



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of SM ACT Behavioral Health Center

on 10/03/2012

CINS/FINS Rating Profile

Standard 1: Management Accountability

1.01 Background Screening	Limited
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Satisfactory
1.05 Interagency Agreements and Outreach	Satisfactory
1.06 Disaster Planning	Satisfactory
1.07 Analyzing and Reporting Information	Satisfactory

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

Standard 2: Intervention and Case Management

2.01 Screening and Intake	Satisfactory
2.02 Psychosocial 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 3: Shelter Care

3.01 Youth Room Assignment	Satisfactory
3.02 Program Orientation	Satisfactory
3.03 Shelter Environment	Satisfactory
3.04 Log Books	Satisfactory
3.05 Daily Programming	Satisfactory
3.06 Behavior Management Strategies	Satisfactory
3.07 Behavior Interventions	Satisfactory
3.08 Staffing and Youth Supervision	Satisfactory
3.09 Staff Secure Shelter	Satisfactory

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

Standard 4: Mental Health/Health Services

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

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

Overall Rating Summary

Percent of indicators rated Satisfactory: 92.86%
Percent of indicators rated Limited: 7.14%
Percent of indicators rated Failed: 0.00%

Rating Definitions

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

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

Review Team

Members

Keith D Carr, Lead Consultant Forefront LLC

Siva Jeya- LSF SE

Susan Spinella- YCC

Persons Interviewed

- | | | |
|--|--------------------------|-------------------------|
| <input checked="" type="checkbox"/> Program Director | 3 Case Managers | 0 Maintenance Personnel |
| <input type="checkbox"/> DJJ Monitor | 1 Clinical Staff | 1 Program Supervisors |
| <input type="checkbox"/> DHA or designee | 0 Food Service Personnel | 2 Other |
| <input type="checkbox"/> DMHA or designee | 0 Health Care Staff | |

Documents Reviewed

- | | | |
|--|---|---|
| <input type="checkbox"/> Accreditation Reports | <input type="checkbox"/> Fire Prevention Plan | <input type="checkbox"/> Vehicle Inspection Reports |
| <input type="checkbox"/> Affidavit of Good Moral Character | <input type="checkbox"/> Grievance Process/Records | <input type="checkbox"/> Visitation Logs |
| <input type="checkbox"/> CCC Reports | <input type="checkbox"/> Key Control Log | <input type="checkbox"/> Youth Handbook |
| <input type="checkbox"/> Confinement Reports | <input type="checkbox"/> Logbooks | 0 Health Records |
| <input type="checkbox"/> Continuity of Operation Plan | <input type="checkbox"/> Medical and Mental Health Alerts | 0 MH/SA Records |
| <input type="checkbox"/> Contract Monitoring Reports | <input type="checkbox"/> PAR Reports | 0 Personnel Records |
| <input type="checkbox"/> Contract Scope of Services | <input type="checkbox"/> Precautionary Observation Logs | 0 Training Records/CORE |
| <input type="checkbox"/> Egress Plans | <input type="checkbox"/> Program Schedules | Youth Records (Closed) |
| <input type="checkbox"/> Escape Notification/Logs | <input type="checkbox"/> Sick Call Logs | Youth Records (Open) |
| <input type="checkbox"/> Exposure Control Plan | <input type="checkbox"/> Supplemental Contracts | Other |
| <input type="checkbox"/> Fire Drill Log | <input type="checkbox"/> Table of Organization | |
| <input type="checkbox"/> Fire Inspection Report | <input type="checkbox"/> Telephone Logs | |

Surveys

- 0 Youth 0 Direct Care Staff 0 Other

Observations During Review

- | | | |
|--|---|---|
| <input type="checkbox"/> Admissions | <input type="checkbox"/> Posting of Abuse Hotline | <input type="checkbox"/> Staff Supervision of Youth |
| <input type="checkbox"/> Confinement | <input type="checkbox"/> Program Activities | <input type="checkbox"/> Tool Inventory and Storage |
| <input type="checkbox"/> Facility and Grounds | <input type="checkbox"/> Recreation | <input type="checkbox"/> Toxic Item Inventory and Storage |
| <input type="checkbox"/> First Aid Kit(s) | <input type="checkbox"/> Searches | <input type="checkbox"/> Transition/Exit Conferences |
| <input type="checkbox"/> Group | <input type="checkbox"/> Security Video Tapes | <input type="checkbox"/> Treatment Team Meetings |
| <input type="checkbox"/> Meals | <input type="checkbox"/> Sick Call | <input type="checkbox"/> Use of Mechanical Restraints |
| <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 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

The Stewart Marchman ACT Behavioral Healthcare agency has begun the process to transition to the use of electronic medical records in its programs. In addition, the agency reports that it has been operating "New Start" a substance abuse prevention work shop with clients with serious substance abuse issues. The agency reports that it is a participating member in the local AlliTeen organization. The agency also reports that it has recently completed a 5K run fundraising event for its programs.

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 Program Director Juvenile Justice Programs, an Assistant Program Director, two Residential Shift Managers, one Non-Residential Shift Manager, two Residential Shift Managers, two Counselors and one Case Manager, eight Youth Specialist and an Administrative Assistant. The Program Director reports to the Vice-President of Juvenile 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

The agency has a current policy in place with regards to Background Screening requirements. The current policy has the components required to meet the minimum requirements of this indicator. The agency completed and submitted the Annual Affidavit of Compliance with Level II Screening Standards to the Department of Juvenile Justice's (DJJ) Background Screening Unit. The Affidavit was sent before the annual January 31st deadline.

The reviewer assigned to this indicator reviewed three (3) new hire screenings and two (2) were screened through DJJ before hire date. This review also reviewed 3 interns/volunteer files and found these files were all screened before their start date. Further, the review assessed 2 five year rescreening files that were completed according to the requirement of the DJJ screening policy. There were screened before their five year anniversary date.

One new hire screening was only screened through the Department of Children and Family's screening process. The staff member's date of hire was January 20, 2012 and her DJJ screening date was completed on September 28, 2012.

1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

Rating Narrative

The agency has a detailed policy that addresses the requirements for this indicator. The agency has posted the Florida Abuse Hotline number at various locations throughout the facility. The agency's orientation process requires residents to be informed about their ability to report all cases of abuse during program orientation process. Residents are also provided the information in writing in the Resident Handbook.

All staff member receives a copy of the Stewart Marchman ACT Behavioral Healthcare employee handbook. In addition, the agency has a detailed Code of Ethical Conduct section included in the employee handbook that list a detailed section that specifically acts as a guide for all employees to follow in delivering professional services to SMA to any clients receiving services in any of its programs.

The agency has not had to impose any formal or documented discipline towards staff for any incidents related to abuse, immoral, unethical or illegal behavior or actions.

A total of six (6) youth surveys were conducted during this onsite QI review. Youth surveyed reported that there were no incidents of major abuse or punishment. However, youth survey responses indicate that two (2) youth indicate that they were sent to their room for punishment

with the door open.

A total of thirteen (13) Grievances were documented. Of these, a total of three (3) grievances document residents experiencing negative comments and interactions with specific staff members. One staff member is mentioned in several grievances. Further, several youth stated dissatisfaction with the current Behavior Management System. All 6 youth surveyed said they feel safe in the program and have never heard staff threaten them or other youth; five (5) youth stated that they have heard staff use profanity/inappropriate language; and none said they have been stopped from reporting abuse. Three (3) youth state that they have not been instructed on what to do in case of fire.

One (1) youth rated that the mental health and substances abuse services and grievance processes Fair. All staff agreed the working conditions are adequate at the program.

An interview with the Residential Supervisor regarding the survey findings and other related staff behavior, client/youth actions that may have impacted the safety and security of the shelter Environment was conducted.

There were no reported DJJ-Central Communications Center (CCC) incidents documented in over a year. A total of sixteen (16) reported internal occurrences were documented.

The agency utilizes a formal SMA Employee Performance Notice to document below satisfactory work performance. This policy uses a multi-step process that consists of Verbal Reprimand, Written Reprimand, Recommendation for Probation and/or Suspension and Recommendation for Termination. This administrative process lists the Areas of Performance Concern that include Knowledge of Work, Volume of Work, Quality of Work, Dependability, Attitude and Work Habits. A review of one (1) agency response to Employees work performance was reported by the agency due to Quality of Work related to the accuracy, completion and timely submission of Biopsychosocials and Treatment Plans. The agency management action took place on September 18, 2012. The agency report documents Objectives and Solutions submitted by the agency for the staff member to follow. There were no documented disciplinary action notices submitted by the agency related to any other staff members at this time.

1.03 Incident Reporting

Satisfactory Limited Failed

Rating Narrative

The agency has a policy on the provision of Reporting for staff members that require reporting of all reportable incidents. There is a specific policy and procedure in place for this Incident Reporting indicator. At the time of this review, there were no incidents documented as reported by the agency since March of 2011. There were a total of sixteen (16) internal incidents recorded.

A review of medication practice revealed that the agency had not reported 2 medication distribution related incidents. These two (2) unreported incidents were CCC reportable, but were documented in the agency's internal incident reports. The review team advised the agency to report the incidents. The agency reported the 2 incidents to the DJJ CCC during the onsite review. The agency should review DJJ Policy 63-F 11.004 (j) Health or Mental Health/Substance Abuse Services Complaint: (3) Omitted medications. Further, it was recommended that the agency update their internal reporting procedures and specify mandatory reporting of incidents that meet CCC reporting requirements.

1.04 Training Requirements

Satisfactory Limited Failed

Rating Narrative

The agency has a policy on that meets the requirements for the 1.04 training standard. The reviewer received five (5) first year training files. Of these three (3) files, did not have hours completed to meet first year employee training requirements. Two (2) of these 3 have already completed their eighty (80) hours. The 2 files that have already made their hour have until January to complete their required training. The third file still has time to complete the required training hours prior their anniversary date.

This reviewer conducted reviews on three (3) staff files that had their annual training completed. Two (2) staff member's training files documents indicate that staff had taken forty hour New Hire Orientation training twice, once in April 2012 and once in June 2012. If the second New Hire Orientation training is subtracted from his total hours then that resulted in only 75 hours completed by this staff member. One on-going staff member's file indicate that they completed 104.25 training hours. Two files are missing training topics that include Sign and Symptoms of Mental Health, Substance Abuse, Universal Precautions and Cultural Competency. Another training file is missing CPR and Fire Safety Equipment training.

1.05 Interagency Agreements and Outreach

Satisfactory Limited Failed

Rating Narrative

The agency has a policy for Interagency Agreements and Outreach that address the general requirements for this indicator. The agency policy was reviewed onsite by the QI team members assigned to this indicator. The agency's approach to meeting the requirements of this indicator is very descriptive and includes specific goals and objectives. The policy was last reviewed by SMA-Beach House Administration in July 2012. It appears that the policy meets DJJ inter-agency requirements with the exception that NetMis Data entry for Outreach Activities is not included.

The agency does not enter outreach activities in NetMIS as per Heather Prince, SMA Program Director. However, the agency maintains an excel spreadsheet of outreach activities. Agency staff members provided the reviewer with a detailed listing of activities from February 21, 2011 through present. Additionally, the outreach staff provided the reviewer with the minutes from the Adolescent Advisory Committee. The Adolescent Advisory Committee is an inter-active workgroup that includes representation by Chief Probation Officer David Kerr.

A sample of agency agreements was conducted by the reviewer. The review agency agreements included: Volusia Schools/Alternative Education; New Start; Outward Bound; Medallion Healthcare and the Domestic Abuse Council. Each agreement was last updated in September 2012. The Bay View Urgent Care agreement was also reviewed. This agreement expired April 10, 2010.

The review of this indicator also included a review of the Community Involvement documentation file. Agency is active with the local Juvenile Justice council; One Voice for Volusia; School Advisory Council meetings and multiple youth focused community events. These community participation events are documented in a binder dedicated to tracking agency/outreach related data.

The agency has a policy for Interagency Agreements and Outreach. The agency policy was reviewed. It is very descriptive and includes specific goals and objectives. The policy was reviewed by SMA-Beach House in July 2012. It appears that the policy meets DJJ inter-agency requirements with the exception that NetMis Data entry for Outreach Activities is not included.

The agency does not enter outreach activities in NetMis as per Heather Prince. However, they maintain an excel spreadsheet of activities. Program staff provided the reviewer with a detailed listing of activities from 2/21/2011 thru present.

Also, the Outreach Staff provided the reviewer with the minutes from the Adolescent Advisory Committee. This is an inter-active workgroup that includes representation by Chief Probation Officer David Kerr.

A sample review was completed of agency agreements. The review included: Volusia Schools/Alternative Education; New Start; Outward Bound; Medallion Healthcare and the Domestic Abuse Council. Each agreement was updated in September 2012. The Bay View Urgent Care agreement was also reviewed. This expired 4/10/10.

Review included the Community Involvement documentation file. Agency is active with the local Juvenile Justice council; One Voice for Volusia; School Advisory Council meetings and multiple youth focused community events. These are documented in a binder dedicated to tracking agency/outreach related data.

1.06 Disaster Planning

Satisfactory

Limited

Failed

Rating Narrative

At the time the review, the agency has a policy that addresses the basic requirements for the Disaster Planning indicator. The agency Emergency Management Plan was assessed onsite by the reviewer assigned to this indicator. The agency's policy related to this standard was revised in May 2012. The agency's plan designates a staff member (Ann Turley) as an Emergency Management Coordinator who provides oversight and direction designated at present.

In addition, the Disaster Plan was reviewed by the Volusia County Fire Safety Management unit. The agency provided a letter dated July 7, 2012 approving the plan with no recommendations. Also, on July 9, 2012 an inspection was completed by the Volusia Fire Management. No findings or recommendations were reported by the entity.

Specifically, Sunshine State Sprinklers completed an inspection of operation of the facility sprinkler system was conducted on June 25, 2012. The overhead hood located in the kitchen was inspected and cleaned on May 01, 2012. The Disaster Plan includes an Emergency Management Drill Schedule. The schedule for the past six (6) months was reviewed onsite. The reviewer also inspected the emergency supply kits listed on the Disaster Plan to ensure that these kits were prepared as documented by the agency. These emergency kits contained the items as described in the plan.

The Disaster Plan also lists "Special Needs" rooms. These rooms are defined in the Disaster Plan for both male and female clients. The plan states that the alarms in these rooms are to be inspected monthly. The agency records document that the agency is compliant with this monthly requirement.

The agency has a policy for Disaster Planning and Events. The agency Emergency Management Plan was reviewed. This was revised in May 2012. The plan designates an Emergency Management Coordinator who provides oversight and direction: (Ann Turley) designated at present.

In addition, the Disaster Plan was reviewed by the Volusia county Fire Safety Management unit. They provided a letter dated July 7, 2012 approving the plan with not recommendations. Also, on July 9, 2012 an inspection was completed by Volusia Fire Management. No findings or recommendations.

Sunshine State Sprinklers completed an inspection of the facility on June 25, 2012.

On May 01, 2012 the Kitchen Hood was cleaned and inspected.

The Disaster Plan includes an Emergency Management Drill Schedule. The completed schedule was reviewed.

The Supply Kits included in the Disaster Plan were observed. These contained the items as described in the plan.

"Special Needs" rooms are defined in the Disaster Plan for Male and Female clients. Alarms in these rooms will be inspected monthly. Compliant.

The agency Policy and Procedure Manual was reviewed. This includes the process and situation for Florida Network notification. **The process for network notification is NOT included in the Emergency Management Plan. It is recommended this process be included in the Disaster Plan.**

Review of the Disaster Policy defines step by step process for evacuation. The evacuation site is identified in the Policy and Procedure Manual.

The agency Policy and Procedure Manual was reviewed. This includes the process and situation for Florida Network notification. At the time of this onsite QI review, the process for notifying the Florida Network state office is not included in the current Emergency Management Plan. It is recommended that this process be included in the Disaster Plan. Review of the Disaster Policy defines step by step process for evacuation. The evacuation site is identified in the agency's policy and procedure manual.

The process for network notification is NOT included in the Emergency Management Plan. It is recommended this process be included in the Disaster Plan.

1.07 Analyzing and Reporting Information

Satisfactory Limited Failed

Rating Narrative

A protocol is in place which states that monthly reports of CINS/FINS occurrences/incidents are brought to monthly Quality Improvement Committee (QIC) meetings for assessment of risk, analysis of trends, and ways to prevent problematic incidents from repetitive events. The procedure includes monthly review of NetMIS data reports, quarterly case record review reports, quarterly review of incidents, accidents, client grievances, annual review of customer satisfaction data, and an annual review of outcome data.

At the time of this onsite Quality Improvement (QI) program review, the agency currently conducts the following activities:

- At BEACH House, QIC issues are discussed in monthly staff meetings, where agenda and minutes reflect that QI topics are presented and reviewed.
- Grievance forms are available to clients, as observed in common area, and completed ones are collected by staff and addressed. The completed forms reflect action taken and final outcomes. More than half of the grievances pertain to areas that are not actual grievance items; for example – complaint of no dessert, being changed to another level based on behavior.
- Customer satisfaction surveys are kept in a binder by month, and are reviewed at the monthly meetings and reflected in the meeting minutes.

The aforementioned activities pertain to BEACH House specifically. There are many more agency-wide Performance Improvement procedures in place. This review team member had the opportunity to meet with Diane King, Clinical Compliance Director and Jennifer Lipman, Compliance Specialist. The measures that are initiated by the agency-wide performance/compliance departments include the following:

- Peer Review is completed quarterly on clinical areas of shelter and non-residential CINS/FINS program files. The shelter has a daily file review by Brian, and CINS/FINS non-residential files are reviewed monthly by Heather.
- Performance measures of Client Satisfaction Survey of both clients and families were tracked for month of August and results compiled.
- There are monthly Risk Review meetings where Incident Reports and trends are reviewed and assessed.

- The Board of Directors plays a very active role in the review of processes and measuring data.

The agency's is currently accredited by Commission on Accreditation of Rehabilitation Facilities (CARF) was documented by a three-year accreditation certificate that is valid through August of 2013. Licensure with DCF is also current and is documented by an approved licensure certificate that is valid through July 2013.

A protocol is in place which states that monthly reports of CINS/FINS occurrences/incidents are brought to monthly QIC meetings for assessment of risk, analysis of trends, and ways to prevent same occurrences from being repeated. The procedure includes monthly review of NetMIS data reports, quarterly case record review reports, quarterly review of incidents, accidents, and grievances, annual review of customer satisfaction data, and an annual review of outcome data.

In practice:

- At BEACH House, QIC issues are discussed in monthly staff meetings, where agenda and minutes reflect that QI topics are presented and reviewed.
- Grievance forms are available to clients, as observed in common area, and completed ones are collected by staff and addressed. The completed forms reflect action taken and final outcomes. More than half of the grievances pertain to areas that are not actual grievance items; for example – complaint of no dessert, being changed to another level based on behavior.
- Customer satisfaction surveys are kept in a binder by month, and are reviewed at the monthly meetings and reflected in the meeting minutes.

The above pertains to BEACH House specifically. There are many more agency-wide Performance Improvement procedures in place. This writer had the opportunity to meet with Diane King, Clinical Compliance Director, and Jennifer Lipman, Compliance Specialist. The measures that are initiated by the agency-wide performance/compliance departments include the following:

- Peer Review is completed quarterly on clinical areas of shelter and non-residential CINS/FINS program files. The shelter has a daily file review by Brian, and CINS/FINS non-residential files are reviewed monthly by Heather.
- Performance measures of Client Satisfaction Survey of both clients and families were tracked for month of August and results compiled.
- There are monthly Risk Review meetings where Incident Reports and trends are reviewed and assessed.
- The Board of Directors plays a very active role in the review of processes and measuring data.

Accreditation: Current Accreditation by CARF was documented by a three-year accreditation certificate that is valid through August of 2013. Licensure with DCF is also current, documented by certificate that is valid through July 2013.

References – Policy and Procedure Manual for CINS/FINS, Florida Network of Youth and Family Services, Policy 6.01 (2012)

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, a part time Beach House Counselor, and three (3) CINS/FINS Service Managers. According to the agency's organizational chart, these services are delivered through is non-residential staff members.

Non-residential services are provided to program participants and their families. The SMA non-residential staff has served a caseload of seventy-eight (78) non-residential clients over the past six (6) months. The non-residential staff are currently serving a caseload of twenty-four (24) youth 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. The program participants receive program orientation materials upon their initial entry to the program. Program information provided to youth and parent/guardians includes confidentiality notices, release of information, service options and other orientation materials. In addition, participants are provided with information related to intake and grievance procedures.

2.01 Screening and Intake

Satisfactory Limited Failed

Rating Narrative

The agency has a policy for Intake and Screening of youth seeking shelter and services that address the general requirements for this indicator. The agency policy was reviewed onsite by the QI team member assigned to this indicator. This includes being accessible twenty-four hours, seven days a week.

A total of six (6) youth files were reviewed to determine the agency's adherence to this indicator. Items reviewed included:

- Eligibility screening within seven (7) calendar days of referral;
- Documentation in writing of Available Service Options, receipt of Rights and Responsibilities of Youth and Parents/Guardians, as well as the service brochure
- Possible Actions occurring through involvement with CINS/FINS services and Grievance Procedures.

Of the 6 files reviewed, all data and documentation required was present. Each file reviewed consistently met the requirements of this indicator.

The program has a process for Intake and Screening of youth seeking shelter and services. This includes being accessible twenty-four hours, seven days a week.

Six (6) youth files were reviewed. Items reviewed included:

- Eligibility screening w/ 7 calendar days of referral
- Documentation in writing of Available Service Option, Rights and Responsibilities of Youth and Parents/Guardians. Parent/Guardian Brochure receipt,

In Addition:

- The following information was made available: Possible Actions occurring through involvement with CINS/FINS services and Grievance Procedures

Of the 6 files reviewed, each file was consistently maintained with data and documentation that was reviewed.

No recommendations.

2.02 Psychosocial Assessment

Satisfactory Limited Failed

Rating Narrative

The agency has a policy that addresses the requirements of the Psycho-social assessment indicator. A sample of six (6) residential and eight (8) non-residential client files were reviewed to assess the agency's adherence to this standard. All residential psycho-social assessments were initiated the same day as the admission. Of the non-residential client files, all were initiated within during the initial intake session with the client and family. All staff members completing psycho-social assessment possessed Bachelor degrees. All client files review contained supervisory reviews as required. A case referred for suicide risk was initial seen and all documented paperwork indicates that it was completed by a Bachelors level counselor. The suicide assessment and other related documents are reviewed the agency's licensed clinician.

Six residential and eight non-residential files were reviewed. The psychosocial assessments in all the files were initiated the same day as the intake and completed within seventy two hours for the residential and within two to three face-to-face contacts after the initial intake. All the psychosocials were completed by a Bachelor's or Master's level staff and signed off by a supervisor. None included a suicide risk and follow-up was unrequired.

2.03 Case/Service Plan

Satisfactory Limited Failed

Rating Narrative

The agency policy for this indicator Case/Service Plan was reviewed onsite and contains all general components to indicate that is meets the requirements for this indicator. A sample of six (6) non-residential and four (4) residential was selected to determine if the agency's practice of service delivery in this area was acceptable. All case contained documentation to indicate that they were developed within seven (7) working days or less of the initiation of the assessment. A review of the case/service plan for each file revealed that all contained evidence of the following:

- Date plan was initiated;
- Individualized goals identified by the screening and assessment process;
- Frequency of the assigned intervention;
- Location where the intervention or goal will be primarily addressed;
- Target dates for completion;
- Signature of youth and parent/guardian ;
- Signature of assigned counselor and supervisor; and
- Plan/Progress reviews and signatures of all parties at 30, 60, and 90 day intervals

One (1) out of the 10 client cases did not contain evidence of the required 30 day plan reviews with required signatures.

Six residential and eight non-residential files were reviewed. The program met all the requirements of the standard. All service plans were completed within the required time frame and had the necessary signatures. All of the service plans has target dates and completion dates listed if the goals had been achieved. Required 30 day reviews are in place for the non-residential files when appropriate.

2.04 Case Management and Service Delivery

Satisfactory Limited Failed

Rating Narrative

The agency policy for this indicator Case Management and Service Delivery was reviewed onsite and contains all general components to indicate that is meets the requirements for this indicator. A sample of six (6) non-residential and four (4) residential was selected to determine if the agency's practice of service delivery in this area was acceptable. In all as counselor is assigned. Where applicable the agency determines is a referral is needed and completes the process to execute a referral to services based upon the identified need that was determined through the completion of the assessment process. Client cases reviewed indicate that the Counselor coordinates the service plan implementation and monitors the youth's and family's progress while in services. None of the cases reviewed required out of home services or other/additional outside treatment at another facility. No referrals to case staffing committee were applicable in this sample of cases reviewed.

The program met all requirements of the indicator with exception. All files were assigned a counselor and all requirements of the indicator were met. The assigned counselor completes and implements the service plan by monitoring the youth and family by phone and/or face-to-face visits. In certain instances multiple referrals were being made for the client. The counselors play an active role during the life of a case, providing

support to the parents as well as arranging additional services as and when necessary. Also, groups as being conducted at the non-residential facility 5 times a week. There is also a case staffing committee in place along with a well documented Case Staffing binder. Six residential and eight non-residential files reviewed.

In one instance, a non-residential case file was missing progress notes but the therapist was able to produce it when asked for them.

2.05 Counseling Services

Satisfactory Limited Failed

Rating Narrative

The agency policy for this indicator Counseling Services was reviewed onsite and contains all general components to indicate that it meets the requirements for this indicator. A sample of five (5) non-residential and five (5) residential was selected to determine if the agency's practice of service delivery in this area was acceptable. All cases indicated that clients received counseling services that are consistent with the client's case/service plan. Three (3) out of the five (5) residential cases contained limited and sparse notes. Of these 3 cases, notes indicate one call to the parent. The second case has very sparse notes with no follow up call to or with the parent. The last case has no notes to indicate follow up calls to the parent had occurred to date. These cases were recent admissions to the residential shelter. All residential cases have evidence that groups are being conducted as required by this indicator. Some documentation is late in the process of service delivery coming 4-5 prior to the case being closed. The agency must clearly document contact with parents/guardians, including case updates, family sessions and other outside referral contacts. Session notes are brief and contain sparse documentation effort by staff.

All the files had good documentation and detailed notes on the youth and the services being offered to the families. The counselors provide individual and family counseling as and when needed however, there is a lack of family sessions being conducted at the non-residential facility. As per the program director, the youth are at the site for such a short time (maximum 10 days) and hence it is a challenge. Recommended documenting that parents are in fact being telephoned in an attempt to schedule the family sessions. Group sessions are being conducted 5 days a week for the residential youth. Presenting issues were consistently documented from screening and carries through the psychosocial assessment, service plan, counseling notes, and discharge plan.

2.06 Adjudication/Petition Process

Satisfactory Limited Failed

Rating Narrative

The agency policy for this indicator Adjudication/Petition Process was reviewed onsite and contains all general components to indicate that it meets the requirements for this indicator. A sample of six (4) non-residential cases were selected to determine if the agency's practice of service delivery in this area was acceptable. In the case selected a combination of parent, therapist and school officials were identified as the person initiating the case staffing. A review of the Adjudication/Petition Process for each file revealed that five (5) out of the 6 files reviewed contained evidence of the following:

- Review of files indicates that once the case was initiated, the staffing was held in seven (7) days or less;
- Notification to the family and of Case Staff committee members occurred in no less than 5 days;
- Evidence of that official Case Staff committee members were included is documented;
- Family is provided a new or revised plan for services;
- Written report of the Case Staffing is provided to the family within 7 days or less; and
- Written reports contains and outlines reasons for the recommendations;

In general, the program has an establish practice that documents that each Case Staffing committee process, and has consistent and ongoing communication with each member. The agency sends notices to family via certified mail to ensure that family receives the case staffing information. Additionally, the agency has processes to ensure that the case staffing process includes a consistent committee meeting schedule. None of the cases required addition court intervention with the circuit court.

There is a formal procedure in place that ensures case staffing meetings are being held when requested by the parent or is recommended by the program. The policy includes a core case staffing committee including a DJJ attorney and school board representative. Meetings are scheduled monthly or based on an emergency situation. There is also a separate binder in which notifications, agenda, sign-in sheets, case staffing report, and other relevant information are kept.

Two case staffing files were reviewed and both cases had been staffed twice, once in June and again in September. One file was missing the notification letter for the parent for when they staffed it the first time but there was a notification letter for the second staffing. Also, they court documentation in the file was not the most current version, there were signatures missing and probably best to have the most current legal documents in file. At the end of the staffing most recent staffing, a list of the recommendations were made for the parents and it was signed off by all the participants. Service plans were also revised and add to the youth files. Counselors also prepared a summary of the case with the CINS/FINS petition prior to the court hearing.

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

At the time the review, the agency has a policy that addresses the basic requirements for the Youth Record indicator. Agency protocol for maintain, storing and completing youth files was assessed onsite by the reviewer assigned to this indicator. The program has a process for maintaining records in a confidential secure location. This was confirmed upon review of the following items:

- Files cabinets for youth that have exited the program are maintained in the office of Assistant Program Director. This area is secure and not accessible to the general public.
- File cabinets containing youth records are in locked cabinet files.
- Exterior of file cabinets is labeled as confidential
- Files contained within cabinet are each stamped "confidential" and allergies or alerts included on exterior. All files are stored in metal cabinets that are marked in alphabetical order.

Full inspections of the following youth files were reviewed:

File A: File stamped confidential; No allergies; Well organized; Intake 2/16/12 Discharge 2/17/12

File B: File stamped confidential; Allergy identified; Well organized; 2 separate admissions: Intake 11/16/10 Discharge 11/26/10 Intake 7/04/12 Discharge 7/22/12

File C: File stamped confidential; No allergies; Well organized; 2 separate admissions: Intake 3/10/12 Discharge 3/19/12 Intake 6/26/12 discharge 7/10/12.

File D: File stamped confidential; No allergies; Well organized; Intake 3/28/12 Discharge 4/7/12

File E: File stamped confidential; No allergies; Well organized; Intake 2/29/12 Discharge 3/9/12

File F: File stamped confidential; No allergies; Well organized: Intake 3/15/12 Discharge 3/24/12

In addition a review of current file storage practices were conducted. The aforementioned files are secured in the Medication Room. There is limited access to this room that requires a key for entry. Files are maintained in individual binders marked confidential with allergy alerts indicated boldly. Each current youth file (6) consistently met the requirements for this indicator.

The program has a process for maintaining records in a confidential secure location. This was confirmed upon review:

- Files cabinets for youth that have exited the program are maintained in the office of Paul Hatto. This area is secure and not accessible to the general public.
- File cabinets containing Youth Records are in locked cabinet files.
- Exterior of file cabinets is labeled as confidential
- Files contained within cabinet are each stamped "confidential" and allergies or alerts included on exterior. Maintained alphabetically in a consistent manner.

6 youth files were reviewed:

– File stamped confidential; No allergies; Well organized; Intake 2/16/12 Discharge 2/17/12

– File stamped confidential; Allergy identified; Well organized; 2 separate admissions: Intake 11/16/10 Discharge 11/26/10 Intake 7/04/12 Discharge 7/22/12

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– File stamped confidential; No allergies; Well organized; Intake 3/28/12 Discharge 4/7/12

– File stamped confidential; No allergies; Well organized; Intake 2/29/12 Discharge 3/9/12

– File stamped confidential; No allergies; Well organized: Intake 3/15/12 Discharge 3/24/12

Review included current file storage. These are stored in the Med Room. Access to this room requires a key. Files are maintained in individual binders marked confidential with allergy alerts indicated boldly. Each current youth file (6) consistently maintained.

Standard 3: Shelter Care

Overview

Rating Narrative

The SMA company has a residential component that earmarks a total of ten (10) CINS/FINS clients. According to the agency's organizational chart the BEACH House youth shelter staff consists of a Director of Juvenile Justice Services, a Assistant Program Director, two Residential Shift Managers, two Counselors and one Case Manager, eight Youth Specialist and an Administrative Assistant.

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 education services are provided through the Volusia County School District. All youth are screened for medical, mental health and substance abuse issues during the intake and admissions process. Youth that indicate a risk on any screenings are referred for further evaluation. The shelter staff members are responsible for youth medication duties, including administering the medication and maintaining the inventories. The youth's parents or guardians are responsible for transporting the youth to all appointments outside of the shelter. All of the staff members responding to the survey reported that the program's Behavior Management System is effective. Additionally, the program has an effective grievance process. Youth indicate on survey results that they feel safe in the shelter environment.

3.01 Youth Room Assignment

Satisfactory

Limited

Failed

Rating Narrative

An operational procedure is in place that thoroughly explains how room assignments are made for youth in program. The following items are considered by the agency during intake/assessment, in order to make the safest and most appropriate matches in assigning rooms to new clients:

- Physical characteristics such as size and weight
- Maturity level as well as chronological age – younger clients separated from older clients
- Level of aggression, attitude, perceived potential for bullying
- Potential susceptibility to victimization, based on history, disability, etc.
- Prior delinquency history, gang involvement, sexual misconduct
- Only youth of same sexes share rooms
- Assessment of potential for suicide – there is a room that is observable by staff for this purpose, and any other safety issues.

Bed assignments are made according to the same type of considerations as mentioned above, and includes the youth' status upon admission. The considerations that are used to make room assignments are very appropriate. Documentation of reasons for room/bed assignments are included in youth's chart and in the SAN's case notes portion of the file. In addition, security risks are also noted on youth board.

In addition, there is a notation in the Emergency Disaster Planning Manual that addresses client residents who may have physical disabilities that require special room requirements. For example, a visually impaired client may need minimal furniture for reducing risk of falling or bumping into items.

A strong awareness of bullying is present, with posters on walls in common areas that reflect the shared responsibility of prevention, protecting others, and notifying adults who can help.

Appropriate measures are taken when a child is at risk for suicide, not only in terms of a safe, observable room, but with alerts in place so that all shifts are made aware.

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Documentation of reasons for room/bed assignments is included in youth's chart, in SAN's note portion. Any security risks are also noted on youth board.

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Appropriate measures are taken when a child is at risk for suicide, not only in terms of a safe, observable room, but with alerts in place so that all shifts are made aware.

References – Policy and Procedure Manual for CINS/FINS, Florida Network of Youth and Family Services, Policy 4.01 (2012)

3.02 Program Orientation

Satisfactory
 Limited
 Failed

Rating Narrative

The agency's Policy and Procedure Manual states that during admission process that each youth receives an orientation to the program within 24 hours of admission. The agency Orientation process is completed by program staff, and includes the following:

- Introduction to staff and peers
- Fire procedures
- List of contraband items
- Program schedule
- Dress Code
- Explanation of client rights and responsibilities
- Explanation of grievance procedures and location of grievance forms
- Location of Florida Abuse Hotline phone number
- How to access medical care
- Services and follow-up available within program
- Visitation schedule
- Telephone and correspondence procedure

- Room Assignment
- Behavior Management Systems, rules, and consequences

Within the agency's procedural manual, it is noted that orientation also covers the fact that only verbal de-escalation techniques are used at BEACH House, with no physical intervention allowed. Orientation is documented in client files in the form of an orientation checklist, which appears in the consents portion of client file, and includes signatures of client and staff at bottom, and staff initials next to the content of each topic discussed at the orientation. In addition, there is a 23-page handout given to each client, which further explains each major topic covered in the orientation. It is noted by this reviewer that some of the language in this handout may be above the reading level of some clients. However, many definitions are provided in the handout, which certainly helps with program terminology.

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References – Policy and Procedure Manual for CINS/FINS, Florida Network of Youth and Family Services, Policy 4.01 (2012)

Recommendation made that language be consistent with reading level of children in program.

3.03 Shelter Environment

Satisfactory Limited Failed

Rating Narrative

Shelter environment is clean and organized. The shelter contains a Day Room, eight (8) single bedrooms (3 boys, 4, girls and 1 observation

room), two (2) large bathrooms, 1 large dining room, kitchen, lobby, Control room, medication room, 2 storage rooms and Supervisors office. The agency has a co-located office adjacent to the youth shelter that houses six (6) offices that service as the office for Director of Juvenile Justice Programs for SMA. This location houses all non-residential counselors and 1 court liaison. The shelter has adjacent green space on the perimeter of one side of the building and court space for basketball and other court games.

The youth shelter dorm areas are clean and free from visible graffiti. All occupied beds contain sufficient linens that are changed twice a week. Both male and female bathrooms include showers, stalls and basins that are clean and free of mold, mildew, dirt or grime. The commons areas are equipped with commercial style couches and chairs. The agency has recently updates several interior areas. Improvements include new couch and chair cushions in the Day room; newly painted walls in the kitchen and bed/dorm hallways; and new carpet was installed in the shelter on September 2012.

The agency has a total of two (2) first aid kits located in the residential youth shelter. One (1) first aid kit is located in the medication room and another is located in the Youth Care Work station area. Both first aid kits inspected in the youth shelter include all required contents. All contents in these first aid kits have expiration dates that have not expired. Agency uses a metal detection wand upon all admissions and when youth return from outings, home visits or runaway events. There are 2 additional first aid kits, one in each transportation van.

The agency provided evidence of inspection of safety equipment including fire extinguishers, sprinklers, alarm system and kitchen overhead hood suppression system.

All lighting in common areas, kitchen, dorm rooms, bath rooms, work stations, emergency lights and exterior lights are in working order at the time of this onsite program review.

The agency prepares all meals in the residential youth shelter. The food maintained in the refrigerator is stored and marked as required. At the time of this onsite review, all dry food storage clean and food is maintained as required.

Major Improvements:

- All cushions in the Day room are newly replaced
- Interiors painted kitchen and bed/dorm hallways
- Carpet was replaced in the shelter on September

First aid kits in vans had items that required updating. The camera surveillance back-up system indicates a file disk error which prevented viewing of recorded video tape to verify and confirm overnight bed check duties. A work order repair request was made regarding an inoperable camera to the company that installed 10/4/2012. During the facility tour the monitored observed that the dishwasher in the kitchen did not have a temperature gauge.

3.04 Log Books

Satisfactory Limited Failed

Rating Narrative

The agency has a detailed operational policy on Logbooks. The shelter utilizes a program log book to document all major events, activities and incidents that occur in the residential youth shelter. The current program log book is a medium sized bond volume that contains 304 pages.

The log book requires that after staff document their entries, that they use color highlighters according to specific activity/event. Major highlighted events include green indicated Shift Reviews; Yellow indicates Safety/Security/Concerns/Absconsions/Medical(including Medication Assistance)/Fire drills; Pink indicates staff have review the logbook; and orange indicates supplies are needed.

Staff members are required to print and sign their names on the first inset page of the logbook. Supervisors document their review of the logbook in Red ink. The agency documents medication distribution, outings, client counts, medication distribution, medication counts, shift exchange, review of last 2 program shifts, daily activity schedule, and shelter walk through for safety and precautionary security checks.

Monitor did not detect any white out, strike through and or spaces across three (3) logbooks covering a period of 03/18/2012-06/15/2012; 06/16/2012-09/15/2012 and 09/16/2012. Direct care staff consistently document that they have documented reading the previous 2 shifts.

Rating Narrative

Policy and Procedure Manual states that there is a daily schedule that is provided and adhered to by BEACH House staff members in order to provide structure and safety for youth in shelter, and to provide access to faith services for youth. The basic schedule includes time for life and social skills, counseling/therapy, homework, access to reading material, organized outdoor and indoor activities, appropriate TV viewing, plus time for individual phone and visitation. Structured time includes a minimum of an hour of physical activity per day. Basketball and other outdoor play is available, encouraged, and built into daily programming. Youth that are scheduled for individual or family therapy may attend those sessions without interference from scheduled group activities. Youth are encouraged, but not required, to participate in religious activities

while in shelter. Visitations from religious leaders are not subject to general limitations of visitation schedule, as it is recognized that religious leaders have minimal opportunities to make visits to the shelter.

Actual Program Schedules were reviewed, and appeared to have a good balance of highly structured time and time that is less structured. There is a Self-Evaluation Group each evening, for youth to reflect on events, behaviors, and challenges of the day. This is facilitated by a staff member, and all clients participate during the evenings that they are present at BEACH House. In addition, there is time allocated for creative expression, which appears to be an effective outlet for the clients, with many artistic items on the walls and in common areas. Reading during leisure time appears to be encouraged and valued by staff, which can be a positive model for future educational and leisure time pursuits.

Time that is totally unstructured is minimal, so that clients do not have too much idle time. Television time is also kept to a minimum. Each child has a copy of the weekly program schedule in his/her orientation handbook.

3.05 Daily Programming

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3.06 Behavior Management Strategies

Satisfactory Limited Failed

Rating Narrative

The Policy and Procedure Manual notes that a Behavior Management System based on the Social Learning Theory is utilized in the BEACH House facility. Behavior is viewed in terms of continuous reciprocal interaction between cognitive, behavioral, and environmental influences. Once again it is noted that the program is a no-touch program. There are different levels within the Behavior Management Program, which include:

- Orientation – the first level, for the first 24-hours
- VIP – as the acronym implies, it refers to Very Important Person, and is based on rewarding the performance of adaptive behaviors, and in such, earning points.
- SVIP – refers to Super VIP, and can be awarded after maintaining VIP status for five consecutive days. Residents are informed that when they achieve SVIP status, they are expected to be role models for other children in the shelter, and that they will take a leadership role with new residents, to help them become accustomed to the program.

Revocation of the VIP or SVIP status is handled in a non-punitive manner, and is staffed with a supervisor. Privileges are granted or lost depending on behavioral status. Indications from staff and documents show that these methods are successful, when combined with positive reinforcement and concurrent training in 'how to talk so that you will be listened to.' Consequences appear to be applied logically and appropriately to the violation.

Staff training reflects and reinforces the Behavior Management System that is in place at BEACH House. Interviews with staff confirm that appropriate staff training is occurring, and that program is effective,

The mentoring aspect of SVIP clients assisting new residents in acclimating to the shelter appears to be a positive approach for both new and SVIP residents. It has the potential to help the SVIP residents feel a sense of importance and belonging, and for the new residents to feel more at ease and welcomed.

Satisfaction Survey results (random samples) reflect consistency and lack of problems in this area. The only behavior management-related issues in grievances were simply complaints that level had been dropped, due to acknowledged behavioral infractions.

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References – Policy and Procedure Manual for CINS/FINS, Florida Network of Youth and Family Services, Policy 4.01 (2012)

3.07 Behavior Interventions

Satisfactory

Limited

Failed

Rating Narrative

Again, protocols indicate that behavioral interventions are utilized with the least amount of force necessary, and without violating the basic rights of clients. Verbal intervention only and never physical interventions are the methods in practice at BEACH House. Loss of privileges is the preferred method, and may include the following:

- Brief time outs
- Brief work assignments
- Taking points away
- Suspending privileges
- Program restriction*
- Drop in level
- Non-participation in outings

Privilege suspension never includes loss of sleep time, meals or snacks, clothing, access to school, legal assistance, health care, or faith services, or denial of contact with guardian. Group discipline is never a method imposed at BEACH House. If a youth is out of control or suicidal, they are not restricted to a regular room, but are closely monitored. *Although staff was interviewed, no one seemed clear on the program restriction portion of the Behavioral Intervention procedure, and they indicated that this was not currently in practice at BEACH House.

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*Although staff was interviewed, no one seemed clear on the program restriction portion of the Behavioral Intervention procedure, and they indicated that this was not currently in practice at BEACH House. It is recommended that this be removed from Policies and Procedures Manual, if not in use.

3.08 Staffing and Youth Supervision

Satisfactory Limited Failed

Rating Narrative

The agency has a policy for Staff and Youth Supervision that addresses the general requirements for this indicator. The agency policy was reviewed onsite by the QI team member assigned to this indicator. The program has a process for 15 minute observation checks of youth in the residential shelter. This onsite review included a check of staff members' ability to consistently conduct and document 15-Minute observation files. These are maintained individually in each youth's file binder.

A random sample of documented youth supervision checks were selected for review. The results from this review indicate that the times noted for checks are used for each log in the youth file. An interview with an overnight staff member revealed that the staff person completes that overnight supervision bed check of all residents in less than one minute bed check due to the size and layout of the residential shelter.

This indicator states that "there shall always be both male and female staff present" for agencies accepting both genders. The agency is compliant with this, however, the agency's policy and procedure manual does not define having both genders. It is recommended that this be updated.

Also, review included check of the "Staff Schedule" from the period of June 23, 2012 through October 5, 2012. The schedule indicates that both genders were consistently scheduled for the said period. The schedule is maintained in a binder. In addition, a minimum of two (2) staff members are regularly scheduled. The employee roster containing names and contact information is included in the "Shift Review" binder.

The reviewer met with Assistant Program Director to review camera surveillance video tape of "Bed Checks" from the camera system. At the time of this onsite QI review, the agency's camera surveillance system was not working accurately. During the time of review, a work order was issued and a technician arrived during the onsite review to make repairs. However, the work initiated by the not completed prior to exit. Therefore, the reviewer was unable to use recent camera video footage to verify and confirm that overnight bed checks are being conducted as documented by the agency.

The program has a process for 15 minute observation checks of youth in shelter. Review included checking of staff 15-Minute observation files. These are maintained individually in each youth's file binder.

It appears from sampling reviewed that all times noted for checks are used for each log in the youth file. Conversation with Brian Dye, Residential Shift Manager – he verbally confirmed that it takes less than one minute total to complete a bed check due to the size and layout of the shelter.

The 3/08 standard state "there shall always be both male and female staff present" this is for agencies accepting both genders. The agency is compliant with this, however, the Policy and Procedure Manual does not define having both genders. It is recommended that this be updated.

Also, review included check of the "Staff Schedule" from the period of 6/23/12 thru 10/5/12. Both genders were consistently scheduled for this timeframe. The schedule is maintained in a binder. In addition, a minimum of two (2) staff are regularly scheduled.

The employee roster containing names and contact information is included the in the "Shift Review" binder

Reviewer met with Paul Hatto to review "Bed Checks" from the camera system. The system was not working accurately. During the time of review, a work order was issued and a technician arrived to make repairs, however, not completed prior to exit. Unable to confirm bed checks via video.

3.09 Staff Secure Shelter

Satisfactory

Limited

Failed

Rating Narrative

This agency is not designated as a Staff Secure receiving facility.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The SMA agency provides screening, counseling and mental health assessment services. The agency has a Director or Juvenile Justice Programs, an Assistant Program Director, two (2) Residential Shift Managers, eight (8) Direct Care Staff, three (3) Counselors and an Administrative Assistant. 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 to distribute medication. The agency provides medication distribution training to all direct care staff members, first aid response, CPR, first aid, 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.

The agency has the benefit of a licensed mental health clinicians that consults with staff members, reviews youth with suicide and if necessary reviews mental health risks and suicide assessments. The agency has a full complement of staff members across all three (3) work shifts. Agency training files indicate that direct care staff members received annual crisis intervention, first aid, CPR, suicide prevention and medication distribution training.

4.01 Healthcare Admission Screening

Satisfactory Limited Failed

Rating Narrative

The agency has a policy on the Healthcare Admission Screening process for youth being admitted to the residential component of the SMA program. A review of the policy and procedure meets the requirements of this healthcare screening process. The reviewer for this indicator selected a sample of six (6) client files to assess the agency's Healthcare Admission Screening process. Of these files, all 6 health screenings reviewed were completed the same day as admission. The healthcare screening included current medications, existing, medical conditions, allergies, recent inquiries or illness and observations for illness injury, pain, physical distress, scars, tatoos, or other skin markings.

The review found that there were two (2) youth on the health screen that asks "is the client being treated for above marked conditions?" and answered "no" to that question. It states just below that question "if no, staff will make a referral to a primary care physician and document referral recommendations on SOAP notes." No feferrals were noted on SOAP notes. One (1) youth file reviewed onsite has an X for the question "is the client being treated for above conditions; vision problems were checked, but the physician's name was unknown.

4.02 Suicide Prevention

Satisfactory Limited Failed

Rating Narrative

The agency policy for the Suicide Prevention indicator was reviewed onsite and contains all general components to indicate that is meets the requirements for this indicator. A sample of ten (10) client case files (4 closed and 6 open) was selected to determine if the agency's practice of service delivery in this area was acceptable. Nine (9) out of ten (10) cases contain documentation that verifies that these cases were screened for suicide during the initial intake and screening process. Nine of the 10 files reviewed have evidence that suicide screening results were reviewed and signed by the supervisor. None of the cases were placed on close supervision watch that require. The agency policy require that all cases that require close watch supervision be referred to an outside source for further evaluation and monitoring.

The nonresidential utilize the CINS/FINS 6 questions method as their tool for screening for suicide while the residential uses the EIDS tool. Since the program does not have a licensed mental health professional, any youth that may have received a positive result of the screening is immediately referred out. As a result, this program does not have the need to conduct sight and sound or one-to-one supervision in terms of suicide prevention. However, it is recommended that since they have now hired a licensed mental health professionals, the program make use this skill and be proactive about suicide prevention.

One of the residential files was missing the EIDS and the counselor was unable to produce it. However she did check in the CINS/FINS intake that she completed the EIDS.

4.03 Medications

Satisfactory

Limited

Failed

Rating Narrative

The agency has a comprehensive policy on Medications that strictly follow the Florida Network Policy and Procedures Quality Improvement Standards. The standards are listed in the same exact sequence and include the same number of indicators per standard. This current policy is titled "Medications" and was approved by the Agency Director on July 2012.

The agency's policy contains content that addresses Medications in two (2) categories listed as Storage of Medication and Steps of Medication Distribution. In general these categories include storage, access, inventory, and distribution of medication in accordance with the DJJ Health Services Manual. A list of designated staff members was reviewed onsite. This Medication Distribution list is currently posted on the outside of the locked cabinet door.

Onsite observations found that all medications in the shelter are stored in a separate office that is adjacent to the youth work station. Youth must be granted access to the work station area in order to access the locked medication storage room. All medication was stored in a locked cabinet. Oral medications were found to be stored separately from topical medications. There were no injectable medications on site, or identified as needed for any youth during the time of the onsite 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. Controlled medications are locked in a cabinet behind two locks (cabinet and locked steel box).

At the time of this onsite review, there were one (1) CINS/FINS youth on Controlled medication. This youth's file was reviewed and found that all general documentation practices including youth's demographics, allergies, side effects, picture, staff/youth initials were documented. The current MDR does include the signature of the staff distributing the medication, but does not include a place for the printed names of staff distributing the medications. The agency maintains a Medication Distribution Binder that is kept in the medication room. The agency does provide over-the counter medication that includes seven (7) over the counter medications. The agency distributes Acetaminophen (Tylenol), Pepto Bismol, Tums Ultra, Ludens Cough Drops, DG Cough Drops, Allergy Pills, Tussin CF Cough/Cold. These medications are only given on an as needed basis during the resident's shelter. The current Weekly OTC Medication counts do not have a signature and or initials section on the weekly Count Form. The agency should add an area that confirms that an individual has signed off on this weekly log for tracking and accountability purposes.

The program utilizes Medication Distribution Record (MDR) that is based on the DJJ medication administration record (MAR). The MDR contained all the necessary information to include: youth's name (printed and signed), date of birth, allergies, side effects, picture of youth, staff and youth initials on MDR when medication is distributed and received by the youth. A review of six (6) client medication records were conducted that included two (2) current and three closed files. At the time of this onsite review, one (1) CINS/FINS client was on prescribed medication and another had received an over the counter medication (tylenol). The youth receiving prescribed medications had documentation that displayed that she did not receive her medication on October 1, 2012. This was documented in the agency occurrence report, but was not reported to the DJJ CCC. The monitor requested all internal occurrences dating back to April 2012. The agency had 1 additional documented occurrence report that indicated a missed medication. Both of these medication errors were reported to the DJJ CCC during the onsite QI review on October 3, 2012.

The agency Disposal Process requires that the shelter staff contact the SMA pharmacy of the medication needing disposal and staff will assure the delivery of the medication to the pharmacy with the medication count sheet, the pharmacist or pharmacist representative will count the medication and sign the Medication Sign/Out form as to the number of dropped off to them for disposal. Residential staff members are to then bring the Medication Sign In/Out form to the shelter for filing in the Medical Record.

A perpetual inventory with running balances was maintained for all medications. At the time of the review, there were no youth taking narcotic or controlled medications.

Sharps are maintained in a locked cabinet in the medication room. The sharps maintained at the shelter consisted of scissors, razors and finger nail cutters. Inventories on sharps are conducted on one time per week on the third shift. The agency provided the previous 6 month inventories dating back to April 2012 to September 14, 2012. Sharps maintained at the shelter consisted of 8 knives, 3 knife for life, 2 pill cutters, 1 large grilling fork, 13 scissors, 1 prong poker, 1 pizza cutter, 12 skewers and 2 peelers. The shelter maintained a daily count of the sharps once per week over the several months from April 2012 to present.

Further review on the agency policy revealed that the agency does not currently address Reporting medication errors or missed medication distribution as needing to be called into the DJJ CCC as a Complaint against Staff. Due to recent concerns regarding risks related to the distribution of medications, the FNYFS has deemed it necessary as of July 1, 2012 for all local CINS/FINS service providers to implement Medication verification procedures. At the time of this onsite review, the agency is not conducting verification of medication distribution as required by the DJJ CCC. The agency must revise its current policy to incorporate the agency's ability to verify all medications entering the residential youth shelter. The agency was advised onsite to review its current medication verification practices and update their policy and practice in the area to be able to meet this requirement.

The agency had Medication training that was provided by a Licensed Nurse Consultant with the DJJ Office of Health Services in February 2012. The training consisted of a review of the actual delivery and documentation process of medications. It also consists of a step by step outline on medication distribution as it is defined in the DJJ Health Service Manual. The nurse also provided training on recommended intake of

medications and verification process that is a requirement for all medications received.

The current Weekly Sharps Counts do not have a signature and or initials section on the weekly Count Form. The agency should add an area that confirms that an individual has signed off on this weekly log for tracking and accountability purposes. Additionally, the OTC Medication Counts do not have a signature and or initials section on the weekly Count Form.

The agency had a total of 2 documented internal incidents that indicated medical errors. These incidents had not been called in to the DJJ CCC as required by DJJ Policy 63-F 11.004 (j) Health or Mental Health/Substance Abuse Services Complaint: (3) Omitted medications. A review of the agency policy states that all medication occurrences (incidents/errors) are to be reported on a Medication Occurrence Report form and investigated by supervisory staff and reviewed by the Director or Nursing and Pharmacist. At the time of this onsite review, there was no initial written or documented follow up regarding the medication errors. During the onsite QI Review, on 10/04/2012 the agency completed a follow up Medication Occurrence Report Response for one of the incidents that occurred on October 1, 2012. At the time of this onsite QI Review, there was no evidence provided to the review team of the Medication Occurrence Report Response Form documented for the Medication dosage incident in September 2012.

Staff members name are not printed on the Medication Distribution Record.

4.04 Medical/Mental Health Alert Process

Satisfactory
 Limited
 Failed

Rating Narrative

The agency has a written procedure to address 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 with appropriate color coded dots to identify various medical/mental health conditions. The agency utilizes a color coded guide for the various conditions to maintain the youth's privacy and confidentiality. The colored dots used by the agency refer to dark green indicates a suicide history; dark blue indicates mental health; orange indicates substance abuse condition; yellow with black dot indicates runaway behaviors; red indicates medical and allergies; pink indicates medical allergies; yellow indicates out of shelter; light green indicates no razors; and brown indicates no outings.

A review of six (6) active CINS/FINS client files was conducted onsite. All client files reviewed contained the appropriate color coded dots which were documented on the dry erase board and the individual client case files. All alerts are posted in three (3) places: front of youth's chart; in the shift review binder and on the medical alert board in the Medication room. All allergies are posted in four (4) places: front of youth's chart; in a concealed vertical sleeve affixed to the front of the refrigerator; in the shift review binder; and on the medical alert board in the Medication room. Two (2) of the 6 open files did include alerts for each youth's respective allergies. Shift Review information forms and log book 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.

4.05 Episodic/Emergency Care

Satisfactory
 Limited
 Failed

Rating Narrative

The has a written policy on Episodic Emergency Care. A review of this policy by the reviewer was conducted and was found to meet the minium requirements for this indicator. The agency provided documentation that indicated that a total of four (4) episodic/emergency events within the last six (6) months. The information provided contained documentation in the logbook and client file that the parent/guardian were notified in three out of four cases. The one (1) incident where the parents were not notified did not contain evidence that the parents were contacted in the youth's client case file. This incident was listed in the logbook, but was documented in the program log book as a first aid incident related to a cut on the leg from shaving. Two (2) separate youth incident were reproted as trouble breathing and 911 was called. In both incidents the parents/guardians were notified and refused to transport youth to the Emergency Room. One youth was take to the Emergency Room and immediately discharged. The second youth was cleared by Emergency Medical Services and remained at the shelter.

The residential shelter has adequate first aid kits, a knife for life suicide prevention tool and a pair of wire cutters. The shelter conducts three (3)

emergency wire cutters. The shelter conducts three (3) per month. The Emergency drill schedule lists various emergency drills such as broken limbs, seizures, head wound, sprained ankle and other. A review of the agency's emergency drill form was conducted by the reviewer and it was recommended that the agency add a column and list what type of drill is being conducted.