



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Sarasota YMCA

on 05/03/2017

CINS/FINS Rating Profile

Standard 1: Management Accountability

1.01 Background Screening of Employees/Volunteers	Satisfactory
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Limited
1.05 Analyzing and Reporting Information	Satisfactory
1.06 Client Transportation	Satisfactory
1.07 Outreach Services	Satisfactory

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

Standard 3: Shelter Care

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

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

Standard 2: Intervention and Case Management

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

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

Standard 4: Mental Health/Health Services

4.01 Healthcare Admission Screening	Satisfactory
4.02 Suicide Prevention	Satisfactory
4.03 Medications	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%

Percent of indicators rated Satisfactory: 92.59%
Percent of indicators rated Limited: 7.41%
Percent of indicators rated Failed: 0.00%

Rating Definitions

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

Satisfactory Compliance	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.
Not Applicable	Does not apply.

Review Team

Members

Marcia Tavares, Lead Reviewer - Consultant, Forefront LLC

Danielle Husband, Regional Director, Youth and Family Alternatives (RAP House)

Mark Olshansky, Residential Program Coordinator, Florida Keys Children Shelter

Danielle Taylor-Fagan, Director of Quality and Integrity, Family Resources

Persons Interviewed

- | | | |
|---|--|---|
| <input type="checkbox"/> Chief Executive Officer | <input checked="" type="checkbox"/> Executive Director | <input type="checkbox"/> Chief Operating Officer |
| <input type="checkbox"/> Chief Financial Officer | <input checked="" type="checkbox"/> Program Director | <input checked="" type="checkbox"/> Program Manager |
| <input checked="" type="checkbox"/> Program Coordinator | <input checked="" type="checkbox"/> Direct- Care Full time | <input checked="" type="checkbox"/> Direct-Care Part Time |
| <input type="checkbox"/> Direct-Care On- Call | <input type="checkbox"/> Volunteer | <input type="checkbox"/> Intern |
| <input checked="" type="checkbox"/> Clinical Director | <input type="checkbox"/> Counselor Licensed | <input checked="" type="checkbox"/> Counselor Non- Licensed |
| <input checked="" type="checkbox"/> Case Manager | <input type="checkbox"/> Advocate | <input checked="" type="checkbox"/> Human Resources |
| <input type="checkbox"/> Nurse | | |
| 1 Case Managers | 0 Maintenance Personnel | 1 Clinical Staff |
| 2 Program Supervisors | 0 Food Service Personnel | 4 Other |
| 0 Health Care Staff | | |

Documents Reviewed

- | | | |
|---|--|---|
| <input type="checkbox"/> Accreditation Reports | <input checked="" type="checkbox"/> Fire Prevention Plan | <input type="checkbox"/> Vehicle Inspection Reports |
| <input checked="" type="checkbox"/> Affidavit of Good Moral Character | <input checked="" type="checkbox"/> Grievance Process/Records | <input type="checkbox"/> Visitation Logs |
| <input checked="" type="checkbox"/> CCC Reports | <input type="checkbox"/> Key Control Log | <input checked="" type="checkbox"/> Youth Handbook |
| <input checked="" type="checkbox"/> Logbooks | <input checked="" type="checkbox"/> Fire Drill Log | 3 # Health Records |
| <input checked="" type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 3 # MH/SA Records |
| <input type="checkbox"/> Contract Monitoring Reports | <input checked="" type="checkbox"/> Table of Organization | 8 # Personnel Records |
| <input type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 10 # Training Records |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 10 # Youth Records (Closed) |
| <input checked="" type="checkbox"/> Fire Inspection Report | <input type="checkbox"/> Telephone Logs | 14 # Youth Records (Open) |
| <input type="checkbox"/> Exposure Control Plan | <input checked="" type="checkbox"/> Supplemental Contracts | 0 # Other |

Surveys

3 Youth 3 Direct Care Staff

Observations During Review

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

Comments

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

Rating Narrative

Strengths and Innovative Approaches

Rating Narrative

Sarasota YMCA, Inc. is headquartered in Sarasota, Florida and is contracted with the Florida Network of Youth and Family Services (Florida Network) to provide direct services to Children/Families in Need of Services (CINS/FINS). Sarasota YMCA, Inc. is located in the 12th Judicial Circuit that encompasses DeSoto, Manatee and Sarasota Counties. Sarasota YMCA is a private 501(c)(3) non-profit social services agency that provides a wide range of social and behavioral services to youth and families in Southwest Florida.

Since the last on-site Quality Improvement review the agency has hired a new CEO for the Sarasota Y, Laura Gilbert. Ms. Gilbert was previously employed with the agency for over 20 years in various positions including Contract Manager for all programs and Vice President of Operations for Evelyn Sadler Jones Fitness Branch. She has also been involved in the community for many years and brings much experience to the position.

Some of the program and facility improvements during the past year include:

§ The program had another incident with bed bugs and went through the process of fumigation. Consequently, new bunk beds were purchased and set up in both dormitories.

§ A Program Coordinator position was created to assist in the daily operations of the Shelter; Charles Harris was promoted to this new position. Mr. Harris continues to perform case manager duties until a new case manager is hired.

§ A new Residential Counselor was hired in December 2016.

§ The program currently has two vacancies: Case Manager and an Administrative Assistant (resigned two weeks prior to the visit).

§ The Y received the Basic Center Grant for the first time in 4 years.

§ Community Partners continue to provide groups for our kids such as, Coastal Behavioral (substance use), SPARCC (domestic violence), AA, NA, Community Aids Network, Planned Parenthood, MADD - Mothers Against Drunk Drivers, and Genesis - health issues.

§ The program has many volunteer groups who provided a variety of services such as: staining the deck, replacing tables and umbrellas, placing big pots of flowers, and painting the main entrance foyer and the kitchen (St. Armand's Lutheran Church).

§ "Done in a Day" project painted the boys dorm room and the day room.

§ A fund raiser was held on March 17 by Shamrock Pub to raise funds for new flooring.

§ The Y Board members take an active role in the program by accompanying youth on outings periodically.

§ The non-residential program has filled 2 counselor vacancy positions, one in DeSoto County and another in Sarasota County.

§ A new Safety Plan is currently being used in both programs.

Standard 1: Management Accountability

Overview

Narrative

The Sarasota Family Young Men's Christian Association, Inc. (YMCA) is a charitable nonprofit organization, qualifying under Section 501(c)(3) of the U.S. Tax Code. Sarasota Y is under the leadership of a Board of Directors and President and Chief Executive Director. In July 2016 Kurt Stringfellow resigned as President and CEO. Laura Gilbert was named as interim President and CEO of Sarasota Family YMCA, Inc. on September 30, 2016 and became the first female President and CEO in Sarasota Y's history when she was promoted to the position on March 16, 2017.

Sarasota Y operates the CINS/FINS Residential and Non-residential programs under the leadership of Sonia Santiago, VP and Clinical Director for Youth and Family Services. The Family Management Services is comprised of 4 full-time and 1 part-time Direct Supervision Consultants; 3 Triad clinical consulting staff; and 1 youth shelter clinical consulting staff. The youth shelter is under the direction of Shad Renick, Program Director. The shelter is staffed by a Program Coordinator, Residential Manager, a Counselor, a Case Manager, six Behavior Coaches, and seventeen part-time PRN Behavior Coaches. At the time of the quality improvement review, the program reported two vacancies for an Administrative Assistant and a Case Manager.

The agency's human resources office handles all its personnel functions including the processing of state and local background screenings and human resource functions. Annual training is tracked according to the employee's date of hire. An individual training file is maintained for each employee, which includes supporting documentation such as sign-in sheets and certificates. The provider agency conducts orientation training to all shelter personnel through a combination of training sources that include the Florida Network, local community resources, and various local providers. Each employee has a separate training file that contains a training attendance form and corroborating documentation for training received.

1.01 Background Screening

Satisfactory

Limited

Failed

Rating Narrative

The provider has a Background Screening Policy and Procedure # 1.01 that was reviewed and signed by the President and Shelter Director in May 2017. The policy and procedures address the background screening of all employees, volunteers, and interns prior to any offer of employment or volunteer service.

Sarasota Y Youth and Family Services (Y) requires all staff and volunteers to complete a DJJ Background Screening (DJJ BSU) in accordance with FS Chapters 39, 435, 984, and 985 with the request for final background screening submitted within five days of their date of hire or start date. Prior to completing a Live Scan, Human Resources will check the clearinghouse database to see if the applicant has a current background screening on file. If the prospective employee's record is not found, the agency will proceed with the submission of a Live Scan. Upon receipt of an eligible screening result, the agency will formally make an offer of employment. An Annual Affidavit of Compliance with Good Moral Character is submitted to DJJ each January for all staff. All employees are re-screened every 5 years from the initial date of hire.

A total of eight (8) applicable personnel files were reviewed for seven (7) new staff and one staff eligible for 5-year re-screening. The seven new staff were hired after the last onsite QI visit and all seven files maintained evidence of eligible screening results prior to hire. The one staff that was eligible for a 5-year re-screening had the re-screening conducted within the required time frame prior to the staff's five-year anniversary date. The program had no volunteers/interns providing service during the review period.

Electronic submissions of Department of Homeland Security E-verify for the seven new employees were verified, confirming the employees' work eligibility.

The agency submitted its Annual Affidavits of Compliance with Level 2 Screening Standards via email to DJJ BSU on 12/19/2016 prior to the January 31st deadline.

No exceptions are noted for this indicator as of the date of the QI visit.

1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy and procedure # 1.02-Provision of an Abuse Free Environment (reviewed August 2016) and HR-4.04 – Code of Conduct and Behavior (revised December 18, 2008) that meets the requirement of the indicator.

The agency requires staff to adhere to a code of conduct that prohibits the use of physical abuse, profanity, threats or intimidation. The Y's personnel policy and procedures establishes the standards and the agency's behavioral expectations of staff conduct that prohibits use of any kind of abuse (verbal, sexual, or physical), threats, intimidation, and use of profanity. Employees sign an acknowledgement of receipt of the code of conduct and behavior policy during hire and the signed copy is maintained in the employee's file.

The policy also requires staff to report all allegations of child abuse to the Florida Abuse Hotline as well as DJJ CCC hotline. The program requires that calls made to the Abuse Hotline be written in a full report and documented in the Communication Log and the youth's file. The hotline number is accessible to youth and is posted throughout the facility.

The program has a current grievance procedure that is utilized by youth to file a complaint. The procedure is reviewed with youth during intake. A copy of the grievance procedures is included in the resident handbook and the program has a grievance box for depositing grievances. Per the program's procedures, youth are instructed to put their grievance in the box and direct care workers do not handle the complaint/grievance process unless requested by the youth.

A random sampling of 3 personnel files verified acknowledgement of receipt of the personnel policy and procedures which includes information about the required code of conduct.

Signs are posted in the shelter living room, dining room, education room, and front lobby that include the abuse registry hotline number. The program reported only one incident of abuse allegation since the last onsite visit and documentation of the report was found in the logbook and on an incident report form. Surveys were completed with three youth on-site during the QI visit. Two of the three youth surveyed were knowledgeable about the abuse hotline and knew the location of the number. None of the three youth indicated they have attempted to call the hotline while in the shelter.

There are grievance forms in the shelter living room in a slot on the wall that is easily accessible to the youth. There is a clear plastic box on a table in the living room for completed grievances to be folded up and deposited. The Program Director has the key and checks the box daily. In the absence of the Program Director, the Administrative Assistant checks the box and gives the grievances to the Program Coordinator for review.

There have been three grievances submitted in the previous six months. All grievances were signed by the Program Director and two indicated that they were resolved. One was signed by the youth. The other youths were discharged/absconded from the program prior to resolution. All three youth surveyed were

familiar with the grievance process.

Per the HR Director, there have not been any disciplinary actions necessary as a result of physical and/or psychological abuse, verbal intimidation, use of profanity, or excessive use of force by staff during the review period.

No exceptions are noted for this indicator as of the date of the QI visit.

1.03 Incident Reporting

Satisfactory

Limited

Failed

Rating Narrative

There is an incident reporting policy # 1.03 which was revised and reviewed in May 2017. The policy references reporting requirements, entities as well as notification processes and procedures and follow-up. There is a staff member identified who reviews incidents daily for risk management purposes.

The provider's procedures include requirements for a two hour time-frame for reporting, a numbering system, filing of reports, staff arrests, "out of the ordinary" incidents, supervisory signature, and serious incidents. Every morning, the previous day's incident reports are scanned to the Y's administrative office for distribution with the 24-hour time report. The program director will sign the original report and maintain these in an incident report file.

Six CCC reportable incidents occurred within the previous six months. All of the incidents were called in to the CCC within the two hour time-frame; all included a supervisor's signature and all of the incidents were documented in the house log. The program completed follow-up communication tasks/special instructions as required by the CCC.

No exceptions are noted for this indicator as of the date of the QI visit.

1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

There is a policy # 1.04 for training requirements, revised and reviewed in May 2017, which specifies positions, number of hours to be completed, and timelines for completion of mandatory training.

The program's procedure outlines the training topics and time-frames for each to be completed and indicates that staff members will have an individual training file that includes documentation of training, including certifications, re-certifications, examinations, practicum, and test results. It also outlines staff members, by position, who will have access to JJIS. The Y requires all staff to attend a Pre-Service Orientation, program orientation, and job shadowing within the first 30 days of hire. During the first year, direct care staff will receive 80 hours of training and in-service staff will receive 40 hours of job related training. A training file is maintained for each staff that includes the current year training onsite.

A total of eight training files were reviewed for this indicator including three training files for staff who were employed after July 1, 2016 and were beyond 120 days, one staff training file for a staff member employed for 13 months, one first year direct care clinical shelter staff training file, and three in-service staff training files.

Three of the four first year staff were on target or had exceeded the 80 hours of training required annually. Completion of mandatory training topics during the first 120 days was applicable to three of the four first year staff. During the first 120 days of employment some of the required trainings were not completed by the 3 applicable staff as well as the one staff who recently completed the first year who did not complete

two of the required trainings.

The three in-service training files reviewed demonstrated evidence of on-going training; however, all three staff had not completed the bi-annual Managing Aggressive Behavior (MAB) training and one of the three did not complete PREA every two years as required. As of the date of the review, all three had completed the mandatory Fire Safety, CPR, and Suicide Prevention; one of the three did not have a current First Aid certification training. All 3 in-service staff had completed the 40 hours of training required annually.

The provider had one applicable first year non-licensed clinical shelter staff during the QI review. There was evidence the staff received training or Assessment of Suicide Risk.

Exceptions:

One of the first year staff, DOH 12/27/2016, had only completed 20.5 hours of training to date and did not show evidence of orientation training.

It was apparent that two of the mandatory training topics were not provided and/or completed by first year staff in the program. The 3 applicable first year training files reviewed for staff hired after July 1, 2017 did not show MAB and Understanding Adolescent Development training during the first 120 days of employment and one of the three staff also did not show the required CINS/FINS Core training during the required time-frame.

The staff who recently completed the first year of employment was missing two required trainings: MAB and Understanding Youth Development.

The three in-service training files did not show evidence of completion of the bi-annual Managing Aggressive Behavior (MAB) training and one of the three did not show receipt of the PREA training required to be completed every two years.

1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

The provider has a policy #1.05 that indicates several sources of information is collected and reviewed for patterns and trends. The Administrative Assistant oversees the data collection, which is shared with staff and identifies strengths and weaknesses as well as improvements to be implemented or modified. The policy was last reviewed in August 2016.

There is a procedure that outlines the specific data that is collected, staff positions responsible for collecting and reviewing the data, and the purpose for the data collection. Specifically, case files are reviewed during intake and discharge by the Program Director, Case Manager, and Director. A quarterly review is done by members of management.

Incidents, accidents, and grievances are reviewed monthly. The Risk Manager reviews incident reports monthly and a summary report is sent to the Executive Director and shelter Program Director. Grievances are reviewed upon submission by the Program Director. Results of the reports and satisfaction surveys are shared monthly at staff meetings and documented in the minutes.

The Administrative Assistant reviews satisfaction surveys and areas of concern are shared with the Program Director, reviewed at monthly staff meetings for trends, and recommendations are put in place if necessary.

Monthly outcomes are reviewed by the Administrative Assistant and shared with management. Areas of concern or those not being met are discussed. An annual review is completed by the Administrative Assistant, Program Director, VP of Youth and family Services, and the Contract Manager.

A review of NetMIS reports is conducted monthly by the Administrative Assistant and management. Data is discussed at monthly staff meetings. Missing data and areas not being met are discussed with staff for a

solution.

There is a monthly review of medication management via the Knowledge Portal or Pyxis Med-Station reports by the Program Director. The Residential Manager and management reviews the medication distribution process on a regular basis.

Case files are reviewed weekly and at intake and discharge. There is a separate form in each youth's file that is reviewed by members of management for completeness.

Incidents and accidents are reviewed and signed by a supervisor as they occur, or within 24 hours. They are reviewed by the Risk Manager who completes a spreadsheet that delineates the type of incidents/accidents for the month which is reviewed by management to determine if there are trends.

There have been three grievances filed by the youth in the previous six months. Grievances were reviewed and resolved by the Program Manager in a timely manner.

All youth complete a satisfaction survey at discharge. A compilation of the data is completed by the Administrative Assistant and sent to management for review at monthly staff meetings.

Outcome data is reviewed by management and discussed at the monthly director's meeting. Progress and trends are reviewed and any necessary changes to the process or system are made.

The VP of Program Services, Program Director, and Administrative Assistant reviews the NetMIS data reports monthly to determine missing data and maintain accuracy - and is shared at monthly staff meetings to determine areas not being met and solutions.

No exceptions are noted for this indicator as of the date of the QI visit.

1.06 Client Transportation

Satisfactory

Limited

Failed

Rating Narrative

The provider has a client transportation policy # 1.06 which was revised and reviewed in July 2016. It is the agency's policy to ensure youth and trained drivers are safe during transports and avoid situations that put youth and staff in danger of real or perceived harm, or allegations of inappropriate conduct by either staff or youth.

The procedure indicates that an approved driver will have a driver's license background check, valid Florida driver's license in good standing, and has taken and passed an on-line and physical driving test. A list of eligible drivers is posted in the staff work area. The program has three vehicles – all Kia vans.

If feasible, a third party will be present in the vehicle while staff is transporting a client. If a third party cannot be obtained, the client's history and recent behavior is considered prior to single party transport. Cameras that record interactions are on each of the vans. Documentation of vehicle use will indicate the name or initials of the driver, date and time, vehicle mileage, initials or name of the passengers, and the purpose and location. Purpose of travel and name of clients will be documented in the log book.

A school transportation schedule is created each evening for the next day, which is signed by a supervisor. If a youth arrives after the schedule has been created, the on-call supervisor is contacted for approval. The name of the supervisor giving approval is documented on the schedule.

A review of the transportation logs for the past 6 months was conducted. All transports are documented in the House Log Book. Documentation includes time of departure and arrival and the names of clients being transported. A transportation log is maintained and includes the date of transport, destination, fuel level, driver, youth transported, driver, mileage to and from the shelter, and repairs needed.

It is the agency's practice to conduct single party transports to school. Agency policy/procedures do not

indicate that single party transport is made only for the school schedule; however, the practice is that no single party transports are made, other than for the school schedule. In order to document approval for single transport to school, a school transportation schedule is created that indicates the youth being transported to school along with the school they will be transported to. This schedule is signed off by the Residential Manager, Director, or other management team member giving approval for staff to provide transportation to school. Should a youth arrive at the shelter after this list is created, a call to the management team member is made to gain permission to transport. Documentation of the approval is written by the staff transporting the youth indicating which management team member provided them with permission to transport specified youth.

Exception:

Agency procedures states that there is documentation of time and purpose of transport; however, they are not included on the vehicle transport form.

1.07 Outreach Services

Satisfactory

Limited

Failed

Rating Narrative

There is an Outreach Services policy, #1.07, which was most recently revised in August 2015 and reviewed in August 2016. The policy states that the agency will participate in local DJJ board and council meetings to ensure services are represented in a coordinated approach to increasing public safety by reducing juvenile delinquency through effective prevention, intervention, and treatment services.

The program's procedures are the following. The Program Director or designee attends the local Juvenile Justice Council, DJJ local and circuit level meetings (to contribute to the implementation of departmental objectives), Safe and Drug Free Schools, Human Trafficking Coalition, and Behavioral Health County meetings.

The Program Director or designee advocates for the effective use of CINS/FINS services by providing a regular report of Y services and activities to the agency leadership. Various outside agencies provide groups for the youth at the shelter.

Written agreements with community partners are maintained by the director. Agreements include services provided and a comprehensive referral process.

The program director attends local meetings which include Safe and Drug Free Schools, Human Trafficking Coalition, and SPARCC meeting a couple of times. The provider was told there are no more local DJJ Circuit meetings; consequently, no staff attended the quarterly DJJ Board and Council meetings. There is a binder containing regular reports made by the Program Director to the agency leadership.

There is a binder that includes recent MOU's and interagency agreements. Included are agreements with the National Runaway Safeline, Coastal Behavioral Healthcare, Inc., MADD, Youth and Family Services, Safe Place and Rape Crisis Center, and The Family Nutrition Program.

Exception:

The Florida Network Indicator and the agency's procedure indicate that DJJ Board and Council meetings will be attended. These meetings have not been attended by an agency representative.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

The Y provides centralized intake and screening twenty-four hours per day, seven days per week for youth who meet the criteria for CINS/FINS, Staff Secure, DV and Probation Respite, and DMST. Trained staff members are available to determine the needs of the family and youth during the screening and intake process. Residential services include individual and family counseling, and group services. Aftercare planning includes referring youth to community resources, on-going counseling, and educational assistance.

The clinical component of the program is under the supervision of a Clinical Director who is a licensed mental health counselor (LMHC). A total of nine Counselors are responsible for providing counseling and case management services and linking youth and families to various community services. Youth are referred to the Y by a family member, school, or a community partner. Upon referral, the youth goes through an intake screening process, followed by an intake, and a needs assessment. A service plan is developed within a week of the completion of the service plan. Case management and counseling services are provided to meet the needs and goals identified during the intake/service plan process. Counseling and supportive services are offered to parents/guardians/family members as well.

Community based counseling consultants are housed in a separate office building adjacent to the shelter. The residential counselor has an office in the administrative offices of the shelter which is accessible to youth allowing easy access to the counselor. Staffing of cases is done on a regular basis and peer record reviews are done quarterly.

The Y is 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. The Case Staffing Committee can also recommend the filing of a CINS Petition with the court. A review of cases staffed by the Case Staffing Committee is indicative that the provider has initiated case staffing for youth and files for CINS Adjudication as needed.

2.01 Screening and Intake

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy related to this indicator, "Eligibility Screening and Intake", policy 2.01. The policy was last revised on 8/2012 and was last reviewed on 8/2013.

The agency's policy indicates that the residential program is available to screen youth for eligibility for services 24 hours a day, seven days a week. The non-residential program will complete screenings and will follow-up with families within seven days of the receipt of the referral. If the youth is not accepted for services into the residential or non-residential program, it is agency policy to provide the family with the appropriate community based referral. If bed space is not available and the youth is accepted for services in the residential program, efforts will be made to find bed space in a near-by shelter or the youth will be placed on a waiting list.

Five Residential files were reviewed. All five of the Residential files showed evidence of the required items being distributed during the intake process. An interview with the shelter director and shelter manager also indicated the information is provided to the youth and families during screening and intake. They also stated the shelter handbook is provided to the youth at the time of intake; however, there is no documentation that the youth received the handbook at that time.

Three Non-Residential files were reviewed. All three of the files contained evidence that the youth and

parent received the required documents at the time of intake. However, all three files showed a delay between the date of the initial referral and the day the screening was completed.

Exception:

Three Non-Residential files were reviewed and all three of the Non-Residential files showed a delay between the dates of the initial referral for services to the day the screening was completed. One case had a referral date of 12/1/16 and the screening was completed on 1/12/17. The second case had a referral date of 9/26/16 and a screening date of 11/3/16. This case did indicate there had been contact with the family on 10/10/16 but the date of screening was 11/3/16. The third case had a referral date of 10/17/16 and a screening date of 11/2/16.

2.02 Needs Assessment

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy titled "Psychosocial Assessments", policy 2.02. This policy was last revised on 8/2012 and last reviewed 8/2013.

The agency's policy indicates a psychosocial assessment will be completed on youth accepted into the Residential or Non-Residential programs within 72 hours (for residential) or 2-3 sessions (non-residential). The agency's policy indicates the psychosocial assessment is needed to have a clear picture of the issues faced by the youth and family, as it gathers information, identifies risk factors and problem areas and their level of severity. The agency's policy also details the required components for the psychosocial assessment.

Five Residential files were reviewed, two were closed and three were open. All five residential files had the Needs Assessments initiated within 72 hours of intake and were completed within 2-3 sessions. All of the residential Needs Assessments were conducted by a Bachelor's or Master's level staff member and all include a supervisor's signature.

Four Non-Residential files were reviewed. All of the non-residential Needs Assessments were completed by a Bachelor or Master's level counselor and all included a supervisor's signature.

Exceptions:

The agency's current policy and procedure was last reviewed in 2013 and the policy is titled "Psychosocial Assessment"; however, the policy is not consistent with the form the agency is using which is now titled "Needs Assessment".

It was noted that 3 of the 5 Residential files reviewed did not have fully completed Needs Assessments. Three of the residential files did not have the comments on the Mental, Physical and Emotional Status completed or indicated as N/A, etc. Three of the residential files did not have comments or explanations on the Clinical Issues summary completed.

It is noted that 1 of the 4 Non-Residential files reviewed did not have the Needs Assessment fully completed. There were blank areas on the form that did not have the required information included.

It is also noted that 1 of the 4 Non-Residential files reviewed had different dates listed for services and when they were provided. The case had a screening and intake date of 11/3/16; however, the initial referral for services was made on 9/26/16 and notes indicate the counselor made contact with the family on 10/10/16 and met with the youth on 10/27/16. The counselor also completed a suicide assessment with the youth on 10/27/16, yet the record reflects the case had an intake date of 11/3/16.

2.03 Case/Service Plan

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy "Case/Service Plans", policy 2.03. The last revision on the policy was 8/2012 and it was last reviewed 8/2013.

The agency policy on Service Plans indicates that the plans will be developed within seven working days following the completion of the comprehensive assessment process. The policy also indicates the plans will clearly address the specific needs of the youth and family and will include time-frames, target dates, contain measureable components, will identify the location where the services will be provided and identify the person that will be responsible for completing the goal. In addition, the agency's policy indicates new goals can be added as new issues are identified or as a need arises.

Four Residential files were reviewed and three Non-Residential files were reviewed.

All of the seven files included target dates, person responsible for completing the goals and the signature of the youth, parent and counselor. All but one Residential file included a supervisor's signature.

The Non-Residential treatment plans included individualized goals but overall some of the treatment goals were not measureable, as indicated by the agency policy.

Exceptions:

It was noted that all 4 of the Residential files had treatment plans completed/signed prior to the Needs Assessment being completed. Through interviews, it was shared that the youth and family sign a blank treatment plan upon admission and the goals are added over time, at a later date. However, the updated treatment plan does not reflect the dates for new goals being added and the signatures from the youth, parent and staff are only from the date of intake.

The Residential treatment plans did not include the location of where the services were to take place.

One Residential treatment plan did not include the signature of the supervisor.

One Non-Residential treatment plan was initiated at the day of intake 1/13/17 (per the date on the top of the treatment plan); however, it was signed by the youth, parent and counselor on 1/27/17.

2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy "Case Management and Service Delivery", policy 2.04. The policy was last revised 8/2012 and was last reviewed 8/2013.

The agency's policy indicates staff will provide services to the youth referred through direct contact and referral services. Upon entering services and completion of a Needs Assessment, a Service Plan is developed specific to the youth/family with identified objectives, services, and referrals. Follow-up is provided for referrals and other assistance offered. Coordination of services with other agencies is part of case management.

Three Residential files and three Non-Residential files were reviewed. All of the files indicated the youth were assigned a counselor who coordinated service plan implementation and monitored the youth/family progress in services. Appropriate referrals were made for the youth as needed. Support for families was evident in 5 of 5 applicable files reviewed.

30 and 60 day follow-ups were completed by the Residential and Non-Residential programs.

The required components of this standard were met by the Residential and Non-Residential programs for all applicable services needed and rendered.

There were no exceptions noted for this indicator.

2.05 Counseling Services

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy "Counseling Services", 2.05. The policy was revised in 8/2012 and last reviewed 8/2013.

The agency's policy indicates the program provides community based services to stabilize families, keep them intact and prevent the youth going into the delinquency or dependency system. Non-Residential services are provided to youth in targeted zip codes and are accepted from a variety of community partners. The agency also works to determine risk factors and services will be provided on an average of 12 sessions.

Three Residential Files and Three Non-Residential Files were reviewed. Both the Residential and Non-Residential programs indicate they are able to provide individual and family counseling sessions and indicate it as necessary. The treatment plans addressed the presenting problems and notes were maintained regarding individual and family sessions. There is an on-going process to review the files on a very regular basis with the clinical supervisor in the Non-Residential program and with the clinical supervisor and the shelter treatment team.

Exceptions:

One Residential file did not include weekly counseling sessions with the youth. The treatment plan also indicated family counseling was needed; however, family counseling appeared to have not occurred. There is documentation of case coordination with the parents over the phone but no family counseling sessions.

One Non-Residential file indicated the youth and family needed monthly family counseling sessions but there was no evidence of family sessions in the file. The treatment plan also indicated the youth needed weekly individual sessions; however, there were gaps in individual sessions being provided. The youth had individual sessions as follows: 11/11/16, 11/28/16, 12/7/16, 1/4/17, 1/12/17, 1/27/17, 2/7/17, 2/22/17, 3/7/17, and 3/21/17.

Seventeen (17) weeks of groups were reviewed from 1/1/17 through 4/29/17. Of the 17 weeks reviewed, 8 of the weeks did not have evidence of 5 days of groups being completed during the week as follows:

The week of 1/8-1/14/17 had 4 days of groups

The week of 2/26-3/4/17 had 3 days of groups

The week of 3/5-3/11/17 had 4 days of groups

The week of 3/26-4/1/17 had 3 days of groups

The week of 4/2-4/8/17 had 4 days of groups

The week of 4/9-4/15/17 had 4 days of groups

The week of 4/16-4/22/17 had 4 days of groups

The week of 4/23-4/29/17 had 3 days of groups

It was noted the current agency policy, 2.05, "Counseling Services" does not include information related to the requirement related to groups and needing to provide group counseling at a minimum of 5 days per

week.

2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

Rating Narrative

The Sarasota Y has a Policy Adjudication/Petition Process, # 2.06 last reviewed on 8/2013. The policy addresses all of the standards regarding the Adjudication/Petition Process.

The Case Staffing Committee will consist minimally of the following persons or their designees: Representative from the Department of Juvenile Justice, School District Representative, Consultant responsible for the case and the Y Clinical Director. Additionally: Community Representatives from areas of mental health, and social services, Local law enforcement, Youth and their parent/guardian or department.

The Consultant assigned to the youth is responsible for coordinating and participating in Case Staffing referrals and, if needed, the petition/disposition process.

A referral to the case staffing committee can be made at any time the youth refuses to comply with mandatory school attendance policies, and/or continues with ungovernable/runaway behaviors. Referrals can also be made if the consultant is unable to assist in resolving the problem or if the youth and family have not made substantial progress with the service plan.

Referrals to Case Staffing can be made through the partnership established with the Sarasota County School Board for youth with excessive absences.

The youth and family are notified two weeks before the scheduled Case Staffing meeting via certified mail. In addition, notification is sent to the home via regular mail. A map is included to assist families.

Referrals to the Case Staffing are dated on the day they are received. A confidential file is prepared and will contain the referral form, a copy of the letter of notification, and the recommendations made by the committee. Copies are given to the assigned consultant.

The consultant will also contact the family at least five working days prior to the scheduled meeting. A case staffing will be scheduled within seven business days in the event that a written request is made by the parent. The written request is stamped on the day it is received. The Chairperson will contact the parent and then arrange the meeting with the committee.

At the conclusion of the meeting the parent is given a copy of the recommendations made, which may include a filling of a petition if deemed necessary.

Within three days of the Case Staffing Committee meeting a letter listing the recommendations made is sent to the Parent/Guardian.

Service Plans are revised to include case staffing recommendations. In the event that a petition is filed, the service plan will include recommendations made for the judicial process.

Petitions are filed by the DJJ attorney within the 45-day time frame as mandated by statute.

Judicial reviews are held to report on the status of the recommendations presently ordered and are prepared by the consultant. Recommendations are prepared for each review.

Termination of the case occurs when progress is consistent.

The case will be monitored and if in the event the youth reverts back to former behaviors, the petition may be reopened.

A total of four youth files were reviewed with two resulting in petitions. This writer also spoke with the Clinical Director about the implementation of the procedures and the organization of client files. All the

procedures seem to be followed as written in the policy and procedures of the Y.

The deadlines for notifications and other dated materials exceed the procedures. For example, notification of a Case Staffing has to take place within at least five days of the staffing, yet in all files reviewed the family was given additional notification time. Another example being that a written copy of the recommendations should be mailed within three days, in all the files reviewed recommendations were sent the very next day.

In each of the files reviewed the school initiated the staffing. This writer did not review a staffing request initiated by the parent/guardian. Notification to committee members was done via e-mail in a timely manner. In all of the case staffing's reviewed representatives from the Y, the school district and a mental health representative was present. In all cases DJJ was represented by the CINS/FINS provider (The Y). Law enforcement was present at three of the four staffings. The State Attorney's Office and DCF is regularly invited but does not attend staffings. Referrals are made for substance abuse counseling per recommendations of the case staffing, however a substance abuse representative does not routinely attend case staffings. As stated above, all of the documentation in the files is consistent with the policy and procedures of the Y. Certified mail receipts are stapled to the inside of the case files. Terminations seem to be consistent with intended goals i.e. attending school for a 30-day period.

No exceptions indicated.

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy "Youth Records", policy 2.07. The policy was revised in 8/2012 and was last reviewed in 8/2013.

The agency's policy indicates that the files are maintained in a secure room or locked file cabinet that is marked confidential and that they will be neat and orderly. Youth records are accessible only by program staff.

Seven Residential files and six Non-Residential files were reviewed to determine the presence of the "Confidential" marking on the front of the file. The files for the Residential and Non-Residential program are all neatly organized and follow the chart organization protocol. Both the Residential and Non-Residential program has an opaque bag to transport files. The Non-Residential program's bag is locking and is marked Confidential on the outside of the bag.

The location of file storage was observed for the Residential and Non-Residential programs. The Non-Residential Program maintains files in large locking cabinets in their office location. The Residential Program maintains the files in two locations. The "soft files" are maintained in the counselor's office and the "hard files" are located in the staff office in the living room in a locked cabinet that is marked confidential.

Exceptions:

The agency policy 2.07 was last reviewed in 8/2013. The policy does not include information related to the requirement of having a locked, opaque bag to transport files from the shelter or within the Non-Residential program.

Four files (purple) did not include a stamp or marking that stated the files were Confidential as required by agency policy and by the indicator.

The Residential Program has an opaque bag for file transport, however, it was not a locking bag and it was not marked Confidential.

Standard 3: Shelter Care

Overview

Rating Narrative

Sarasota Y shelter 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 Y residential team is comprised of twenty-three (23) Behavioral Coaches, including six full-time and seventeen part-time/ PRN positions. In addition, there is also a full-time Program Director, Program Coordinator, 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. The dormitory is divided into two separate areas, one for the boys and one for the girls. There are 2 large bathrooms, one on each dorm wing.

3.01 Shelter Environment

Satisfactory

Limited

Failed

Rating Narrative

The Sarasota Y Shelter has a Policy and Procedure 3.01 on Shelter Environment, last reviewed in 8/2016. The policy addresses the indicator regarding shelter environment.

The Y shelter's Health and Fire Safety Inspections are completed annually. Furnishings are kept in good repair. The Y shelter is treated for insects monthly. A local landscaping company is contracted to maintain the grounds. Bathrooms and showers are cleaned daily as part of youth chores. Walls, doors and windows are checked for graffiti daily. Upon arrival to the program each youth is assigned their own bed and provided with clean sheets. Proper lighting is provided throughout the Y shelter and checked inside and outside daily. Youth lockers are located in the dorms and kept locked. Each youth also has a box in the staff office which is only accessible through the staff. Per the program's procedures, each child will participate in life skill-building groups five nights each week. At least three afternoons each week, youth have the opportunity to participate in "adventure-based" counseling.

On a daily basis children are provided at least one-hour physical activity. Shelter youth have access to the Y Berlin Branch and Bari Brooks Teen Center. The Sunday program schedule will include a period of time for volunteer participation in religious services. Alternative activities will be provided for youth who do not wish to participate in religious services. Children are afforded access to religious literature when requested. A moment of silence is observed prior to each congregated meal. Homework time or tutoring is offered daily Monday-Friday. The Y shelter's daily programming schedule is posted in the kitchen and living room.

Health and fire safety inspections reviewed onsite are current. The State of Florida Department of Health County Group Care Inspection was conducted on 3/15/2017. One violation for maintenance was found and a repair was done the next day. This reviewer observed the completed repair. Alliance Fire and Safety visited the shelter on 7/7/2016 and Piper Fire Protection visited the shelter on 1/16/2017. A satisfactory Sarasota County Fire Department inspection was conducted on 8/9/2016.

All of the furnishings seem to be in good repair and new bunk beds had been placed in the dorms the week prior to the QI Review. In 2016 the shelter was tented for bed bugs and a practice is in place for new youth coming into the shelter to have all of their clothes placed in a dryer and luggage stored separate from the

dorms.

A walk through the shelter grounds provided evidence that the grounds are well maintained by a local landscaping company that comes to the shelter every Friday.

Staff reported that youth sign up weekly for assigned chores and that, on Saturdays, youth and staff do a thorough cleaning of the bathrooms. Staff also reported that they check the bathrooms daily and clean as needed before shift changes. This reviewer observed clean bedding for all of the beds as well as storage of additional bedding. This writer did not observe any graffiti on the walls or shelter grounds.

Lighting appears to be adequate in all spaces this writer observed. The lights in the girl's restroom initially seemed to take a long time to come on; however, in subsequent visits it seemed to come on without problem. Staff reported that due to the age of the building electrical repairs are frequently made.

This reviewer observed locks on all of the closets and dressers located in the youth bedrooms and staff open and close the locks. In addition, a secure locker is located in the staff office and youth may secure valuable items in the office.

An activity schedule is located in the living room and kitchen. A variety of activities are offered and an activity log is kept in the staff office with a summary of youth participation in groups, recreation etc. Youth have access to a variety of physical activities both at the shelter and at the adjoining YMCA facilities. These activities include swimming, basketball and other sports. Staff accompany youth to all YMCA activities.

According to the shelter director, if more than one youth express an interest in participating in a faith-based activity, shelter staff will transport them. If only one youth expresses an interest, families are encouraged to take youth to church etc.

There is an education room in the shelter and youth are required to spend a minimum of one hour after school engaged in tutoring, homework, silent reading or an activity that stimulates the mind such as building a puzzle. A tutor is available to the youth 2-3 days a week. A sign in sheet is kept for the education room and for tutoring.

Insect infestation is controlled by Good News Pest Solutions who does monthly treatments at the shelter.

No exceptions indicated.

3.02 Program Orientation

Satisfactory

Limited

Failed

Rating Narrative

The Sarasota Y has a written policy 3.02, for Program Orientation, which was last reviewed in 8/2016. The policy addresses all of the requirements of the indicator regarding program orientation.

According to the Program Coordinator, when a youth comes into the shelter, the assigned office staff does the intake with the youth and reviews all of the orientation material with the youth. In the event that a youth comes in to the shelter late at night, the tour of the shelter may take place the following morning so as not to disturb the other youth who may be sleeping. At the time of intake, each Resident is given a resident handbook and the parent/guardian is given a parent handbook. Staff review all of the items listed in the intake checklist.

This writer reviewed the files of three youth who received orientation on 4/13/2017, 3/26/2017, and on 5/1/2017. Orientation occurred during the first 24 hours in three of three files reviewed. During the orientation, the three youth and/or family received the following: a resident handbook that includes information about the program such as behavior management rules and disciplinary action, grievance procedures, emergency procedures, important phone numbers, activity schedule, and shelter rules. During the admission, youth are assigned a room and given a tour of the shelter.

In one of the three files reviewed, the signature of the youth was obtained for the orientation; however, the signature of the guardian was missing. Staff had been aware of the missing signature and attempts had been made to contact the guardian in order to get the signature.

No exceptions indicated.

3.03 Youth Room Assignment

Satisfactory

Limited

Failed

Rating Narrative

The Sarasota Y Shelter has a Policy and Procedure, 3.03 for Youth Room Assignment, last reviewed in 8/2016. The policy addresses all of the requirements of the indicator regarding Youth Room Assignment.

At the time of intake, screening and risk assessment forms will provide information about youth such as physical characteristics, gang affiliation, current alleged offenses, prior delinquent history, trauma history, reported risk and observation of level of aggression, attitude, past involvement in assaultive or aggressive behavior, sexual aggression or predatory behavior or demonstration of emotional disturbances as well as existence of medical or mental health issues, physical disabilities and suicide risk. Based on this information, shelter staff will assess perceived risk and assign youth to sleeping quarters. Room assignment is made based on a variety of factors such as age, medical issues etc.; youth may also be placed in a single room depending on risk assessed. If youth are deemed to exhibit "special needs" such as suicide risk, substance abuse, physical aggression issues, or risk of violence or runaway, the alert system delineated in policy 4.04 will be employed.

Per the Shelter Director, staff doing intakes are empowered to make decisions as to room assignment for youth at the time of intake based on information outlined in the agency procedures. In practice, staff usually consults with the Shelter Director and room assignments are made based on needs and safety of the youth. Intake information was reviewed for three youth. Information gathered at the time of intake for all three youth are consistent with agency policy and procedures to determine room assignments.

No exceptions indicated.

3.04 Log Books

Satisfactory

Limited

Failed

Rating Narrative

The Sarasota Y Shelter has a Policy and Procedure, 3.04 on Logbook Requirements, last reviewed in 8/2016. The policy addresses all of the requirement of the indicator regarding log books.

Log book entries that could impact the security and safety of the youth and/or program are highlighted. All entries are brief and legibly written in ink and include: date and time of the incident, event or activity. Names of youth and staff involved are documented including a brief statement providing pertinent information, and the name and signature of the person making the entry. All recording errors are struck through with a single line. Staff initial and date the correction. Whiteout is prohibited. The program director reviews the log weekly and makes recommendations. The oncoming supervisor and direct care staff, reviews a minimum of the previous two shifts, and signs an entry.

The reviewer reviewed random pages from the log book dated 1/11/2017 thru the present date. The logbook seems to have color-coded highlights to indicate various information such as yellow indicating an intake or discharge, blue indicating an AWOL return, orange for staff notes, etc. Entries are brief and generally legible. Dates and times are indicated. Recording errors are struck through with one line and initialed. The Program Director is exceeding the agency policy and reviewing the log books more than once weekly. Direct care staff and supervisors are reviewing the log book when coming on shift and documenting it. This reviewer observed oncoming staff doing logbook reviews during the onsite visit.

No exceptions indicated.

3.05 Behavior Management Strategies

Satisfactory

Limited

Failed

Rating Narrative

The Sarasota Y Shelter has a Policy and Procedure 3.05 for Behavior Management Strategies, last reviewed in 8/2016. The policy addresses all of the requirements of the indicator regarding behavior management.

At the time of intake, the level system is explained to residents and is also included in print in the resident handbook. The level system uses daily points to determine a resident's level as well as their status for weekend activities. Residents apply for a level change when they have accumulated points. Points are tallied daily at the end of third shift.

Staff are trained in behavior management and crisis intervention through the Florida Network or other training source. Behavior Coaches will discuss inappropriate behaviors with residents and assist with examining decision making. Consequences for serious behavior violations will result in "major" disciplines that require supervisory review. Consequences are for individuals and not used as group punishment. Residents may be rewarded through achieving Master's Level privileges.

Staff will not employ physical intervention techniques unless the safety of the resident, other residents, or staff is involved. Staff will be trained in verbal de-escalation techniques including the five second rule, where youth are trained to exit the room and remove the "audience." Police will be called to control a violent youth who presents immediate danger to himself/herself, other youth or staff. If staff need to physically engage youth only a nationally recognized technique will be used, approved by Florida Network and DJJ. When a hands-on technique is used, an incident report will be generated.

Disciplinary techniques do not deny youth regular meals, snacks, clothing, sleep, physical or mental health services, educational services, exercise, correspondence privileges, contact with parents/guardians, attorney of record, JPO or clergy. YMCA does not use "room restriction," confinement, or any other form of unsupervised sanctions at any time.

The reviewer interviewed a program Behavior Coach, Program Coordinator, and the Program Director about the implementation of the behavior management strategies. All three individuals shared information consistent with the Y's policies and procedures. The focus seems to be on the cultivation of positive behaviors and staff seems to take into account the individual challenges a youth might be having as well as their particular strengths. One example involved a youth who was commended for only using inappropriate language 15 times one day, when the previous day he had used similar language about 30 times.

Youth earn points daily and based on their overall behavior for the week are able to go on various outings. The Y uses a "Master's Program" to encourage positive behaviors. Youth and staff will set individualized behavior goals and if the youth meets the goal he/she can chose a staff member of the same gender to go on an outing chosen by the youth.

At the time of intake, staff discusses the behavior management strategies with youth. Staff are taught the strategies during staff training and are provided feedback by supervisors who observe staff interacting with youth.

Staff interviewed discussed how they use verbal de-escalation techniques with youth who are agitated as well as the five second rule for youth to exit a room when another youth is agitated. In addition, youth who may be verbally arguing with each other need to be a minimum of ten feet apart from one another.

The Y is currently in the process of switching from the TEAM intervention system to the Managing Aggressive Behavior intervention system. Trainings are scheduled for May 23 and 24th.

No exceptions indicated.

3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

Rating Narrative

The Sarasota Y Shelter has a Policy and Procedure, 3.06 for Staffing and Youth Supervision, last reviewed in 8/2016. The policy addresses all of the requirements of the indicator to ensure adequate staff to youth ratio of one staff to every six youth during awake hours and one staff to every twelve residents during the sleep period. Overnight will always have two staff on duty.

The program posts its staff schedule in the staff office. Staff members are expected to cover their shift; if they cannot make it to work there is a PRN phone list to obtain alternate coverage. If it is an emergency, staff members are expected to call the on-call manager who will attempt to find coverage. If nobody can be found to cover the shift, staff members may be required to stay over or someone from management team (male or female, as needed) will cover the shift.

During sleeping hours, youth will be observed by staff at least once every ten minutes. Observations will be documented in real time in the appropriate log. Youth who are at risk of harm to self or others will receive supervision as directed by policy and procedure 4.02.

Youth on bed rest due to illness or physician's orders are observed once every ten minutes and documented on the bed rest sheet in real time. After completion of bed rest, the sheet will be put in the resident's file.

The Y's practice seems to be consistent with the agency's policies and procedures. This Reviewer interviewed a Behavior Coach who showed a copy of the staff schedule and discussed how staff to youth and/or gender ratios is maintained. In addition, the Behavior Coach discussed how shifts are filled when someone cannot work their shift and the teamwork that has been cultivated among staff. The Y uses part time employees to fill gaps in the schedule.

The Y uses a bed check form to document ten minute checks when youth are asleep. The Y also uses a bed rest checklist form to do ten minute checks on youth who are on bed rest. Youth on sight and sound have a suicide observation log that is documented every thirty minutes. Youth are always within eye sight of staff when they are on sight and sound.

No exceptions indicated.

3.07 Special Populations

Satisfactory

Limited

Failed

Rating Narrative

There is a policy 3.07 that was revised and reviewed in 3/2017. The policy indicates that staff secure youth are generally not served in the program, but when there is placement, it must meet the legal requirements for necessity. The shelter complies with the criteria for serving domestic minor sex trafficking, domestic violence respite, and probation respite youth.

The program has specific procedures that meets the requirement for the intake, orientation, assessment, case planning, and aftercare – as well as established criteria for documentation, supervision, data entry, services, and communications related to the special populations it serves. The procedures include all the elements required by the indicator.

The program has had two special population youth within the previous six months, a domestic violence respite youth and a staff secure youth. The staff secure youth had multiple admissions and exits due to absconding. The program provides in-depth orientation, assessment, and service planning, enhanced supervision and security, parental involvement and collaborative aftercare.

The DV Respite file reviewed showed evidence that the youth received orientation upon admission and

there was clear evidence of parental involvement. The file also had evidence of a pending domestic violence charge and the placement did not exceed 21 days. Services provided were consistent with CINS/FINS program requirements.

No exceptions indicated.

3.08 Video Surveillance System

Satisfactory

Limited

Failed

Rating Narrative

The Sarasota Y Shelter has a Policy and Procedure 3.08 for Video Surveillance System, last reviewed in 7/2016. The policy addresses the requirements of the indicator regarding Video Surveillance for 24 hours a day, 7 days a week operation.

The surveillance system guarantees staff accountability while capturing activities at the shelter to ensure safety of all youth, staff and visitors. The surveillance system provides deterrence to misconduct as well as providing video evidence of any situation in the shelter involving allegations. The Y's video surveillance system has the capacity to capture and retain video photographic images for a minimum of 30 days. The video surveillance system records dates, time and location. In addition, the resolution of the cameras enables facial recognition. There is a backup system that allows operation of the cameras during power outages.

There are 16 operational cameras in the shelter. There are 8 cameras on the interior and 8 cameras on the exterior of the facility. The cameras are located where youth congregate and visitors enter and exit. There are no cameras in the bathrooms or sleeping quarters. Individual camera locations are documented in policy and procedure 3.08. All cameras are visible to youth and staff, there are no hidden cameras. Parents and youth are informed of the cameras.

The video surveillance system is accessible to the Program Director, Residential Manager, Residential Counselor and Case Manager. The Program Director has off-site capabilities to view cameras. A supervisory review of the cameras is done once every 14 days. The results of the reviews are documented in a log book. The reviews assess shelter activities and random overnight shifts.

All video recordings will be made available for third party review after a request from program quality improvement visits and/or when an investigation is pursued after an allegation of an incident.

The Program Director has the video surveillance system in his office. The Program Director demonstrated the use of the video surveillance system, which had excellent resolution. The system is motion activated which allows the Program Director the ability to quickly assess gaps in bed checks during the overnight shift should they happen. The system also allows for zooming in when reviewing a particular camera.

There are sixteen cameras used in the system, eight indoors and eight outdoors. None of them are placed in private spaces such as bathrooms or sleeping areas.

The video surveillance system was recently installed, as the previous system had been struck by lightning. The Residential Manager does weekly reviews of the video surveillance system and documents the review on a form kept in a separate binder as well as documenting in the log book. A notice is posted on the front door of the shelter informing visitors of the presence of the video surveillance system.

In addition, at the time of intake parents/guardians initial that they are aware of the video surveillance system and that they give consent for youth to be recorded. If law enforcement wants to review the video surveillance system, they make a request to the Shelter Director who in turn provides the opportunity to review the system. In addition, a zip drive can be installed directly to the video surveillance system to download video should it be needed.

No exceptions indicated.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

Sarasota Y has specific procedures related to the admission, interviewing and room assignment of youth to ensure the safety and appropriate supervision of youth admitted in the program. Upon admission, program staff will interview youth. An initial assessment occurs to determine the most appropriate room assignment.

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

Staff on duty at the time of admission immediately identifies youth who are admitted with special needs and risks, such as risk of suicide, mental health, substance abuse, physical health, or security risk factors, etc. The Clinical Director and Residential Program Director are notified immediately if risks and/alerts are present and recommendations regarding placement and supervision are provided to the direct care staff. This information is documented on the alert board, youth alert forms, and in the youth files using a color-coding system.

Youth admitted to the shelter with prescribed or over-the-counter medication will surrender those medication to staff during admission. The agency stores prescribed medications in the Med-Station 4000 cabinet. Several staff members are trained as regular users and there are 2 Super Users of the Pyxis Med-Station 4000. The provider contracts with a RN whose main responsibility is the provision of medical care and/or medication management in the facility. Topical and injectable medications are stored separately from oral medication. Refrigeration is available for medication requiring cool storage. The program has a list of staff who are authorized to distribute medication ensures that an approved staff is scheduled on each shift. Medication records are maintained for each youth and stored in a MDR Binder.

4.01 Healthcare Admission Screening

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy and procedure 4.01 to address healthcare admission screening. The policy was last reviewed in 8/2016.

At initial intake the contracted nurse, if present, or non-healthcare staff is to complete the health screening using information obtained through the preliminary screening and utilizing the CINS/FINS intake assessment form, to assess any immediate medical needs, any current condition or contagious illness or communicable disease, or chronic medical condition. Consent for distribution of medications and emergency medical needs are to be signed. If youth is in need of emergency medical treatment, arrangements will be made for the youth to go to the emergency room; parents are expected to transport youth to medical appointments and non-emergency medical visits.

The preliminary health screening is to include current and past medications for physical or mental health, allergies, existing acute or chronic medical conditions, recent illnesses or injuries, the existence of current pain or other physical distress, observations for evidence of illness, injury or physical distress and the presence of scars, tattoos or other skin markings. Any allergies are highlighted on the Medical and Mental Health alert sheet and food related allergies are posted in the kitchen.

The provider had two nurses contracted until 2 weeks prior to the QI visit. Per the Program Director, one of the nurses left without officially notifying the program.

Three youth files were reviewed and each contained a completed preliminary healthcare screening identifying each youth's healthcare concerns that were completed by non-health care staff. There was no evidence of the nurse reviewing any of the three intakes completed by direct care staff.

The program's health screening form addressed chronic medical conditions inclusive of diabetes, pregnancy, seizure disorders, cardiac disorders, asthma, tuberculosis, hemophilia, and recent head injuries. Documentation evidenced youth on current medication, with allergies, and recent injuries (broken toe). The program has procedures to include a referral process and necessary mechanism for follow-up medical care for youth admitted with chronic medical conditions.

Exception:

The agency's policy and procedures last reviewed in August 2016 does not include the requirement for the nurse to review all intakes within 5 days if s/he was not present to conduct the health screening. There was also no evidence of this practice documenting it occurred.

4.02 Suicide Prevention

Satisfactory

Limited

Failed

Rating Narrative

The program has a comprehensive policy and procedure 4.02 to address suicide prevention. The policy was last reviewed in 8/2016.

The program's policy includes the protocol for the assessment of suicide risk during initial screening and at intake. Mental health and substance abuse screening begins prior to the admission through completion of the Y's screening/intake form that determines whether the youth meets criteria for shelter admission. The program also requires a comprehensive mental health and substance abuse screening at the time of admission using the CINS/FINS Intake Assessment form. If suicide risk is indicated during the suicide risk screening, the youth is placed on one-to-one supervision with documentation made in the log book and in the client file. The youth will be assessed within 24 hours (or within 72 hours if admission is between 5pm on Friday and 9am on Monday) by specified licensed mental health staff or non-licensed mental health staff working under the supervision of the licensed professional. Any screenings completed between 5pm Friday and 9am Monday with an indication must have an assessment of suicide risk (ASR) completed on the morning of the next business day. While on sight and sound, behavioral and warning signs will be constantly monitored and documented on the observation log every thirty minutes. The youth will remain on sight and sound until the assessment of suicide risk is completed and the clinical director has cleared the youth for standard supervision.

There were three files applicable for CINS youth with assessments of suicide risk completed during the review period. All three youth were screened for suicide risk during the initial intake and screening process. All three youth were placed on sight-and-sound supervision and two of the three youth remained on the supervision level until the licensed professional completed the ASR and cleared the youth for standard supervision. Documentation evidenced the three youth were placed on the appropriate level of supervision based upon the results of the suicide risk assessment. Staff documented the youth's behavior consistently every 30 minutes on two of the three youth's precautionary observation log sheets.

Exception:

The observation log for one of three youth who was placed on sight and sound did not indicate the time the youth was removed from sight and sound and observation ended prior to clearance by the licensed professional. It was noted in the progress notes of the youth's file that the ASR was completed by the licensed professional at 8:20 pm. Observations were documented every 30 minutes between 4:30pm and 7:30pm with the exception of one record where there was an hour lapse between observations, outside of the 30 minute requirement.

4.03 Medications

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy and procedure 4.03 for the distribution, secure storage, access, disposal, and inventory of medications. The policy was last reviewed in 8/2016.

The program's written procedure includes protocols for the following:

- Verification of the original prescription medication with the label completed by the pharmacy
- Storage of all medications in the Pyxis med-station which is inaccessible to youth
- Maintaining a minimum of two super users for the med-station
- Storage of controlled medication in the med-station
- Storage of oral medications separately from injectable and topical medications
- Utilization of secured refrigerator solely for the storage of medication with storage temperature requirements
- Allowance for nurse and only designated and trained staff with user permissions to have access to secured medication
- Inventory of controlled substances via shift-to-shift counts
- Maintenance of a perpetual inventory for OTC medication which must be inventoried at least weekly
- Secure sharps and documentation of weekly inventory counts of same
- Utilize the Medication Distribution Log form to document distribution of medication by all staff
- Conduct a review of medication management practices at least monthly via the knowledge portal or med-station reports. All discrepancies will be cleared on each shift.

All medications, including controlled medications, were stored in the Pyxis med-station, which was inaccessible to youth. The agency verified youth medications with the parent/guardian at admission. The program had two super users for the med-station including the program director and shelter coordinator. Oral medications were stored within the Pyxis med-station separately from both injectable and topical medications. The program maintained a secured refrigerator which is used only for the storage of medication.

When on duty, the nurse conducts medication pass. Only staff designated with user permissions had access to the Pyxis med-station and limited access to controlled substances is maintained via a required electronic staff witness log in to the station. Controlled substances were perpetually inventoried. Sharps were secured in a locked box with documentation of weekly inventories. The program did not have any syringes at the shelter during the visit. The Individual Client Medication Distribution Log form was used to document distribution of medication by all staff to each youth. Monthly medication management practice was conducted by the program, with the exception of April 2017, via the knowledge portal as required by network policy and copies were maintained in a binder.

Exceptions:

Weekly inventory of OTC meds was not observed to be done since July 2016. The program records each time youth receives OTC medication on the OTC Medication Record form but it does not include the perpetual inventory.

There was no review of the medication management practice via Knowledge Portal or Pyxis Med-Station

report for the month of April 2017. The reports were being done by the Administrative Assistant who left 2 weeks prior to the QI review. Reports completed are for transaction types and discrepancy summary only.

4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy and procedure 4.04 for Medical/Mental Health Alert Process. The policy was last reviewed in 8/2016.

All youth are screened upon admission to the shelter for physical, mental health, and substance abuse needs by non-medical staff. The program has a medical alert system in place such that staff is aware of youth who are admitted with allergies or a medical/mental health condition. Per the program's procedures, staff are alerted via seven means: a red dot on the client's file and on the census board; a medical and mental health alert form in the file; a green dot on the census board for youth on sight and sound until the alert is removed; indication of the medical issue or medications on the screening form; posting of allergies in the kitchen; and a red star next to the youth's name on the census board and on the file.

The program has a current medical/mental health alert process in place for the identification and communication of alerts for youth in the shelter. A review of the process indicated staff are informed of youth alerts through a variety of ways including a red dot on the client's file and on the census board; a medical and mental health alert form in the file; indication of the medical issue or medications on the screening form; and posting of allergies in the kitchen. None of the youth were on sight and sound during the onsite visit to verify agency notification for this alert. Observations of postings and interview with the program director revealed the program was no longer using a green dot for identification of sight and sound or using a red star on the file/census board to flag alerts.

Three applicable files were reviewed and were found to include applicable medical or mental health conditions or allergies. All three youth were placed on the program's alert system, which identified the alert for medical and mental health conditions. Staff were trained during orientation as to the program's alert system and provided information and instructions to recognize/respond to the need for emergency care for medical and mental health problems. Color-coding used by the program are as follows: yellow – suicide risk; blue - medical condition; orange – sharps restriction; green – allergies; and red – medication.

Exceptions:

Provider's Policy and Procedure 4.04 indicates the "sight and sound" alert color is green; however, the program is currently using a yellow dot on the youth's file and alert board for sight and sound alerts.

Per the P&P, a red star is placed next to the youth's name on the census board and on the file; this is no longer a current practice of the program.

4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy and procedure 4.05 for Episodic/Emergency Care. The policy was last reviewed in 8/2016.

All direct care staff are to be trained in CPR/CCR, first aid, and knife for life. Notification of the need for medical attention is to be made to the youth's parent/guardian as soon as possible. Parents/guardians are

expected to transport youth to any medical appointments. Should there be a medical emergency, arrangements will be made by the program for the youth to go to the emergency room.

Documentation must be maintained of the details of each medical/dental care issues in the communication log and in the youth's daily log notes. The program's policy also indicates documentation of first aid and emergency medical care in the Episodic First/Aid Emergency Care Log, Episodic First Aid Critique Log, and client record. Procedures also outline reporting requirements, which requires all incidents meeting the criteria for DJJ reportable critical incidents to be reported to the Central Communications Center within two hours.

All direct care staff completed training in cardio pulmonary resuscitation (CPR), first aid, and emergency medical procedures. The program director indicated there was no incident of youth requiring off-site urgent medical care during the review period. It is the program's practice to complete an incident report for any incident requiring off-site medical care although no practice was applicable. Per the program director, the program documents all off-site care in the communication log and does not maintain a separate Episodic First/Aid Emergency Care Log or Episodic First Aid Critique Log as indicated in its policy and procedures 4.05.

During the tour of the facility, the knife for life was observed to be located in the staff control office and first aid kits (2) are located in 2 office locations and in each of the three agency vans.

Exceptions:

The agency's policy and procedures state that all instances of first aid and emergency medical care will be documented in the Episodic First Aid Emergency Care Log. The program has a separate log for documentation of First Aid administration but a log for documenting emergency medical care is not maintained.

The current policy and procedure does not address verification of receipt of medical clearance, discharge instructions, and follow-up care upon return to the shelter for youth who were transported off-site to a medical facility.