Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Sarasota YMCA

on 01/27/2016

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Indicator	Rating
2.01 Screening and Intake	Satisfactory
2.02 Needs Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management and Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petitiion Process	Satisfactory
2.07 Youth Records	Satisfactory

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

Standard 3: Shelter Care

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

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

Standard 4: Mental Health/Health Services

Indicator	Rating
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:96.00%
Percent of indicators rated Limited:4.00%
Percent of indicators rated Failed:0.00%

Rating Definitions

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

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

Review Team

Members

Ashley Davies, Lead Reviewer and Consultant, Forefront LLC

Vernon Pryer, DJJ, Regional Monitor

Tiffany Martin, FNYFS, Project Manager of Operations and Research

Tenia Rumph, Family Resources - Bradenton, Program Director

Tim Langlo, YFA, CINS/FINS Non-Residential Supervisor

Persons Interviewed

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

1 Case Managers
1 Clinical Staff
0 Food Service Personnel
1 Health Care Staff

0 Maintenance Personnel
1 Program Supervisors
0 Other

Documents Reviewed

- [ ] Accreditation Reports
- [x] Affidavit of Good Moral Character
- [x] CCC Reports
- [ ] Confinement Reports
- [x] Continuity of Operation Plan
- [ ] Contract Monitoring Reports
- [ ] Contract Scope of Services
- [x] Egress Plans
- [x] 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
- [x] Program Schedules
- [ ] Sick Call Logs
- [ ] Supplemental Contracts
- [x] Table of Organization
- [ ] Telephone Logs
- [x] Vehicle Inspection Reports
- [ ] Visitation Logs
- [x] Youth Handbook

5 Health Records
5 MH/SA Records
15 Personnel Records
8 Training Records/CORE
5 Youth Records (Closed)
5 Youth Records (Open)
0 Other

Surveys

4 Youth
5 Direct Care Staff
0 Other

Observations During Review

- [ ] Intake
- [x] Program Activities
- [ ] Recreation
- [ ] Searches
- [x] Security Video Tapes
- [x] Medical Clinic
- [x] Medication Administration
- [x] Posting of Abuse Hotline
- [ ] Tool Inventory and Storage
- [x] Toxic Item Inventory and Storage
- [ ] Discharge
- [ ] Treatment Team Meetings
- [x] Social Skill Modeling by Staff
- [x] Staff Interactions with Youth
- [x] Staff Supervision of Youth
- [x] Facility and Grounds
- [x] First Aid Kit(s)
- [ ] Group
- [ ] Meals
- [ ] 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

Since the last on-site Quality Improvement review the agency has had some staffing issues at the shelter. There are currently sixteen shifts each week that are being covered by part-time and PRN staff due to a shortage in full-time staff. The positions of Residential Counselor and Quality Improvement are vacant creating additional work for current staff having to fulfill the responsibilities of those vacant positions, as well as, their own positions. A new position of Residential Manager was added in October 2015, which has helped relieve some of the workload issues.

Geckos (a local restaurant in Sarasota) created a partnership with the agency. They produced a shoe drive and were able to donate 250 pairs of shoes to the shelter.

The Y Angels bought all the youth in the shelter presents for Christmas.

The agency has secured some grants and were able to have the flooring, tables, and desks re-done.

The agency also has the United Way Grant and County Grant that support the shelter.

The non-residential component has also had some staff issues; however, current staff have helped by taking on a larger caseload.

The shelter has had one Domestic Violence youth since the last on-site review. It was reported that the local police department does not like to arrest the youth. If it is not necessary, they will bring the youth straight to the shelter instead of the JAC.

Standard 1: Management Accountability

Overview

Narrative

The Sarasota Family YMCA is governed by a Board of community volunteers that are dedicated to the advancement of the YMCA's mission to build "strong kids, strong families, strong communities". The Sarasota YMCA Board of Directors represents a vast cross-section of professions and industries. 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.

Sonia Santiago is Vice President and oversees the residential and non-residential CINS/FINS programs and related services in the Sarasota, Florida region. Additionally, at the time of this on-site Quality Improvement review the agency's organizational chart lists Shad Renick, Program Director. Mrs. Santiago, LMHC is also responsible for the Non-Residential Program Director/Clinical Services Director. The agency is experiencing some staffing issues at the time of the review; however, this did not impact the quality of services being provided to the youth. There is a Residential Counselor position vacant, as well as, a Quality Improvement position. In addition, there are sixteen shifts each week the agency fills with part-time or PRN Behavior Coaches due to not having enough full-time Behavior Coaches. The agency did bring on the position of a Residential Manager in October 2015, which has helped fulfill some of the responsibilities and duties of some of the vacant positions.

The agency has formal rules that govern the behavior of all staff members including an employee handbook and code of conduct. In addition, the agency has a centralized human resources department that oversees all major background screening duties. The Sarasota YMCA has a minimum of 80 hours of training for all new staff members and a total of 40 annual hours of training for on-going staff members.

1.01 Background Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has written procedures for conducting new background checks and for the re-screening of background for all staff, volunteers and interns every five years. The program consistently completes a driver's license check and local law enforcement check of all staff prior to offering them employment. A review of staff personnel records from the last annual compliance review (02/24/2015) confirmed background screening, driver's license, and local law enforcement checks were being conducted. Nine center staff received an eligible background screening from the Department's Background Screening Unit (BSU) prior to hire and volunteering. The Annual Affidavits of Compliance with Level 2 Screening Standards for all staff was submitted to the Department on December 30, 2015. The shelter's corporate personnel staff completes the forms for the applicable employees.

A review of six applicable files for rescreening confirmed that the program submits rescreening request sixty–days prior to the hire anniversary. Each file reviewed revealed favorable rescreening background results were in each file. The program hasn't utilized the services of any interns, mentors or volunteers during this review cycle.

1.02 Provision of an Abuse Free Environment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The shelter has written policy and procedures that promotes the high standards of professional conduct work performance and the well-being of the youth. A review of fourteen staff personnel records found that each staff signed the receipt of the Young Men's Christian Association's (YMCA) Employee Handbook and Oath of Loyalty acknowledging the Standard of Conduct that all staff must adhere to. The code of conduct details the expectations for ethical and professional behavior, including the expectation for staff to interact with youth in a manner which promotes their emotional and physical safety.

Youth and staff surveys confirmed that access to the Florida Abuse Hotline is unhindered. Five staff and four youth were surveyed. All youth reported feeling safe at the shelter. Each youth surveyed reported that the staff were respectful when talking to the youth. All staff and youth feedback from surveys supported the program is free from profanity and physical, psychological and emotional abuse. All staff surveyed were able to describe the program's practice for allowing youth to call the Florida Abuse Hotline to report allegations of abuse. Observations identified during the shelter's tour revealed signage of abuse registry numbers throughout the shelters in all common areas.

1.03 Incident Reporting

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The shelter has established policy and procedures regarding reporting (which includes the Department of Juvenile Justice's criteria for reporting abuse). All shelter staff are trained on the procedures and are required to adhere to the shelter's procedures regarding abuse reporting. The shelter had five Central Communications Center (CCC) reports in the last six months. A review of the reports found that all was reported to the Central Communications Center (CCC) within the required two-hour time frame of the caller gaining knowledge of the incident.

1.04 Training Requirements

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Four staff training files were reviewed for documentation of first year training. The shelter's training plan and documentation verified new staff completed a minimum of 80 hours during the first

year of hire. Each first-year training file reviewed documented staff completed the essential skills training—CPR and First Aid, Crisis Intervention and Suicide Prevention.

Four training files were reviewed for annual in-service training. Each file documented the staff exceeded the required forty-hour training requirement. Each staff had current first aid and cardiopulmonary resuscitation (CPR) certification. All staff also had documentation of the professional ethics and suicide prevention training. All staff receive instructor-led training throughout the calendar year by administrative staff, contracted mental health, and medical providers. All five surveyed staff indicated that they feel adequately trained to perform their jobs.

1.05 Analyzing and Reporting Information

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy regarding the analyzing and reporting of information. Direct care staff and directors meeting minutes were provided as evidence that the program reviews data and outcomes as required. Youth files are reviewed monthly as evidenced by documentation in files. The program started to use the Pyxis med-station in December, so no quarterly review of medication management practice via Knowledge Portal or Pyxis Med-Station Reports were available at this time.

1.06 Client Transportation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a Client Transportation policy in place that was implemented in August 2015. The policy requires staff who transport youth to pass a driver's license background check prior to being hired and must have a valid Florida driver's license. Prior to providing transportation, staff must pass an on-line training through the Y as well as a physical driving training administered by administrative personnel. All staff who have completed their driver's training and are in good standing get covered under the Y insurance policy.

When feasible a third party will be present in the vehicle while transporting a youth. However, if a driver is transporting a single youth, there must be evidence the Program Supervisor or Director is aware prior to the transport and consent has been given and documented. The Y has installed cameras in each of the vans used in transportation to monitor interactions between staff and youth. These cameras are to be monitored by the Director on an as needed basis. Documentation of the vehicle use will indicate the name or initials of the driver of the vehicle, the date and time of the transportation and the purpose of travel and location.

In practice the agency keeps a transportation log that is used for every transport. The log documents the date, time, staff initials, destination, a list of all youth being transported, and the gas level. The shelter completes a risk evaluation on each youth during the admission process to the shelter. Any youth not approved for single client transports will be documented at that time. All staff employed at the shelter have passed a thorough eligible driver screening process. There was documentation each staff had a valid driver's license, passed a written driving test, as well as, a physical driving test. The agency did not have an actual list of all the approved drivers; however, one was being develop at the time of the review.

Each day the staff develops a list of all transports for the day. Every transport is listed and includes the youth going and the staff who will be doing the transport. Single client transports are also included on this list. The Residential Director signs this list, indicating approval, however; this approval is usually done when the transports are already in progress. It was recommended that the staff develop this list the day prior to ensure the Residential Director can approve the transports and single client transports, prior to them occurring. There is documentation in the log book that single client transports involving youth and staff of opposite gender were approved prior to the transport occurring.

There were instances of transports that start as a multi-youth transport but at the end are single client transports due to the other youth being dropped off. In those occurrences it was recommended the driver call the program and notify the supervisor on duty that the transport had turned into a single client transport.

1.07 Outreach Services

☐ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy to address this indicator. The program provided documentation of meeting minutes as proof of participation/attendance for the following meetings: Sarasota County Juvenile Justice Council Meeting, Safe & Drug Free Schools Advisory Committee, and Circuit 12 Coalition Against Human Trafficking. The program has 24 written interagency agreements. Those agreements did not specify what services would be provided or the length of time for the agreement.

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 to status offenders that include runaways, truants, ungovernable and lockout youth. Trained staff members are available to determine the needs of the family and youth upon call or referral for services.

Residential services are provided and includes 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 a case-by-case basis.

The Sarasota YMCA Family Counseling component 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.

The agency's organizational chart lists Mrs. Sonia Santiago, LMHC as the Vice President and Clinical Director. Mrs. Santiago oversees all CINS/FINS residential and non-residential staff and members. Additionally, the organizational chart lists Shad Renick as Shelter Director.

2.01 Screening and Intake

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place for Screening and Intake. There were five non-residential files and four residential files reviewed. All files documented the eligibility screening was completed within seven calendar days of the referral. All five files contained documentation that youth and parents/guardians received a list of available service options, rights and responsibilities of youth and parents/guardians, the Parent/Guardian brochure, the grievance procedure, and the possible actions occurring through involvement with CINS/FINS services (including case staffing, CINS petition, and CINS adjudication).

2.02 Needs Assessment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There were five non-residential files reviewed. All Psychosocial Assessments were completed within three face-to-face contacts and were conducted by Bachelor's or Master's level staff. No youth was identified with suicidal ideations/issues during the course of the intake/needs assessment, but two of the youth either admitted to threatening suicide or feeling hopeless. A suicide risk assessment was completed immediately by the counselor to determine any issues and was reviewed by a licensed mental health professional.

There were four residential files reviewed. All Psychosocial Assessments were completed by Bachelor's/Master's level staff. Two of the files noted suicidal issues during the course of the Psychosocial Assessment. Suicide Assessments were completed and reviewed by a licensed mental health professional.

2.03 Case/Service Plan

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There were five non-residential files reviewed (three open and two closed). In the two closed files, the Case/Service Plans were not signed by the parent/guardian, but it was noted that the parent/guardian had participated by phone. In one of the files, the 30 day Case/Service Plan Review was out of compliance by one day.

There were four residential files reviewed. Three of the four reviewed had pre-printed Case Review goals including: 1) positive adjustments to the shelter, 2) attend school daily, and 3) counseling for the individual and family. Only one of the files had two added specific goals for the client. However, the issues noted in the Psychosocial Assessment were being addressed by the counselor with progress documented in the progress notes. It was recommended that these also be documented on the Case/Service Plan.

2.04 Case Management and Service Delivery

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place for Case Management and Service Delivery.

There were five non-residential and four residential files reviewed. All files document service plan implementation and youth's/family's progress in completing services. All cases had a counselor/case manager assigned. All files documented support for families. None of the non-residential cases required court hearings/related appointments and case monitoring/review of court orders. All closed residential files documented up-to-date follow-up.

2.05 Counseling Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There were five non-residential files reviewed. Counseling was provided to the youth and the family in appropriate instances. Case notes directly referenced the Case/Service Plan. Clinical reviews were held regularly.

There were four residential files reviewed. The main issues were the counseling services were not connected to the Case/Service Plan in three of the four files. However, the issues noted in the Psychosocial assessments were being addressed during the actual counseling sessions as indicated by the case notes.

2.06 Adjudication/Petitiion Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There were three Case Staffing and/or Court files reviewed (one CCS only and two with both CCS and court). The Case Staffings were represented by the school, DJJ/Provider, and law enforcement in three of the four files. It was noted that a representative from Coastal will be representing a Mental Health Agency. All parties were notified within required time-frames. Case/Service Plans were updated to reflect recommendations from the committee.

2.07 Youth Records

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place for Youth Records. A total of nine files were reviewed. All files were marked “confidential”, kept in a secure area, and locked in a file cabinet. The areas with the file cabinets could also be locked. All youth records were neat and orderly.

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 Sarasota YMCA shelter facility is located in central Sarasota near the intersection of Bahia Vista Street and Tuttle Avenue. The shelter is adjacent to the YMCA's gymnasium which provides access to recreational opportunities for youth during their shelter stay. The shelter building includes a common/day room and girls and boys dorm style bedrooms. The shelter also includes an industrial kitchen, dining room, laundry room, Shelter Director and Staff offices, large patio, open courtyard area and a multipurpose/activity/computer room.

The Sarasota YMCA residential team is comprised of twenty-three (23) Behavioral Coaches, six full-time and seventeen part-time and PRN positions. In addition, there is also a full-time Program Director, Residential Manager, Case Manager, and Administrative Assistant. The Behavioral Coaches 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.

3.01 Shelter Envonment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedures for the shelter environment.

There is a thorough Emergency and Disaster Preparedness Plan. It was revised in August 2015 and includes all areas consistent with Florida Network Policy and Procedure 5.05. Annual fire inspection was conducted 1/22/16 by Piper Fire Protection. The report found all fire safety equipment to be in good condition and functional with no discrepancies.

Fire and Emergency Drills were conducted 3 times per month and detailed feedback is provided to staff on drill forms in order to improve responses to incidents and to maintain consistency with practice. Fire drills are primarily conducted by full time staff. Recommendation: Avoid utilizing the Emergency drill for instances that are consistent with typical occurrences within the shelter environment (e.g. complaint of back pain or cramps, sore throat, argument between 2 residents).

Facility does have a knife-for-life, stocked first aid kit, wire cutters and bio-hazard waste disposal bin located in staff office. The Current Health Inspection is posted in the kitchen dated for 5/22/15. The last residential group care inspection as well health inspection was conducted during the review on 1/27/16. There are no findings on the report. DCF Child Care License is posted in the entrance lobby and dated for June 2015. A large laminated copy of the daily activity schedule is posted in the kitchen and recreational room. An additional copy is provided to residents in the resident handbook.

Bedrooms are clean and have sufficient lighting. All youth have linens and pillows in addition to a personal locker utilized to store personal belongings. Beds are marked by letters that correspond to youth lockers. Youth rooms are well-organized and clean with no hazardous materials identified. Doors to resident restricted areas are locked. CCC information is posted in the staff office while general rules are posted in youth common area along with grievance forms. However, there wasn't a grievance box present for youth to submit grievances. 3 grievances were reviewed, however only one included a date that the grievance was resolved.

Exterior areas of the facility were well-maintained with no sight of equipment or materials that could be potentially hazardous to staff or youth at facility.

Cameras are operational. There are 16 located throughout the interior and exterior of the shelter. There are also 3 cameras located in the vans (1 per vehicle). All bathrooms were found to be clean and in good working order. Within the boys bathroom there were chemicals stored behind a locked door. Remaining chemicals were stored behind a locked door along with extra hygiene supplies in the laundry room. Daily schedule is posted in the kitchen and in the common area. The MSDS book is updated with chemical counts (conducted weekly). Laundry room equipment is working properly.

Recommendation: Avoid utilizing the Emergency drill for instances that are consistent with typical occurrences within the shelter environment (e.g. complaint of back pain or cramps, sore throat, argument between 2 residents).

Exceptions

Install a grievance box for residents to submit grievances.

There is siding missing on bottom exterior of on one of the girl's showers. During Group Care Inspection by local Health Department, the inspector requested the repair be made. This was not, however, a finding on the report from the Department.

3.02 Program Orientation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedures for program orientation. There were five files reviewed (three open and two closed). All files were consistent with ensuring both residents and parents were properly oriented into shelter services and environment within 24 hours of intake. The Y currently utilizes a Shelter Intake Checklist to indicate what items were reviewed at the time of intake. Intake checklist includes items indicated in policy. The Y also has each client sign a Safe Place Agreement to provide information and steps regarding notification of staff concerning thoughts/plans of harming self or others. Additionally, a resident handbook is distributed to each client at this time. Handbook contains detailed information regarding the shelter, youth rights, Behavior Management System, meal information, abuse/neglect reporting, medical care, education, religious services, and other pertinent information to ensure residents are informed.

Recommendation: Maintain consistency regarding documentation of Resident Intake Checklist through initialing each component reviewed.

3.03 Youth Room Assignment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedures for Youth Room Assignments. There were five files reviewed (two open and three closed). All files were consistent with ensuring the proper information was collected to make appropriate room assignments. Information collected included youth age, gender, history of violence, physical size or strength, suicide risk and gang affiliation. Based on client files, shelter staff are consistent with utilizing system through answering questions in a thorough manner. Consistently in files there were detailed explanations for room assignments as well as interactions during the intake.

Recommendation: Maintain consistency regarding documentation of room assignments by placing a check, or an "X" in the spaces that ask questions or indicate an answer by N/A.

3.04 Log Books

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedures for maintaining and updating appropriate information in the logbook. The Y has a printed logbook alert system that is utilized consistently by staff. The alert system includes highlights that are to be made to indicate the type of entry. When applicable, logbook entries had proper color highlights that corresponded to information written in the book. Two logbooks were reviewed for this indicator (September 2, 2015 – January 17, 2016 and January 17, 2016 – current). Medication notices, staff notes, incidences, shift summaries and youth census updates were included.

Additionally, Program Director provides feedback to staff through written notes upon review of the logbook concerning significant information that needs to be shared with incoming staff. Corrections were made using the strikethrough and initial method.

3.05 Behavior Management Strategies

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy on Behavior Management Strategies last reviewed in August 2015. The system is a level based system with five different levels—0, I, II, III, and Masters level. The system is explained in the Youth Shelter Resident Handbook each youth receives at admission. The level privileges and restrictions are printed in the handbook. The system uses daily point sheets for each youth. The youth earn points for completing certain tasks and maintaining certain behaviors throughout the day. How many points a youth receives each day will determine their eligibility for moving up a level. Youth with the appropriate point values may apply for a level change. Points are tallied on a daily basis. Youth earn more privileges with each level they move up. Once a youth moves up a level they must earn (at a minimum) the points required for that level or they will be dropped down a level. Once a youth reaches Master's level they qualify for a Master's level outing of their choice.

A sample of training files was reviewed and confirmed staff had received training on the Behavior Management System. Youth survey's revealed youth are never sent to their rooms for punishment reasons. A review of a sample of daily point sheets revealed staff are consistently using the system appropriately and fairly. When the youth did not earn points for a certain task, staff would document on the back of the point sheet the reasons why.

3.06 Staffing and Youth Supervision

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

The agency has a policy in place to address Staffing and Youth Supervision Requirements. Documentation reviewed reflects the shelter maintains the required ratios of 1 staff to 6 youth during awake hours and 1 staff to 12 youth during sleeping hours. Documentation reviewed reflected they have a minimum of two staff present on each overnight shift. The program makes efforts to maintain at least one staff on duty of each gender; however, they only have six full-time staff leading 16 shifts weekly to be covered by PRN (or part-time) staff. Recently a full-time Residential Manager was hired to help provide coverage and address staffing needs.

The program has a video surveillance system that maintains footage for 14 days. Reviewed documentation and video coverage on 1/23/16 reflects staff performs observations of the youth every 10-minutes while they are in their sleeping rooms.

Exception

On 1/22/16 and 1/26-27/16 third shift camera footage showed staff not completing bed checks per policy. A review of documentation indicated staff falsely documented 10-minute bed checks for both of those shifts. The program placed a call to the CCC and reported a plan to address those two staff members.

3.07 Special Populations

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy regarding special populations. The program reports that they have not served any staff secure, probation respite, or domestic minor sex trafficking youth in the past 6 months. There was one domestic violence respite closed case file to review. This youth did not have a length of stay that exceeded 14 days. The services documented were consistent with all other general CINS/FINS program requirements. The case plan in the file did not reflect goals focusing on aggression management, family coping skills, or other interventions designed to reduce reoccurrence of violence in the home. The supervisor reports that the counselor that created this plan was a new employee and is no longer employed with the agency.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The Sarasota YMCA residential program provides screening, counseling and mental health assessment services. The agency has a Program Director and Residential Manager that oversees daily operations. The program has direct care staff members that are trained to screen, assess and notify all employees 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 CINS Intake form to determine eligibility and various screening methods to determine the presence of risks in the youth's past mental health status, as well as, their current status. The agency also screens for the presence of acute health issues and the agency's ability to address these existing health issues. The agency also uses a general alert board and a 2-colored system for notification. This is to inform all staff members on each shift of the health and mental health status of all youth in the residential youth shelter.

The Sarasota YMCA CINS/FINS program assists in the delivery of medications to all youth admitted to the youth shelter. The agency operates a detailed medication distribution system using the Pyxis Med-Station 4000 Medication Cabinet. The agency utilizes a nursing agency and has a Registered Nurse (RN) on-site at least five days a week. The RN provides training for staff and oversees the medication distribution process. The agency provides medication distribution, first aid response, CPR, fire safety, emergency drills and exercises, suicide prevention, observation and intervention techniques training to all direct care staff members.

4.01 Healthcare Admission Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedures on Healthcare Admission Screening that was last reviewed in August 2015. If the nurse is on-site at the time of the youth's admission then the nurse will conduct the screening, otherwise non-health care staff will conduct the screening. During the screening and admission process the youth and parent/guardian will be questioned about any medical needs or problems. The youth are screened for serious and/or acute medical, mental health, and substance abuse conditions. If the youth has any of these conditions, the parent/guardian will establish guidelines for daily medical care and routines. If there is a need for medical follow-up the nurse or non-healthcare staff will document any communication with the parent/guardian. If the youth has not been treated for a condition, the nurse or non-healthcare staff will follow-up with the parent/guardian to schedule an appointment as soon as possible and document communication.

A total of five residential files were reviewed (3 active and 2 closed). All five files documented the initial Healthcare Admission Screening was completed using the CINS/FINS Intake Assessment Form. Three of the youth documented current medications and the reasons for the medication were listed. None of the youth had any chronic medical conditions requiring follow-up medical care; however, the agency does have procedures if needed.

4.02 Suicide Prevention

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There is a policy and procedures in place on Suicide Prevention that was last reviewed in August 2015. At admission, youth are screened for mental health, substance abuse, suicide risk issues using the CINS/FINS Intake Assessment Form. Staff also document observations of behaviors that indicate orientation to time, place and person, depression, and agitation. If the youth answer "yes" to any of the six applicable questions on the CINS/FINS Intake Assessment the youth will be placed on constant sight and sound supervision until a face-to-face suicide risk assessment can be completed by a qualified professional. If at any time during the screening any staff observes or believes a youth presents an immediate threat to themselves or others, the youth will be placed on one-to-one supervision and staff will immediately call 911 and/or follow Baker Act procedures.

Youth on sight and sound supervision are not allowed to go to school, will not be transported outside of the shelter, and will sleep in an individual room in direct supervision of overnight staff until clearance is issued by the Clinical Director. If youth are not identified as at risk of suicide after the intake procedures, no further assessment is needed and the youth may be placed in the general population for the purpose of service delivery.

There were three closed youth files reviewed. All three youth documented a "yes" on at least one of the six applicable questions on the CINS/FINS Intake Assessment form. All three youth were immediately placed on sight and sound supervision until an Assessment of Suicide Risk (ASR) was completed. All three files documented the ASR was completed on the same day as admission by the Licensed Mental Health Counselor (LMHC). All three youth were removed from suicide precautions and placed on standard supervision. There were thirty minute observations of the youth the entire time on suicide precautions. There was documentation in the logbook for each youth when placed on and removed from suicide precautions. There was also a case note in the youth's file for each instance of suicide precautions. Youth on sight and sound supervision during the overnight hours either sleep in the single occupancy room or on the couch, so they can be easily monitored by staff.

4.03 Medications

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedures for medications. All medications were stored in the Pyxis Med-Station with the exception of OTC. There is a refrigerator on-site in the staff office for medication usage. The staff office also has a list posted of designated persons that have access and permission to administer medications. OTC medications, sharp disposal, locked sharps (razors assigned to youth) are also in the staff office behind an appropriate number of locks. Medication records contain youth name, date of birth, allergies, medication side effects, youth picture, staff and youth initials, staff and youth signatures, and full printed name of each staff. Counts are completed each shift for all medications on site. Agency currently has 2 site specific Super Users (Program Director and Administrative Assistant) with both having some knowledge of running reports on the Knowledge Portal website.

4.04 Medical/Mental Health Alert Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy and procedure in place for the Medical/Mental Health Alert process that was last reviewed in August 2015.

When a youth comes into the shelter with allergies or a medical/mental health condition of which the staff needs to be aware, staff will be alerted by several different means. A red dot is placed on the youth's file and on the census board. A Medical and Mental Health Alert Form is placed in the front of each youth's open file; any youth on sight and sound supervision will have a green dot on the census board until cleared for normal supervision by the Clinical Director. Medications and/or medical issues are identified on each youth's screening form in the youths file. If a youth has a food allergy, the information is posted in the kitchen. A red star next to the youth's name on the census board and on the file indicates an alert.

Staff members are required to check if there any new alerts posted at the beginning of each shift. Changes and updates are required to be posted in the communication log and on the youth's daily log note. All staff members are required to be trained on the Alert system to ensure that they are aware of the system and able to recognize and respond to medical and mental health issues that require emergency care or treatment.

There were five open residential youth files reviewed. All five files had the Medical and Mental Health Alert Form completed in the file. The alerts identified on the Alert Form coincided with the alerts identified during the screening and assessment process. Any youth on medication or with medical alerts were also identified on the census board in the staff office. All alerts are also documented in the logbook under the youth's initial intake note.

4.05 Episodic/Emergency Care

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy and procedures in place for Episodic/Emergency Care that was last reviewed in August 2015. The current policy is designed so that the Sarasota YMCA Youth Shelter ensures client/resident safety by providing rapid and appropriate emergency medical and dental care. The policy requires that all instances of first aid and/or emergency medical care are documented in the Episodic/First Aid Emergency care log, Episodic First Aid Critique Log, client record, and in the communication log. All parents are required to be notified immediately of any medical/dental emergencies. The policy also requires all staff who have direct care responsibilities to maintain current training in CPR/CCR, first aid, and knife-for-life.

The shelter has had one instance of off-site first aid care in the last six months. The incident was reported to the CCC and the youth's guardian was also notified. The incident was documented in an incident report, in the log book, and also in the youth's file. There was no follow-up care required. The shelter has conducted thirteen emergency medical drills over the past six months. The drills occurred on various shifts and various topics. Some of the drills were actual instances of staff providing first aid care on-site. All drills were documented on the Emergency Drill form and included date and time of drill, staff and youth involved, nature of the drill, length of drill, response time, notes, and a critique/follow-up.

The shelter has two first aid kits. The main first aid kit is located in the staff work area and the second, smaller kit is located in the kitchen. Both of these first aid kits are checked weekly by staff and restocked if needed. The weekly check also includes a documentation of the expiration dates of items in the kit. There was documentation provided which verified these weekly checks for the last six months. The shelter has a knife-for-life and wire cutters located in the staff office in a locked box.

A sample of staff training files was reviewed and confirmed these staff had current first aid and CPR certifications.