviewer found that the program is meeting the requirements of this standard.

The program establishes an Initial Treatment Plan upon admission of a youth into its Residential shelter and then timely completes a Formal Service Plan within seven (7) days of intake. In fact, only one residential file reviewed took the program more than three (3) days to develop an individualized Service Plan – it was done in four days. All four of the non-residential files reviewed indicate that the assessment and service plan were completed on the same day of the youth's intake into the program.

This reviewer observed that the program clearly notes in its Service Plans the services and treatments to be provided by type and lists the accountable service provider/staff person. However, this reviewer found generalized statements in the residential Service Plans pertaining to frequency (e.g.: all therapy sessions) and the shelter location was implied, but not clearly identified. However, the individualized and prioritized needs and goals identified in the psychosocial assessment of the youth were clearly documented as were the dates of initiation and target date for completion; however, no actual completion dates were observed in the four residential files reviewed due to the youth leaving the residential program. All of the Service Plans reviewed were signed by the youth, the youth's parent (if available: in one instance of self-admit the absence of the youth's parent was noted) and by the counselor/case manager and that staff person's supervisor.

Because none of the residential youth files reviewed were in the program more than 30 days, there was no opportunity for this reviewer to verify 30-day reviews of the program's Service Plans by the counselor/case manager and parent. However, all of the non-residential files show appropriate reviews and, where youth and/or parent's signatures are missing, the case manager clearly noted attempt(s)/absence.

2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy in place to ensure appropriate case management and service delivery. The policy establishes a procedure for review and update (as necessary) of Service Plans at 30, 60, and 90 day intervals at which time the program staff may terminate the case as successful due to substantial completion of the plan, revise the plan, or refer the youth for more formalized case staffing and potential judicial action. Plans are reviewed every six (6) months thereafter. All Service Plan reviews or updates require at a minimum signatures of program staff, the youth, and the youth's parent or guardian (if available). The program's policy indicates that reviews are documented and stored in the youth's Service Activity Notes (SANs).

After reviewing eight (8) case files, which represented two open residential files, two closed residential files, two open non-residential files and two closed non-residential files, this reviewer found that the program is meeting the requirements of this standard. Each file reviewed had a counselor/case manager assigned and an individualized Service Plan in place. The SANs section of the program's records included numerous on-going assessment notes, identified problems and needs. The counselor/case managers coordinated the Service/Treatment Plans and each was signed by the youth, the youth's parent or guardian (if available) and the counselor/case manager and their supervisor. This reviewer observed that the program's counselor/case manager made referrals to additional services, monitored and followed-up with outside service providers on youth's progress and accompanied a domestic violence respite youth to his court hearing. The case plan follow-ups are included in the non-residential files, while the residential follow-ups are documented separately. As the youth is no longer in the shelter, it is difficult to ensure residential follow-ups at appropriate intervals. The reviewer notes that in one instance, the 30 and 60 day follow-up of a residential client was done on the same day.

2.05 Counseling Services

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy in place that outlines the purpose of its counseling services and establishes a procedure for provision of those services. The policy requires that:

1. All case files reflect coordination between presenting problems, bio-psychosocial assessment, case/service plan, reviews, case management and follow-up
2. Individual case files are maintained on each youth and adhere to confidentiality laws
3. Service notes on each youth's progress are maintained in chronological order; and
4. An on-going internal process ensures clinical review of case records, youth management, and staff performance.

After reviewing eight (8) case files: two open residential files, two closed residential files, two open non-residential files and two closed non-residential files, this reviewer found that the program is meeting the requirements of this standard. The records indicated that each youth was provided individual and family counseling (as possible) as well as group counseling at least 5 days a week for the residential clients. Each record indicated that a bio-psychosocial assessment was completed by qualified licensed staff and identified problems that were included in the youth's case/service plan. Case notes were maintained in the Service Activity Notes (SANs) section of each of the youths' files in chronological order and clearly documented progress toward meeting the goals outlined in the case/service plan. This reviewer found that a program supervisor periodically reviewed and signed the case records' notes indicating that the program has an on-going internal process of clinical review of and staff performance.

2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy in place for cases that cannot be resolved by the counselor/case manager (referred to as Service Manager). The policy establishes that a reminder notification will be provided "within 5 working days of the scheduled committee" meeting to all attendees. This reminder is to be sent via certified mailed to parents/guardians. The program's policy conforms to the requirements of this standard with regard to the composition of the Case Staffing Committee, which requires a representative from:

1. The youth's school district,
2. The Department of Juvenile Justice and
3. The program

And may also include:

1. Mental health or Substance abuse services provider
2. Social worker
3. Youth and/or youth's parent/guardian
4. Program therapist and/or supervisor
5. Any other person requested by child or family.

The program's policy requires that the committee's recommendations be recorded and included in the youth's file and a copy provided to the youth and youth's parent/guardian.

After reviewing four (4) of the program's case staffing files, this reviewer found that the program is meeting the requirements of this standard. The program is providing timely notice to parents via certified mail and to other committee members appropriately either via e-mail, letter or phone call. Although no instances of a youth's parent requesting a staffing were observed, it is recommended by this reviewer that the program's policy require a committee meeting to be convened within 7 days of such a parental request as required by this indicator. The program provided two closed staffing cases, which were not labeled confidential and its content were loose inside a single envelope-style folder. However, the materials were in the same order as the tabbed files and this reviewer was quickly able to locate and verify the scheduling, notifications, substance, composition and follow-up on each case staffing committee. In two instances, the parent of the youth failed to attend the case staffing committee and it appeared that no recommendations were made as a result. The program does update the case/service plan to incorporate the recommendations of the case staffing committee and, if possible, this is signed by the youth and the youth's parent/guardian. The program's records indicate that the counselor/case manager is preparing a summary report for each youth after the case staffing that provides a basis for each of the committee's recommendations. This reviewer was not provided any case files that required the case manager to prepare review summary prior to a judicial hearing.

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

This program has a policy in place that requires each youth record to be maintained in a neat and orderly manner and marked confidential. This reviewer observed a total of twelve (12) case files, six (6) of which were closed. All but four (4) closed files were properly marked "confidential"; those (4) were non-residential and case staffing files and the materials were generally loose in a single pocket file. The closed non-residential and the closed case staffing files were not marked "confidential". There were also two case staffing files that were not in a folder, but merely held together with a binder clip. This reviewer would recommend a cover for the 'no-show' case staffing files and a confidential marker on all closed files. However, because the materials are stored in a locked room with access only to staff, the program is meeting the requirements of this indicator.

Standard 3: Shelter Care

Overview

Rating Narrative

The residential shelter is co-located with the agency's non-residential counseling staff. These offices are located adjacent to the residential shelter so that all staff members have easy access to the residential facility to provide counseling, supervision and other support services. The program has access to the licensed mental health therapist to respond to youth with service mental health issue and to provide consultation and support to direct care staff members. The BEACH House youth shelter serves both CINS/FINS and DCF referral populations in the residential environment. The youth shelter provides services residential services twenty-four hours a day, 365 days per year. The youth shelter operates 3 work shifts and is staffed with both male and female staff members on each shift. The shelter is not a staff secure facility, however; accept CINS/FINS and Domestic Violence youth. At the time of the review the shelter had seven CINS/FINS youth.

3.01 Shelter Environment

Satisfactory

Limited

Failed

Rating Narrative

The Disaster Plan was reviewed and all protocol appears to be in compliance with regulations. The Annual Fire Inspection was also reviewed and dated 7/2/14. Beach House is in compliance with fire drills. They appear to complete at least two per month. Beach House appears to complete at least one mock emergency drill per quarter. Knife for live is placed in the facility and in the vans. A fire and safety inspection was completed on 7/2/14 by Lloyd E. LaLonde with no concerns. Beach House received a satisfactory report from the Dept. of Health Food Service on 8/8/14. For Facility and Site Inspection Beach House has a DCF Child Care License displayed in the front entrance of the facility. I found no concerns with the cleanliness of the facility. All doors were secure at the facility. The facility had multiple laminated sheets that described the layout of the building. All surveillance cameras appeared operational. No concerns with lighting in the facility No contraband was found in rooms, bathrooms or common areas. All areas of bathroom and shower appeared to be clean. MSDS sheets were reviewed and facility appeared to be in compliance. There was access to grievances if the youth needed them. There were daily activity schedules posted in more than one area.

3.02 Program Orientation

Satisfactory

Limited

Failed

Rating Narrative

In this section five files were reviewed to determine if SM Act was in compliance with Program Orientation. All five files documented the youth received an orientation upon admission to the shelter that met all requirements of the indicator. Orientation checklists were signed by the youth and staff.

3.03 Youth Room Assignment

Satisfactory

Limited

Failed

Rating Narrative

Reviewed five open files for alerts coming from the service plans and biopsychosocials. All alerts matched the alert board in the Beach House office. There were no concerns in this area.

The youth appeared to be placed in rooms according to gender, age, and suicide history.

3.04 Log Books

Satisfactory

Limited

Failed

Rating Narrative

Logbooks were reviewed and all staff signed the front of both logbooks reviewed. The correct highlights were put in place and it appears the staff are highlighting significant events. On 7/2/14 a female youth was Baker Acted. This documentation matched the program shift review sheets. The staff appear to be consistent with reviewing the logbook every shift. Assistant Program Director needs to be more consistent with reviewing the logbook

3.05 Behavior Management Strategies

Satisfactory

Limited

Failed

Rating Narrative

Reviewed the BMS and it appears to explain the system well. There are three motivational levels that appear to enhance positive behaviors and increase accountability. All consequences along with discipline appear to be fair. Youth are given specific examples of maladaptive behaviors. Self Evaluation Group is put in place for youth to self reflect how their day went. Spoke to a staff and they were aware of how the behavior management system works and how administrators monitored if it was consistently being implemented. Spoke to a youth as well and they knew all the levels and how staff distributed consequences.

3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

Rating Narrative

Program policy meets all staff/youth requirements. From reviewing the staff schedule SM Act appears to be within compliance. At times there was one staff scheduled but the program remained in staff/youth ratio. They also have well positioned surveillance cameras that observe the youth in house. Staff document every fifteen minutes the status of the youth in the building. It appears that SM Act meets all requirements and guidelines of staffing and supervision.

3.07 Special Populations

Satisfactory

Limited

Failed

Rating Narrative

Each of the youth admitted under the DVR program had documented domestic violence charges making them eligible for admission under the DVR program requirements. The service plans in each of the three files addressed the DVR placement issues such as anger management, conflict resolution, coping skills and decision making. All youth were transitioned out of the program before the end of the fourteen day time frame. The agency does not provide Staff Secure Shelter services.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The SMA agency provides screening, counseling and mental health assessment services. One BEACH House Counselor is a Licensed Mental Health Counselor (LMHC). The Stewart Marchman ACT agency has staff members that are trained to screen, assess and notify all staff members of conditions and risks of all youth admitted to both residential and non-residential CINS/FINS programs. The agency provides risk screening and identification methods to detect youth referred to their programs with mental health and health related risks. Specifically, the agency utilizes a screening form to determine eligibility and various screening methods to determine the presence of risks in the youth past mental health status, as well as their current status. The agency also screens for the presence for acute health issues and the agency's ability to address these existing health issues. The agency also uses a general alert board and colored dot system to inform all staff members on each shift of the health and mental health status of all youth in residential youth shelter.

The agency also assists in the delivery of medication to all youth admitted to the residential youth shelter. The agency operates a detailed medication distribution system. The agency designates certain staff to distribute medication. The agency provides medication distribution training to all direct care staff members, as well as, first aid response, CPR, fire safety, emergency drills and exercises, and training on suicide prevention, observation and intervention techniques. Agency staff members are also required to notify parents/guardians in the event that a resident has a health injury.

4.01 Healthcare Admission Screening

Satisfactory Limited Failed

Rating Narrative

The agency has a policy for Medical Services that addresses the requirements for this indicator. Upon admission to the shelter, Staff use the CINS/FINS Intake Assessment Form to screen youth for medical, mental health, and substance abuse concerns. The shelter also completes a Health History Addendum and Body Chart on each youth. The Health History Addendum includes a Tuberculosis Screening and a Lice Screening.

There were seven open youth files reviewed for Healthcare Admission Screening. In all seven files the CINS/FINS Intake Assessment Form was completed at admission, as well as, the Health History Addendum and Body Chart. One of the seven youth was on medications and they were listed as well as the reasons for the medications. None of the youth had any chronic medical conditions requiring follow-up medical appointments; however, the shelter does have procedures in place for referrals and follow-up medical care if needed. One youth did report having asthma; however, did not use an inhaler or any other medication and the parent reported no follow-up care was needed. One youth was on medication for a kidney issue, and another youth documented seasonal allergies.

4.02 Suicide Prevention

Satisfactory Limited Failed

Rating Narrative

The agency has a policy in place; however, what is in practice does not follow what is in policy. Policy meets the requirements of the Florida Network, practice needs to be revised to follow policy. Youth admitted to the program are screened for suicide risk using the CINS/FINS Intake Assessment and the EIDS. If the youth receive "hits" on these screenings, requiring a further assessment be completed, the youth are seen by the licensed counselor; however, no written suicide risk assessment is completed. The licensed counselor makes a clinical judgment as to whether or not the youth is to remain on suicide precautions or be placed on standard observation. The youth are required to sign a "no suicide contract" and are then cleared for admission. This meeting with the licensed counselor does not always occur within the required twenty-four hour time frame and is not always documented. The counselor completes an in-depth biopsychosocial on the youth that includes a suicide risk assessment section that meets the requirements outlined in the CINS/FINS manual; however, this biopsychosocial is usually completed after the required twenty-four time frame for the suicide assessment. A majority of the time the youth have already been removed from suicide precautions prior to the biopsychosocial being completed. There were also no thirty minute observations of the youth while waiting for this meeting with the licensed counselor, there were only the ten minute observations of the youth when placed in a room.

It is recommended that all staff be re-trained on your suicide prevention policy. It is also recommend the agency implement a suicide risk assessment instrument and this instrument be submitted to the Florida Network for approval.

4.03 Medications

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place for medication storage, access, and inventory. The shelter has a list of staff members that are designated to have access to medications. All medications in the shelter are stored in a separate office, in a locked cabinet, which is adjacent to the staff work station and is inaccessible to youth. Controlled Medications are stored in a locked box inside the locked cabinet. Oral medications are stored separately from topical medications. There were no injectable medications on site, or identified as needed for any youth during the time of the review. The shelter has a system in place for refrigeration of medication if needed, however there was no medication that required refrigeration during the time of review. Sharps are stored in a locked cabinet in the medication room and are inventoried weekly.

There were four closed files reviewed for medication administration. All four files documented the prescriptions were verified with the parent and the pharmacy. The shelter completes the Medication Sign In/Out Form, which documents all medications the youth is on, dosage, amount received, and is signed by the staff and parent. All four files contained the youth's Medication Distribution Record (MDR). These MDR's reviewed documented the youth's name, date of birth, any allergies, side effects of the medication, dosage, instructions, full signature of all staff giving medication, full signature of the youth, prescribing physician, and date medication was verified. Each MDR documented when the medication was given, staff initials, youth initials, and perpetual inventory with running balance. All four files documented the youth's medications were given as required.

All controlled medications are inventoried three times each day, on each shift, and also by maintaining a perpetual inventory. This was documented in the logbook and on the shift review forms. All other medications were inventoried weekly and by maintaining a running perpetual inventory. When the youth are released from the shelter the staff complete the Medication Sign In/Out Form, which documents all medications the youth was taking and how much is left of each medication. This form is signed by the staff and guardian upon returning the medication to the youth's guardian.

A review of staff training files revealed staff have been trained in the medication administration process.

The shelter has two CCC reports in the last six months relating to medication errors. Both incidents happened during the month of July 2014. Both instances involved a youth missing a dose of medication. The incidents involved two different staff members and there was documentation each staff member was re-trained on the medication administration policy and both received a verbal warning. The shelter also has implemented a dry erase board in the staff work station that documents each youth on medication and the time the youth is to receive the medication. There have been no further incidents relating to medication errors since July 2014.

4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written procedure to address the medical and mental health alert process for all youth admitted to the youth shelter. The shelter utilizes a large dry erase board located in the Youth Specialists' office and is concealed from plain view. The shelter uses a color coded alert system with each color identifying a different alert. The applicable color coded dots are placed next to the youth's name on the alert board. The colors used are: dark green for a suicide history; dark blue for mental health; orange for substance abuse; yellow with black dot for runaway behaviors; red for medical and allergies; pink for sexual issues; yellow for out of shelter; light green for no razors; and brown for no outings.

A review of six open youth files was conducted. All applicable alerts were documented in the youth's file and on the alert board in the staff office. All files also had a sticker on the front of the file checked "yes" for alerts. If the youth had any allergies then they were also documented on the front of the file. Alerts are also documented on the logbook and on the Shift Review Forms. These forms and logbook entries were reviewed to indicate staff were provided sufficient information and instructions regarding the youth's medical conditions, allergies and information to allow them to recognize and respond to the need for emergency care and treatment. Any dietary alerts were documented on a form hanging on the refrigerator in the kitchen.

4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy on Episodic/Emergency Care that meets the requirements of this indicator. A review of the Episodic/Emergency Care Log revealed there were no incidents logged since the last on-site review requiring first aid or emergency care. However, a review of incident reports for the last six months revealed there have been two instances in which first aid or emergency care was utilized. In one incident the youth was having breathing problems and 911 was called. The incident was documented on an incident; however, there was no documentation the youth's parent was notified. The shelter did provide documentation on the shift review meeting form that the youth's parent was notified. The second incident involved a youth running into a dumpster while playing basketball. The youth sustained a cut to his face and was later throwing up. The youth's parent was contacted and the youth was taken to the ER. The entire incident was documented on an incident report.

The shelter has adequate first aid kits, a knife for life, and a pair of wire cutters. The shelter conducts two medical drills each month, one on first shift and one on second shift. The drills cover an array of emergency medical situations. All staff have current CPR and first aid certifications.