Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Sarasota YMCA

on 01/16/2013

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 Interagency Agreements and Outreach	Satisfactory
1.06 Disaster Planning	Satisfactory
1.07 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 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/Petitiion Process	Satisfactory
2.07 Youth Records	Satisfactory

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

Standard 3: Shelter Care	
3.01 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	No rating

Percent of indicators rated Satisfactory:88.89%
Percent of indicators rated Limited:0.00%
Percent of indicators rated Failed:0.00%

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

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

Overall Rating Summary

Percent of indicators rated Satisfactory:96.43%
Percent of indicators rated Limited:0.00%
Percent of indicators rated Failed:0.00%

Rating Definitions

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

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

Review Team

Members

Keith Carr, Lead Reviewer, Forefront LLC/Florida Network of Youth and Family Services

DeEtt Bailey, Community Relations Specialist, Family Resources Inc.

Andrew Coble, Vice President of Prevention, Youth and Family Alternatives, Inc.

Shelia R. Woods, Prevention Specialist, Florida Department of Juvenile Justice

Tom Popadak, Training Director, Florida Network of Juvenile Justice

Persons Interviewed

- [x] Program Director
- [ ] DJJ Monitor
- [ ] DHA or designee
- [ ] DMHA or designee

4 Case Managers
3 Clinical Staff
0 Food Service Personnel
0 Health Care Staff

0 Maintenance Personnel
8 Program Supervisors
7 Other

Documents Reviewed

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

8 Health Records
7 MH/SA Records
9 Personnel Records
11 Training Records/CORE
8 Youth Records (Closed)
17 Youth Records (Open)
4 Other

Surveys

3 Youth | 6 Direct Care Staff | 0 Other

Observations During Review

- [x] Admissions
- [ ] Confinement
- [ ] Facility and Grounds
- [ ] First Aid Kit(s)
- [ ] Group
- [ ] Meals
- [ ] Medical Clinic
- [ ] Medication Administration
- [ ] Posting of Abuse Hotline
- [ ] Program Activities
- [ ] Recreation
- [ ] Searches
- [ ] Security Video Tapes
- [ ] Sick Call
- [ ] Social Skill Modeling by Staff
- [ ] Staff Interactions with Youth
- [ ] Staff Supervision of Youth
- [ ] Tool Inventory and Storage
- [ ] Toxic Item Inventory and Storage
- [ ] Transition/Exit Conferences
- [ ] Treatment Team Meetings
- [ ] Use of Mechanical Restraints
- [ ] Youth Movement and Counts

Comments

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

Strengths and Innovative Approaches

Rating Narrative

Sarasota Family YMCA is the local service provider of Child in Need of Services and Family in Need of Services (CINS/FINS) programs in the Southwest Florida region of State of Florida. The Sarasota YMCA agency has been in operation for more than 65 years. The agency's programs impact over 70,000 lives through four (4) fitness branches and offer more than fifty (50) youth and family development programs within 4 Counties.

The Sarasota YMCA CINS/FINS program serves both male and female youth between the ages of ten (10) to seventeen (17) years that are status offenders (locked out, runaway, ungovernable and/or truant, homeless, abuse, neglected, or at-risk). The program provides a full range of residential and non-residential services designed to maintain family structure, reduce truancy, as well as prevent and reduce the number of children that enter the Department of Juvenile Justice (DJJ) and the Department of Children and Families (DCF). Residential services provided include education, recreation, counseling, referrals, and behavior management components. The non-residential services program consist of individual and family counseling and case management services. The program is a designated Safe Place site. The Department of Children and Families has licensed the Sarasota YMCA Youth Shelter as a Child Caring Agency (CCA), with the current license in effect until May 2013.

At the time of this onsite review, the Sarasota YMCA has completed physical plant renovations to its dining hall, kitchen and added an expansive outside concrete pad for recreation. The agency has recently completed trainings in Core residential and non-residential topics and in medication during the 2012 training year. Other topics included Trauma Informed Care. The agency created a Quality Improvement Specialist in March 2012 to enhance the agency's overall Quality Assurance/Improvement efforts. Youth Shelter Program Director is Chair of a committee which is part of the local Human Trafficking Task Force.

The Sarasota YMCA is certified by the Council of Accreditation (COA). The Council on Accreditation (COA) partners with human service organizations worldwide to improve service delivery outcomes by developing, applying, and promoting accreditation standards. In addition, the agency participates in community involvement efforts by participating in Sarasota County stakeholders Coalition.

A local restaurant is very supportive of the Shelter and hosts several events to secure funds and resources that included:

- Hosting a pillow drive where 300 pillows were donated to the Shelter allowing for each child who is placed there with a new pillow that they take with them on discharge
- Halloween Pumpkin Carving Activity for Shelter Youth
- celebration free food to their customers, if they made a donation to the Shelter.
- Year long campaign to assist in the purchase of a new van for the Shelter
- Hosted a carnival

To acknowledge the new Safe Place logo, a back to school book fair was organized and held at the Berlin Branch of the YMCA. The local fair also offerred free school supplies to participants. Twenty-Five Community Agencies participated. A grant allows for the Safe Place Coordintor to present to students at all Middle Schools in Sarasota County schools to inform students on the program and other residential and non-residential services.

Standard 1: Management Accountability

Overview

Narrative

The Sarasota Family YMCA is governed by a Board of community volunteers that is comprised of approximately 15-25 community members who are dedicated to the advancement of the YMCA's mission to build strong kids, strong families, strong communities. A Metropolitan Board of Directors oversees the operations and strategic planning of the entire corporation. This board is comprised of chairpersons from the branch boards of management and community leaders. The Sarasota YMCA Board of Directors represents a vast cross section professions and industries.

John Halcomb, Executive Director oversees the youth and family programs and the services provided through its branches of services in Sarasota Florida service region. Additionally, the agency's organizational chart lists Nicole Hartsock, Residential Program Director and Sonia Santiago, LMHC as the Non-Residential Program Director/Clinical Services Director. The agency also includes Fern Ellenwood, Assistant Program Director, Charles Harris, Assistant Program Director and Karen Mersinger, Quality Improvement Specialist.

The agency has recently completed trainings in Core residential and non-residential topics. The agency hosted an agency-wide medication during the 2012 training year that was provided by the DJJ Office of Health Services. Other recent training topics included training courses on Trauma Informed Care.

Sarsota YMCA Staff paricipate in community meetings that include the Behavioral Health Stakeholders meeting, Safe and Drug Free Schools, Juvenile Justice Council, Alternative to Suspension and School Boarad Interagency meetings.

1.01 Background Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency maintains a background screening policy and procedures that require all staff members to be background screened and to receive results prior to being hired. All staff are background screened prior to employment and re-screened every 5 years as required. The document used to verify background screening is generated from the Department of Juvenile Justice Office of the Inspector General Background Screening Unit. The spreadsheet is also set up to provide an alert via an expiration date (5 years) for the current screening, thus prompting a timely re-screening.

The Annual Affidavit of Compliance with Good Moral Character Standards was completed by the program and sent to DJJ on January 7, 2013. The program is in compliance.

1.02 Provision of an Abuse Free Environment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program posts the Florida Abuse Hotline number at various locations throughout the residential youth shelter. The abuse reporting hotline number is posted in the main areas of the commons rooms.

The agency informs all youth of these procedures during program orientation and in the Resident Handbook. In addition, all staff members receive a copy of the Agency's Code of Conduct upon hire. The handbook requires that all staff members report inappropriate behavior and all forms of abuse related acts committed by staff or clients/residents.

At the time of this program review, the reviewer of this indicator conducted a discussion with the Residential Supervisor staff behavior and client/youth actions that may have impacted the safety and security of the shelter environment. The supervisor provided all inter-agency written reports that occurred within the last six (6) months including work performance and disciplinary reports.

The agency utilizes a management/supervisory intervention approach that involves the documentation of staff member work performance and behavior in the work environment. The agency form used is named the Sarasota YMCA Corrective Counseling Form. This form lists specific work performance and behavior related observation made by the agency's Program Director and Assistant Program Directors. Sarasota YMCA management uses the form to document the observations made by management; the reason for counseling; the corrective action required; and employee comments if any. Administrative actions/measures that Sarasota YMCA management can take include documenting a record of verbal counseling, written counseling, suspension and termination.

At the time of this onsite program review, the agency provided a total of nineteen (19) Corrective Counseling Forms or administrative write ups

related to poor or disallowable staff work performance incidents. Of these, the majority are related to poor work performance, personal conduct, absenteeism, insubordination, policy violation and safety violation issues. This policy uses a multi-step process that consists of verbal coaching and a progressive approach to addressing these issues on a case-by-case basis. The agency also uses a graduated progression of disciplinary steps that include written reprimand, disciplinary probation, decision to issue leave and suspension. The agency had one (1) Corrective Counseling Form that was a written Counseling regard to an incident involving a staff person that involved an altercation with two (2) residents. One of the residents was a CINS/FINS and the other was a DCF resident. A review of inter-agency or program reviews of behavior and staff member performance was conducted regarding this case. The agency policy on Behavior Interventions requires that staff members are not permitted to employ physical intervention techniques unless safety of the child, other children, or staff is involved. The agency policy further states that staff will be trained in positive parenting and verbal de-escalation techniques. These include employment of the “five second rule”, where youth are trained to quickly exit the room when a youth generated disturbance occurs – removing the “audience” and children that might escalate the situation. Further the policy states that the local policy department will be called to control a child that is violent to the point where he or she presents an immediate danger to themselves, other youth or staff members. The policy also requires staff that staff will consult with management and be granted permission to employ physical intervention prior to doing so. Lastly, the policy states that a hands-on report and an incident report will be generated and filed in each case where a hands-on intervention is necessary. The reviewer did not initially find this incident and another in the agency’s internal incident reporting binder. This incident report and the hands-on incident report were found in the employee’s file clipped together with the Counseling Corrective Action Form (CCF) and were provided to the reviewer. The review of this indicator also interviewed another direct care staff person that witnessed this incident and was involved in try to resolve the matter. The staff member reported that the youth initiated a confrontation by coming becoming involved in disucssion that staff was having with another female resident. The male resident launched at the staff member and the staff member had to restrain and hold the youth until they were able to get the youth to calm down. The female staff member being interviewed also stated when the youth jumped at the male staff member she was between both of them and all parties fell to the ground. The femail staff member sustained an injured shoulder that she her should during the incident that she is now receiving medical treatment. No other parties were injured. The agency management stated that the staff member was in within their policy as a result of him attempting to protect the other parties and trying to calm the youth.

Another incident report involving a youth that made unsubstantiated accusations against the program was not initially found in the agency’s internal incident report binder. As a response to this incident, the management issued a Corrective Counseling form following this incident on the same day that this incident occurred. In June 2012 documentation of an earlier CCF that this employee failed to complete the required number of annual training hours. A third CCF on this staff member documented that the staff member did not show up for a shift in October 2012. All three (3) CCFs reflect written documentation on this staff person. The agency has no other incidents involving threats, physical or verbal abuse related incidents.

During this onsite program review, the shelter housed a total of ten (10) residents on 11/16/2012 and nine (9) residents on 01/17/2012. Six (6) of the 10 were CINS/FINS residents were in the youth shelter on day one and five (5) of the 9 were CINS/FINS residents on day two. The remaining residents were DCF clients and not eligible to be surveyed. A total of three (3) out of 3 youth surveys were conducted onsite. The results indicate that they were familiar with the abuse reporting and grievance reporting processes. In addition, youth reported that they feel safe in the program and have never heard staff threaten them or other youth; no youth stated that they have heard staff use profanity/inappropriate language; and none said they have been stopped from reporting abuse.

Six (6) staff members were surveyed during this onsite program review. Six out of 6 staff members stated that they never observed staff using profanity or using threats, intimidation, or humiliation when interacting with the youth and one (1) staff members stated that theyobserved a co-worker using profanity when speaking to youth. Five (5) out of 6 staff members stated that they have never observed youth ever been sent to their room or an isolation room for punishment.

A DJJ CCC Incident reported on January 7 or 11, 2013 by a another agency in the South West FL indicated that a child that had been recently discharged from the Sarasota YMCA Youth Shelter. The reviewer inquired about these allegations and was informed that an abuse allegation was made against this youth by his sister who was also in the Sarasota YMCA that resulted in him being discharged due to the alleged victim also being housed at the residential shelter. This youth was sent to a nearby youth shelter (Family Resources - Bradenton) and reported to Family Resources staff that Sarasota YMCA staff made hime wash his mouth out with soap and sleep in the outside utility shed overnight. The reviewer interviewed the Sarasota YMCA Program Director and was informed that the youth had several behavior problems while at the Sarasota shelter. Many of these are documented in the youth's Sarasota YMCA client case file. The Program Director reported that this former resident made these allegations in retaliation to being discharged. This incident report documenting the agency’s reporting of the allegation made by his sister was documented, but was not located in the agency’s Incident Report binder.

One youth reported that they were familiar with the abuse reporting process, but did not know where to find the number to make the call if necessary.

1.03 Incident Reporting

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a comprehensive policy to address this indicator marked that is labeled as 1.03 Incident Reporting. The agency’s policy program specifies that agency notifies the Department’s Central Communications Center (CCC) within two (2) hours of the incident, or within 2 hours of becoming aware of the incident. The current policy was last reviewed in July 2012 and is signed by the agency’s Program Director. The reviewer assessed a total of thirteen (13) internal incidents, one (1) DJJ CCC Incident and two (2) program grievances. A review of the CINS/FINS residential program grievances indicates 2 grievance reports that center around staff member resident disagreement with the

behavior management system and negative comments involving program residents. A review of the DJJ CCC incident indicates an incident related to a medication error committed by a Direct Care staff person. This incident was reported within the 2 hour reporting requirement. Of the DJJ-CCC incidents all were reported within the 2 hour time requirement. Discussion with a minimum of 2 Direct Care staff on each shift indicated that each staff member was knowlegeable about the 2 hour incident reporting requirement.

Two incidents were not initially located in the agency's main incident reporting binder. The reviewer reported this finding to the agency. The agency's Program Director stated that one incident was clipped to an internal Corrective Counseling Form (CCF). The agency reported that second misplaced incident report was inadvertently placed in the client's file. This binder maintains both DJJ CCC and Internal incidents. The agency must ensure that all incidents are consistently placed and maintained in the agency's Incident Report binder.

An incident involving a youth that made unsubstantiated accusations against the program was not initially found in the agency's internal incident report binder. The agency must place all incidents in the Incident Report binder.

1.04 Training Requirements

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a written policy and procedure in place which include all training requirements indicated in the standards. Training files for 2 non residential staff and 7 residential staff were reviewed.

Four of these files were reviewed for compliance with the Annual Training requirements (2nd year and after). Two out of four staff reviewed did not complete the minimum number of training hours required. This resulted in disciplinary action for one of the staff members. One file had 40 hours of training with all required training having been completed. The Third file contained documentation of 56 hours of training having been completed. This staff member still needs to complete 2 of the required training topics, but has adequate time to complete this before the training year ends.

Five files were reviewed for compliance with first year training. Four out of five files contained documentation that 80 hours of training had been completed. Of these four files, three contained documentation that all required training topics were completed. One file was missing documentation that Signs and Symptoms of Mental Health and Substance Abuse was completed. One file reviewed had 63.5 hours of training. This staff member still has time to complete the remaining 16.5 training hours before completion of their first year of employment

Four files were reviewed for compliance with the Annual Training requirements (2nd year and after). Two out of four staff reviewed did not complete the minimum number of training hours required. This resulted in disciplinary action for one of the staff members.

Five files were reviewed for compliance with first year training. One file was missing documentation that Signs and Symptoms of Mental Health and Substance Abuse was completed.

1.05 Interagency Agreements and Outreach

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has various agreements and community partnerships that are in direct relation to the various needs of the children serviced. Examples include 1 an agreement with Alcoholics Anonymous and Narcotics Anonymous to address alcolol and other drug use/abuse issues. The second is Planned parenthood, Health Department, Police department and the State of Florida Guradian Ad Litem Program to address various concerns as it relates to youth education, parenting and other information. The program has forty-four (44) agreements currently in place with twnety-seven (27) of the agreements in the process of being updated via letters sent to agencies.

The program has a designated lead staff member to coordinate all of the ourtreach activities. The program conducts group discussions, life skills, counselor groups or presentations on a nearly daily basis. The documentation includes an intervention log and sign in sheet.

Outreach activities are documented in the NETMIS data base.

1.06 Disaster Planning

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a written disaster preparadness plan that is contained in a binder with tabs for ready reference of information. The

emergency/disaster preparadness plan lists an evacuation procedure, and also procedures to follow in case of severe weather warning. The program has three (seven passenger) vans to be utilized in case of evacuation from the shelter. All program employees can operate the agency's transportation van. The preparadness plan includes conditions under which an evacuation would occur and has identified a specific evacuation facility. However if in the event this shelter is not available then the program would be advised by Risk Managment in Human Resources. In the event of an actual emergency, the agency follows its procedures that include an official notification to The Florida Network Hurricane state office in Tallhassee.

All of the emergency preparadness necessities including a first aid kit, hiegene supplies, propane, radio etc. are housed in a locked closet The contents of the emergency supply boxes clearly list the contents of each box on the outside of the box. All staff have key access to the emergency supplies. Each employee is trained for emergency response, hurricane preparadness, fire saftey training and evacuations as evidenced in employee binders.

1.07 Analyzing and Reporting Information

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a formal YMCA policy 1.07 that addresses analyzing and reporting information on agency programming and operational issues. The agency operates internal quality review teams to assess trends, issues, incidents and other risk management issues. An internal Sarasota YMCA Quality Improvement review team or Audit Review Committee conducts routine reviews of residential and non-residential files on a quarterly basis. Staff members from administration that participate on this team include Laura Gilbert, Director of Contract Administration, Susan Bailey Foster Care Fiscal Administrator, Sonia Sontiago, Clinical Director and Karen Marsinger, QI Specialist. The agency maintains minutes demonstrating proof are reflected in the Shelter Staff meeting. The shelter Program Director receives the outcome of the file review and informs staff of the results at staff meetings.

The agency reported an initiative to increase the rate of satisfaction surveys completed by youth and families receiving service. The data from the review of satisfaction surveys for the child and the parent feedback is used to improve services delivered to clients and their families. The results captured in surveys are discussed and studied in staff meetings. Then agency increased the rate of survey completion by requesting that staff ensure that surveys were being completed at each resident's discharge. The agency set a goal of 80-85% goals of survey completion. This initiative began July 2012 and through this initiative the agency increased the number of surveys that it was receiving and achieved a higher rate of completed surveys through this process.

The agency reported an initiative to reduce the rate of medication errors conducted by staff members providing prescribed and over the counter medications to youth shelter residents. The agency addressed the medication error issue by securing training from a DJJ Nurse Consultant with the DJJ Office of Health Services in November 2012.

Follow up on the Behavior Intervention internal incident from December 2012. A review of the incident and Behavior Intervention procedures was reviewed at the January 2013 staff meeting.

The agency also produces a monthly report on the youth shelter and incorporates this information in the Sarasota Youth and Family Services Director’s Report. This report contains number of clients, admission, discharges, percentage of successful discharge, bed days and other categories.

The agency has a Council On Accrediation committee for the agency. The group meets monthly to complete the self-study in preparation for the upcoming re-accreditation visit scheduled March for 2013. The agency COA certification officially expires in 2014.

The YMCA has a Safety Team to reduce and prepare for risk management issues. This group is lead by the agency Senior Vice President of Risk Management. The groups discusses accident, medical emergencies, and general safety issues. The agency discusses best practices and work place safety. The safety committee meets quarterly. The agency Program Director receives and reviews a YMCA Incident Data Report for all social services on a monthly basis. All incidents documented by the program are submitted to the SVP or Risk management as incidents occur. All incidents that occur on the weekend are reported on the following business day.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

Sarasota YMCA is contracted to provide both CINS/FINS residential and non-residential services for youth and their families in Sarasota and DeSoto Counties. The program provides centralized intake and screening twenty-four hours per day, seven days per week status offenders that include runaways, truants, ungovernable and lockout youth. Trained staff members are available to determine the needs of the family and youth. Residential services, including individual youth, family and group services. Case management and substance abuse prevention education are also offered on an as needed basis. Aftercare planning includes referring youth to community resources, on-going counseling and educational assistance on an as needed basis.

At the time of this review, according to agency's organizational chart lists Mrs. Sonia Santiago, LMHC as the Clinical Director and Director of Non-Residential Services. Mrs. Santiago oversees seven (7) staff members in the 2 aforementioned counties. Counselors employed on a full time and part time basis depending on their position. Counselors are responsible for providing case management services and linking youth and families to various community services.

The Sarasota YMCA Family Counseling component or non-residential program is also responsible for coordinating the Case Staffing Committee, a statutorily-mandated committee that develops a treatment plan for habitual truancy, lockout, ungovernable, and runaway youth when all other services have been exhausted or upon request from the parents/guardians. This component of the agency also recommends the filing CINS Petitions with the court as needed.

2.01 Screening and Intake

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

A total of 10 files were reviewed, 6 from non-resdiential and 4 from residential. All files were found to be in compliance with the screening ocurring within 7 days of the referral.

A copy of the parent and client handbook was provided by program and clearly explains service options, rights and responsibilities, a description of CINS and possible actions of their involvement, and grievance procedures. This is documented on a Resident Intake Checklist which is signed by the youth. This was completed in all files reviewed.

Non-residential counselors provide several pieces of paperwork to the parents and youth explaining rights and responsibilities, grievance procedure, service options, and a description of CINS. This is also evidenced by a form the family signs stating they have received this documentation. This form was completed in all files reviewed.

Policies and procedures reflect the practice and are in line with the requirements of the standard.

2.02 Psychosocial Assessment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

A total of ten (10) files were reviewed, 6 non-residential files and 4 residential files. Nine (9) of the 10 files contained a completed psychosocial assessment that fell within the required timeframe for both residential and non-residential. One residential file was a recent intake on 1/14 and the psychosocial was not completed, however, it was inititiated on 01/15/2013 thereby satisfying the requirement.

Nine (9) out of 10 applicable files contained signatures from a masters and bachelor's level clinician, and 9 out of 10 applicable files contained supervisory signatures indicating reviews.

None of the files reviewed had any indication of suicide ideation and did not need any further assessment or follow-up. Policies and procedures reflect the practice and are in line with the requirements of the standard.

2.03 Case/Service Plan

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

A total of 10 files were reviewed, 6 from non-residential and 4 from residential. Nine (9) out of 10 files contained case plans, the one that did not

was a residential file and the intake date was 1/14, so a case plan was not applicable.

All 9 applicable files showed a completion date either the day of or within a few days of completion of the psychosocial, but all within the 7 days allotted.

Each case plan has initial goals set and non-residential utilizes the presenting problem from the screening as an initial goal. The plans showed that once the client was involved in the process, more individulaized goals were developed.

Each applicable plan contained all the necessary information with very minor exceptions.

All case plans for non-residential were reviewed on time and standard practice was that the counselor highlighted the review in the progress notes. Residential did not have any files beyond 30 days.

2 residential files were missing parent signatures.

2.04 Case Management and Service Delivery

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

A total of ten (10) files were reviewed, six (6) from non-residential and four (4) from residential. One file from residential was a recent intake as of 1/14 but the file is also involved with non-residential and the two are coordinating services per the documentation in the file.

The remaining nine (9) files show good involvement by both residential and non-residential staff with the clients and their families. Progress note reviews detail multiple interactions with parents and guardians. All of the non-residential files have a closure/discharge form that details services provided which are also reflected in the notes. The non-residential files showed multiple interactions with the Triad school in the area which deals with youth with behavior issues. The non-residential program participants also have access to YMCA services to include health and wellness referrals.

Residential provides one counseling staff and one case manager who collaborate on each youth with the counselor focusing on the clinical piece and the case manager providing referrals and support as needed.

Two (2) of the residential files reviewed required out-of-home placement due to CINS court orders. Both of these referrals were from the non-residential team and services were being coordinated as noted by weekly case reviews that are documented on the form "Service Plan Review" and involve the clincal director who oversees the non-residential program.

2.05 Counseling Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

A policy and procedure are in place and address the basic requirements of the standard. A total of ten (10) files were reviewed, six (6) with non-residential and 4 with residential. All files showed evidence of active engagement and counseling provided for both individual and family. One file was noted as an intake on 01/14/2013 so this file did not contain a completed psychosocial assessment, but the assessment had been initiated per the standard. All other files contained completed psychosocial assessments and case plans. The progress notes were easy to follow and again showed good involvement and engagement on both the residential and non-residential files.

Clinical reviews are held weekly at the shelters and are documented on a form titled "Service Plan Review". These staffings are also attended by the clinical director. The clinical director also conducts clinical reviews on the non-residential files every two weeks as documented on a form called "Supervision Log". Each of these forms were noted consistently in all the files reviewed except the new intake and showed an awareness and focus on the case plan and pertinent goals.

In non-residential, two community groups are offered which are a parenting group and an anger management group. These group run in six week cycles and are open to the community.

In residential, group is delivered in three different formats: teh shelter utilizes an employee of the YMCA to conduct Adventure Based Groups which are more interactive, these occur three to four times per week at 3pm. The shelter also has outside agencies come and do groups at normal group time which is 7:00pm. Some of these groups are Hospice, Planned Parenthood, and Al-Anon. The staff also conducts group at

7pm if there is not an outside source which are called Life-Skills Groups. The program keeps a group log with all the group notes. A review of the six month period showed that groups are being conducted a minimum of 5 days per week. For example, July conatined 31 group notes, August 23, September 22, October 30, November 23, and December 26.

2.06 Adjudication/Petitiion Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policy and procedure in place that contains all requirements contained in this indicator. A total of six (6) files were reviewed for this indicator. All files included documentation of the progression in services by the agency. All files contained documentation that the family and the case staffing committee members were notified of the meeting within the required time frame. All files contained documentation that the parent / guardian was provided with a written report of the case staffing committee meeting outcome within the required time frame.

Of the 6 files reviewed, one contained documentation that the parent / guardian made a written request for case staffing services. This files contained documentation that the meeting was schedule for the day after the referral was received.

Of the 6 files reviewed all contained documentation that a revised plan of services was provided as a result of the case staffing committee recommendations.

2.07 Youth Records

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Program youth files are mainitained in binders which facilitate the neat and organized manner in which information is stored. The tab system provides extrememely easy access to information. All binders and folders are maked confidential. The youth records binders are organized according to procedure and contain the required release forms and receipt of informance procedure etc.documents as evidenced on the signed resident intake checklist in each youth file. The "soft files" which contain extremely confidential information is kept in an office under pad lock and "hard files" also confidential but are for every day use are stored in a locked room in a locked cabinet with access only to staff who check out keys daily for access to facility and files.

Standard 3: Shelter Care

Overview

Rating Narrative

Sarasota YMCA is licensed by the Department of Children and Families (DCF) for twenty (20) beds and it primarily serves youth from Sarasota and DeSoto Counties. The shelter also provides services to youth referred to them from the Department of Children and Families. The shelter building includes a common or day room, girls and boys sleep dorm style bedrooms, dining room, kitchen, laundry, staff offices and a multi-purpose/activity/computer room.

The Sarasota YMCA shelter facility that is located in central Sarasota near the intersection of Bahia Vista Street and Tuttle Avenue. The facility is located in an accessible area and is close to available public transportation. The shelter is adjacent to the YMCA's gymnasium which provides access to recreational opportunities for yout at the shelter and also has a Teen Center for other positive youth related activities.

During the quality assurance review, the shelter was found to be in good condition and the furnishings in good repair, and the rooms and common areas were clean. The dormitories are divided into two (2) areas separated by the common room for the boys and one for the girls. There are 2 bathrooms located near each dorm. The sleeping rooms house ten (10) youth each; each youth has an individual bed (bunk bed), bed coverings and pillows. Further, there is an individual close watch or supervision room for youth on sight and sound or elevated supervision status. In addition, the youth have access to a recreational games, volley ball court and basketball. This youth shelter is not designated by the Florida Network of Youth and Family Services to provide staff secure services.

The Sarasota YMCA residential team is comprised of a total of twenty-seven (27) Residential staff members (full-time, part-time and on-call). This number of residential staff members includes one (1) Program Director, two (2) Assistant Program Directors and 2 counselors and a Quality Improvement Specialist. The Direct Care workers are responsible for completing all applicable admission paperwork, orientating youth to the shelter, and providing necessary supervision. The youth care workers are responsible for processing new admissions, and providing orientation of youth to the shelter; the supervision of youth; and for maintaining inventories on all sharps and medications. Youth care workers also assist in the delivery of self-administered prescribed and over-the-counter medications.

The property is nicely landscaped and well maintained and clear of hazards or debris. The facility is also well lighted, secure and appropriately furnished.

The facility recently re-tiled the kitchen floor and will be purchasing two new vans in the next few months to replace other vehicles currently used in tranporting residents.

Reviewed staff training records, communication log, and youth files.

Visible review of Hot line numbers and forms posted.

3.01 Youth Room Assignment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policy in place that includes an initial classification of youth for the purpose of giving the youth an appropriate room or living area assignment that addresses any risk of violence or spcial needs concerns, to maintain the safety and security of the facility as well as the youth. The reviewer examined six files. Six (6) of the 6 files were in compliance of Florida Network Services guidelines. The intake form is clearly written for maximum understanding and signatures of both guardian and youth are present. The facility is not equipped for the intake of suicidal or extremely vioent youth, in which case that youth would be referred elsewhere. The programs alert system to carry information forward from staff/shift to staff/shift is their communication log.

3.02 Program Orientation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policy in place to give youth an opportunity to learn about the program and its expectations through a one on one process. The orientation is done within a twenty four hour window upon arrival at the facility. Five of the five youth files reviewed document the components of orientation which include each youth being given a handbook that has fun graphics and can be easily read and understood by the age group serviced. During orientation the youth are taken on a tour of the facility. There are shelter lay out signs posted in several areas of

the facility in case of emergency. The orientation covers grievance procedures, a list of contraband items, disciplinary actions, dress code, visitation and room assignment etc. The hand book also contains the hot line number.

Four of the five staff files reviewed document staff orientation training.

One of the five staff files reviewed does not document staff orientation training, with the exception of meds orientation.

3.03 Shelter Environment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

A brief initial tour and a more detailed and extensive follow-up tour of the facility were conducted by this reviewer while on site. The Residential Program Director assisted this reviewer during the tour to complete the related checklist items as listed in the review tool for this indicator. Several photos were taken during the tour to document the property location, facility design and youth living conditions.

The facility has a comprehensive emergency disaster plan that is in a clearly marked binder and posted on the wall near the front entrance. A second copy is located in the Emergency Hurricane Supply closet located in the staff bathroom. The plan is reviewed annually by the YMCA Youth and Family Program Services Director and updated as needed. No changes were made during the last two years to the comprehensive agency plan however the Program Directors update their own emergency contact lists for staff under their supervision.

Emergency evacuation plans are posted throughout the facility at key locations. These plans list the location of exits (4), fire extinguishers (5) and first aid kits (3). The designated temporary evacuation site is the Teen Center located next door to the facility. First aid kits, health supplies, chemical supplies and agency vehicles are inspected weekly by a designated staff member.

All agency vehicles (3) are secured and are equipped with the required safety equipment which was inspected and observed during this review. The facility is equipped with a knife for life, wire cutters and bio-hazard spill kits and disposal containers that are all located in the youth care staff office.

Fire safety inspections are conducted by the Sarasota County Fire Inspector on an annual basis. The last inspection was conducted on 3/29/12 and no violations were noted. The fire sprinkler system was inspected by Alliance Fire & Safety and found to be operating properly on 5/9/12. The overhead kitchen hood system was inspected by Cintas Fire Protection and approved on 11/19/12. Fire extinguishers were inspected by Cintas Fire Protection in December of 2012 and are valid through 12/2013.

Fire safety training is provided for all residential staff, fire drills are conducted as required monthly and quarterly emergency drills are also scheduled and performed. A fire safety training is scheduled for 1/18/13.

Facility group care and food service health inspections are performed annual. The group care inspection was conducted on 11/19/12 and the result was satisfactory with two minor corrective actions being noted (maintenance) and both have been corrected. The food service health care inspection was conducted on 10/29/12 and was rated satisfactory with two minor corrective actions being noted. Both were corrected by the time of this site visit. During this CQI review all food storage areas were inspected and found to be in compliance with Health Department standards and applicable food safety practices.

The facility is equipped with 16 cameras that are located in both the interior and exterior of the facility. The cameras are all operational and provide excellent coverage of the facility. Monitors are located in the youth care staff office and in the Program Director's office. The facility is well maintained, furniture is in good working order and no grafitti was observed during the tour of the facility. The exterior of the property was also inspected and found to be clear of any hazards, trash or debris. All exterior and interior doors were securely locked and key control practices were observed anf followed during out site visit.

An approved list of chemicals (20) is located in storage areas and MSDS sheets are maintained for each producted that is approved for the facility. The MSDS binder is stored in the staff office area and all chemicals are inventoried once a week.

Grievance forms are located in a plastic wall pocket outside the staff office. A large, poster-sized daily master schedule is posted in the dinning room and in the living room of the facility.

3.04 Log Books

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a written policy that addresses all of the key elements of this indicator. The policy identifies the purpose and important role the program log book plays in communicating critical client care information between staff on different shifts and across various positions at the

facility.

The program log book is reviewed by three program administrators on a regular and on-going basis that exceeds the weekly requirement for supervisory review and comment. The Program Director and both Assistant Directors review the log book on an almost daily basis. Their reviews are consistently documented and highlighted in pink to distinguish them from other comments in the log book.

All direct care staff (Behavior Coaches, Counselor, Case Manager, QI Specialist) reporting for work are required to read the log book and document this review of the previous two shifts and/or days depending on their various work schedules.

The log uses a color coding (highlighter) system to distinguish the various types of entries in the log book:

- Yellow: Intakes / Discharges
- Red: Medication / Allergies
- Green: Sight and Sound Supervision
- Pink: Supervisory Review
- Blue: AWOL Youth / AWOL Return
- Orange: General Staff Notes

There are also four "codes" that are used for facility security purposes and program status:

- Code Green: No deficiencies or issues (All clear)
- Code Yellow: Caution (sight and sound status, verbal threats of violence)
- Code Red: Extreme Caution (1:1 supervision, severe weather threat)
- Code Black: Program Closed or Evacuated (Disaster Plan Implemented)

The log book is very comprehensive in terms both content and details. Many program safety (physical health and mental health issues) and facility security issues (Key control, Perimeter checks) are clearly addressed and documented by staff working in the program.

A few rare and minor exceptions were noted in terms of how errors or mistakes are corrected in the log book. This is a fairly common issue across all CINS/FINS programs and does not appear to impact program operations but still needs to adressed to be in compliance with CQI standards.

I interviewed one of the Assistant Directors about this issue and they indicated to me that the issue had been addressed with staff on several occasions at staff meetings but that there are still a few rare exceptions to the agency's written policy, procedures and practices.

Rating Narrative

The agency has a written policy and procedure that addresses all key elements of this indicator. The daily program master schedule is posted in the dinning room, the living room and also can be found in the client handbook given to residents at intake. It contains specific activities related to the educational, developmental, social, physical and spiritual development of the youth in the program.

All youth attend school while at the facility. Youth that are not yet enrolled in school are provided educational activities from 9AM-12 noon each day at the shelter in the classroom. During our site visit one youth who was not in school was trnasported to the library for an educational outing.

Daily recreational activities are also provided for all youth. At least one hour of physical exercise is offered to youth who also have access to excellent recreation resources provided by the YMCA at the gymnasium located adjacent to the facility. An adventure based counselor also provides specific, targeted activities that promotes and supports healthy physical development for youth in the program.

Faith based activities may be attended if youth request it. Staff are able to transport youth to a variety of local faith based activities throughout the week to promote positive spiritual development.

The program's Behavior Management System also supports the opportunities for youth to particpate in a variety of on and off site events on weekends and weekdays.

3.06 Behavior Management Strategies

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure that adresses all of the key elements of this indicator. All staff recieve training in the use and implentation of the YMCA Behavior Management System (BMS).

The YMCA shelter program utilizes a behavior management system that is clearly defined in the Client Handbook provided to youth during the intake process. During the intake process the BMS point/level system is explained to youth along with the associated priviliges and consequences at each level.

Each of the levels has specific privileges defined for that level. There are five levels in the YMCA BMS:

- Level 0: Intake (first 24 hours)
- Level 1: 375 points
- Level II: 550 points
- Level III: 700 points
- Master Level: 900 points

Youth earn points throughout the day that are recorded by staff on an individual youth point sheet. The points are totaled up on the overnight shift and youth are placed on the appropriate level for the following 24 hours based on their point accumulation. Youth may move between levels (up or down) after each 24 hour behavioral assessment period. Youth may also be offered the opportunity to earn extra points for volunteeruing to complete extra tasks or chores or assisting staff with daily programmatic activities.

Youth may lose points or be dropped a level for any of the following reasons: fighting, threatening, stealing, lending/borrowing clothing, cursing, sneaking food into dorms or being suspended from school. Running away from the facility or being suspended from school are considered major rule violations and results in the youth being dropped to Level 0.

The YMCA BMS defines 8 general rules for youth to follow and 5 "Cardinal Rules" that may require reporting to law enforcement for their involvement if any criminal acitivity is discoverd by staff at the facility. The BMS also defines specific rights and responsibilities for youth and staff to follow durign their time at the shelter to encourage appropriate behaviors, positive relationships and a safe environment.

If youth feel that an error was made in the daily points or level assignment they can verbally appeal to a behavior coach or a program supervisor and file a formal grievanvce if the issue is still not resolved.

An interview with program staff indicated that they believe the current BMS is effective, especially for youth who placed at the facility for less than 30 days, but may lose some effectiveness for the few youth who stay for longer periods of time. The program administrators are currently reviewing the YMCA BMS point and level system and evaluating making some operational changes to the system to make it even more effective for both short-term and long-term placements.

3.07 Behavior Interventions

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of indicator 3.07 and defines the "rules of enagagement" for staff to folow during behavioral crisis interventions at the facility.

All staff are trained in Techniques for Effective Aggression Management that includes verbal de-escalation skills, personal safety strategies and self defense techniques. In addition to TEAM, some staff are training in other Crisis Intervention curriculums such as Managing Aggressive Behavior (MAB) or Crisis Prevention Institute (CPI).

In most situations, the agency does not use physical restraint techniques to manage aggressive or out of control youth and typically rely on law enforcement to handle those types of situations. However the policy does allow for certain limited situations where immediate action or intervention may be necessary by staff to prevent seriously bodily harm or injury from occurring to youth or staff.

- Only staff are allowed to discipline youth.
- Group punishment is not permitted.

- Room restriction is not used by this program.
- Youth are allowed to take self-imposed or staff directed time-outs in the courtyard which is monitored via video cameras.
- The five second rule is implemeneted in crisis situations to remove other youth from the area.
- Corrective counseling is applied and documented when apparopriate or necessary.
- Evidence of this was found during this CQI site review.

There was one recent incident where an internal incident report was filed on an event that occureed in the kitchen area of the facility. A male staff member was physically assaulted (punched in the face) by a female youth. The male staff member attempted to restrain the female youth at which time a male youth became involved in the incident by attempting to grab the staff member. It was questionable as to whether the staff member followed agency policy in the use of physical intervention and/or approved self-defense techniques.

However, given the nature of the program service (24/7 Crisis Shelter) and the type of clients served (youth who have experienced severe or chronic trauma and/or who may be highly at risk of delinquency) there may be some occasions where staff have to use "minimal force necessary" to help control the acutely aggressive behavior. Therefore, there may be some excpetions why immediate life safety issues are invloved (serious injury ior death, suicidal/homicidal threats or actions) where staff must use there discretion and minimal force necessary to respond to the situation.

3.08 Staffing and Youth Supervision

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The facility is a 20 bed shelter and is staffed by a total of 27 employees. There is a Program Director, 2 assistant directors, a Quality Improvement Specialist, A counselor, a case manager and 7 F/T youth care staff and 14 P/T youth care staff. The agency refers to their youth care staff as "Behavior Coaches".

The agency has a written policy and procedure that addresses all elements of this key indicator. There are three 8 hour shifts for youth care staff and some that are scheduled to overlap the primary shifts. The three shifts are 6:30 AM to 3:30 PM, 3:30 PM to 11:30 PM and 11:30 PM to 6:30 AM. One staff works AM and PM hours primarily to assist with youth school tranportation duties. The awake hours staffing pattern is for 3 youth care staff to be on each shift and during sleeping hours there are 2 staff scheduled.

All shifts are within the required staff to youth ratios (1:6 / 1:12) and there is a male and female scheduled to be on eavch shift. An interview with the Program Director and one of the Assistant Directors indicated that this requirement is met consistently and that there are only very rare exceptions to this policy.

A review of 6 months of staff schedules indicated that the staff coverage requirements are being met on a consistent basis.

Four exceptions were noted during this site review based on an analysis of Employee Corrective Action Forms that were completed by program supervisory staff on 2/26/12, 3/1/12, 10/10/12 and 11/20/12. In each instance there was a gap or lapse in youth supervision by staff that led to corrective actions being taken by program administrators. In each case the agency took the appropriate actions to address the program safety issues in an attempt to resolve the staff performance issues and documented this effectively.

3.09 Staff Secure Shelter

☐ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Not applicable. The agency is not contracted to provide Staff Secure shelter services. The agency would place staff secure youth at the contracted facilities located in Fort Myers, Bartow or Clearwater.

Not applicable.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The agency screen all youth admitted to the youth shelter on a battery of health screening questions. The agency also has several measures in place to address emergency, accidents, injuries and safety and security events. The agency has disaster plans, knife-for-life, wire cutters, and first aid kits that are located in multiple locations throughout the facility, to include the staff station, medication room, and kitchen. All medications are stored in a locked cabinet in the direct care staff office. The program's behavior management system consists of four (4) levels (Level 1, Level 2, Level 3 and Master Level). Youth start on the orientation level and advance up or down the levels depending on the total number of points accumulated each day; and privileges are based on the youth's level.

Oversight of clinical services is provided by the Sonia Santiago, LMHC Clinical Director. The agency also employs other Licensed staff members. The program director is currently working towards completing her licensure. Youth admitted to the program are screened using the CINS/FINS Intake Form. If a youth answers "yes" to any of the six (6) questions pertaining to suicide risk on the CINS/FINS Intake form, an Assessment of Suicide Risk is completed. A medical and mental health alert system with general alerts is in place. The system is practical and staff interviewed onsite have are familiar with the alert system and understand it well. Staff members are also trained to provide first aid as needed when emergencies occur.

4.01 Healthcare Admission Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policy an procedure in place that contains all required elements of this indicator.

The program utilizes the CINS / FINS Intake Assessment for completion of the preliminary health screening. This instrument contains all required screening areas as listed in this indicator.

Four (4) closed files and two (2) open files were reviewed for this indicator. Of the six files reviewed all contained documentation that a preliminary health screening was completed by direct care staff at admission.

Of the six files reviewed, one indicated that the youth was admitted with a suspected chronic health condition. This file contained documentation that the guardian was aware of this condition. The guardian was given a referral for follow up and took client to an appointment. The condition was ruled out during this follow up and no further medical treatment was required.

The programs policy for this indicator states that "When a resident complains of medical or dental discomfort, staff should immediately notify the parent/guardian". Three (3) files contained documentation that the client had made complaints regarding medical or dental discomfort. All 3 of these files contained documentation that the guardian was notified of the complaint and that the guardian did seek medical follow up. This documentation was also found in the program daily log book, referred to as the Com Log.

One file contained documentation on the preliminary health screening that the youth was in need of eye glasses and that she was experiencing dizziness on a daily basis. The file and program log contained no documentation of follow up or referral for an eye exam or to a physician to address daily dizziness.

4.02 Suicide Prevention

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

A total of 4 files were reviewed, three closed and one open file for residential. Three files had indicators for a suicide assessment upon intake, one file indicated a suicide assessment during the youth's time at the program due to an accident while shaving followed by some verbalizations from the youth. All 4 files contained proper documentation for youth identified as an initial risk and were not removed from sight and sound until reviewed by their clinical director.

The agency utilizes a code system for the communication log whereby green highlighting indicates a youth is currently on sight and sound. A written designation of "code green" indicates that a youth is off watch.

Until a review by the licensed professional is complete, youth are placed on constant sight and sound or one to one supervision per the policy. Nonoe of the files reviewed indicated that one-to-one supervision was necessary. All files held watch sheets which are titled "Suicide Precautions - Observation Log". 3 of 4 files reviewed showed compliance with this reporting requirement which was done in 30 minute intervals.

All 4 files showed the clinical director's signature on the clinical assessment which is typically performed by the shelter counselor. The staff or clinical director would then make an entry into the communication log noting that youth had been removed from watch once the clinical director had made this decision.

The policies currently state that the program uses the SPS, however, this is true for non-residential only. The program needs to designate this distinction more clearly in their policies.

One file, NS, contained a sequence error on the observation sheets where the third shift stopped documenting on the first section of the observation log and moved the watch to the third section of the log. Per the practice of following the sections by sequence, the shift should have continued the count on the second section. In addition, on the first section the staff omitted an observation at 2am, however, on the entry that was carried over to the third section the 2am entry was included.

There was inconsistency with the staff highlighting a youth note in the communication log where 2 of the 4 files notes in the log were not highlighted. This is not in the standard, however, but it appears the use of green to signify both a youth on watch and an "all clear" status may be confusing.

Policy states "While asleep, observation of activity will be conducted every 10 minutes" for youth on watch. The observation log sheets are consistently observing youth every 30 minutes, however, the normal bed check for all youth is 10 minutes and kept in a separate log called "Bed Checks". This may need to be clarified to differentiate a youth on watch versus a youth in general population during sleeping hours.

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4.03 Medications

☒ ☐ ☐

Satisfactory	Limited	Failed

Rating Narrative

The agency had written procedures that addressed the safe and secure storage, access, inventory, disposal and distribution of medication in accordance with the DJJ Health Services Manual. The current policy listed as Sarasota YMCA 4.03 listed all the aforementioned requirements, however the policy does not currently list the specific components of the agency's verification of medication brought to the youth shelter upon the youth being admitted. Further, the current policy does not make reference to sharps maintained by the agency or the frequency in which sharps will be counted.

The agency provided a current list of twenty-three (23) staff members that are trained and authorized to distribute medications. The file review indicated that all staff are trained on medication distribution and documentation. The staff members are also verifying medication of all residents that are admitted to the youth shelter. The agency uses the Medication Receipt Transfer and Disposition form to conduct verification of all resident medication.

Observations found all medication was stored in a double locked cabinet that was inaccessible to the youth. The agency maintains oral, topical and over the counter (OTC) medications that are stored in three separate locked drawers. Each drawer also contains an individual metal locked box. The agency also provides over the counter medications. The agency currently maintains Pepto Bismol, Tylenol and cough drops. The shelter had a secured refrigerator designated for medication. At the time of the review it was empty. A perpetual inventory with running balances was maintained for all medications. At the time of the review, there no youth currently in the youth shelter taking narcotic or controlled medications. The agency does accept OTC from the parent/guardian if prescribed by the client's physician.

A total of eight (8) client files were review to assess the agency's adherence to medications requirements. At the time of this onsite program review, the agency reported having one (1) CINS/FINS youth on a prescribed medication. The agency utilizes a Medication Distribution Log (MDL) to document medication distribution practice for each resident. 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. Five out of eight (8) client files had evidence that medication distribution practices were executed and documented as required. Three resident files had exceptions. One resident from December 2012 had two (2) documentation errors, one that did not document the medication count and another entry that did not document the staff's initials. Another client file is missing documentation of a count on a shift July 2012.

The sharps maintained at the shelter consisted of razors, tweezers, first aid scissors, office scissors, nail clippers, knife, safety scissors, razors and pill cutters. The shelter maintained a daily count of the sharps at each shift change for the last six (6) months. Sharps counts are documented in separate tabs section in a 3-ring binder. The agency provided evidence of documented sharp counts from July 2012 to January 13, 2013. Sharp log indicates that staff members initial the current count of each individual sharp on all 3 work shifts.

The agency also requested and secured training from the DJJ Office of Health Services in November 20, 2012. A total of eighteen (18) staff members were trained during the November 2012 training led by the DJJ Office of Health Services.

A review of the Central Communication Center (CCC) reports indicated the agency had one (1) incident that was related to a medication error. This error involved a youth that was administered a whole dose of her prescribed medication instead of a half of dose on October 10, 2012. The youth received the medication in 10mg tablets and that the staff was utilizing a pill cutter to cut the pills. The error was discovered by management that the staff provided the youth the entire tablet (10mg). The DJJ PAM reviewed the situation with the staff regarding cutting the pill and instructed that the pharmacy needs to be asked to cut any and all future medication. The PAM further explained the difference of administering medication versus assistant with medications.

The agenc policy on this indicator does not include medication instructions or information related to medication verification requirement and sharps inventory requirements and procedures. The agency began the initial process of revising its current medication policy to include the aforementioned areas during the QI review.

Overall, the agency's has policy and procedures that require updating to ensure that they reflect the requirements of both Florida Network and DJJ policies.

4.04 Medical/Mental Health Alert Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policy and procedure in place that addresses all requirements of this indicator. A total of five (5) files were reviewed for this indicator (two open and three closed). Five out of 5 files reviewed indicated that the youth has either a current or past medical condition or a mental health condition. In each case there was proper documentation that the programs alert system policy was followed.

The program has a client information board which indicates which youth has a medication alert. This board was observed to be accurate and reflected proper alerts for current clients. Additionally alerts are placed on client files, on a Medical and Mental Health Alert form located in the client file, on the resident contact list in the client file and on the residents screening from in the client file. If a youth has a food allergy it is the programs policy that the alert be posted in the kitchen on the refridgerator. There were no youth in the program during the review with a food allergy.

The procedure also contains a statment that "An informational Sheet regarding the side effects of any medication is stapled to the resident's Medication Administration Log." Staff interview revelaed that this procedure has been updated and that these infomrational sheets are now located in a separate log titled "Medication Description, Side Effects and Interactions". These informational sheets are no longer attached to the individual Medication Administration Log.

The programs policy and procedure for this indicator contains a statment that "An informational Sheet regarding the side effects of any medication is stapled to the resident's Medication Administration Log." Staff interview revealed that this procedure has been updated and that these infomrational sheets are now located in a separate log titled "Medication Description, Side Effects and Interactions". These informational sheets are no longer attached to the individual Medication Administration Log.

4.05 Episodic/Emergency Care

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policy and procedure in place that includes all of the requirements of this indicator. The Emergency Medical Procedures Response Protocol for Clients / Staff is located in the Disaster Preparedness Manual.

Five files (two open and three closed) were reviewed for this indicator. Of the five files, three contained documentation that off site medical care was required during the client's stay. All of the files contained documentation that medical follow up was initiated by the parent and that the client returned with instruction from the treating physician. Documentation was also found in the programs daily log referred to as the Com Log.

The program parent / guardian notification policy was follwed in all three cases and files contained documentation of this. Documentation was also found in the programs daily log referred to as the Com Log.

The program also maintains an Episodic Log in which they document any incidents that required transportation by Emergency Medical Services or Baker Acts. There have been no incidents requiring emergency medical transport within the review timeframe.

Seven training files were reviewed for evidence of training on the program's emergency medical procedures. All training files contained documentation that the staff members had attended this training.

Three staff were interviewed regarding the location of the Knife for Life. All staff were aware that the Knife for Life was in a locked box inside of the direct care staff office.

During the review first aid kits were observed to be located in the direct care staff office, the kitchen, the staff restroom and the program vans. Three staff were interviewed and were aware of the location of each of the first aid kits.