



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of SM ACT Behavioral Health Center

on 02/23/2017

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	Satisfactory
1.05 Analyzing and Reporting Information	Satisfactory
1.06 Client Transportation	Satisfactory
1.07 Outreach Services	Satisfactory

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

Standard 3: Shelter Care

3.01 Shelter Environment	Satisfactory
3.02 Program Orientation	Satisfactory
3.03 Youth Room Assignment	Satisfactory
3.04 Log Books	Satisfactory
3.05 Behavior Management Strategies	Satisfactory
3.06 Staffing and Youth Supervision	Satisfactory
3.07 Special Populations	Satisfactory
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	Satisfactory
2.06 Adjudication/Petition Process	Satisfactory
2.07 Youth Records	Satisfactory

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

Standard 4: Mental Health/Health Services

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

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

Percent of indicators rated Satisfactory:96.30%
Percent of indicators rated Limited:3.70%
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

Ashley Davies, Lead Reviewer and Consultant, Forefront LLC

Terry DeCerchio, Director of CINS/FINS Contract Operations, The Florida Network

Marybeth Dick, Residential Supervisor, Youth and Family Alternatives

Mike Marino, Regional Monitor, Department of Juvenile Justice

Naomi Thompson, Residential Counselor, CDS Central

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 type="checkbox"/> Program Manager |
| <input type="checkbox"/> Program Coordinator | <input checked="" type="checkbox"/> Direct- Care Full time | <input type="checkbox"/> Direct-Care Part Time |
| <input type="checkbox"/> Direct-Care On- Call | <input type="checkbox"/> Volunteer | <input checked="" type="checkbox"/> Intern |
| <input checked="" type="checkbox"/> Clinical Director | <input checked="" 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 checked="" type="checkbox"/> Nurse | | |
| 2 Case Managers | 0 Maintenance Personnel | 2 Clinical Staff |
| 1 Program Supervisors | 0 Food Service Personnel | 0 Other |
| 1 Health Care Staff | | |

Documents Reviewed

- | | | |
|---|--|--|
| <input type="checkbox"/> Accreditation Reports | <input checked="" type="checkbox"/> Fire Prevention Plan | <input checked="" type="checkbox"/> Vehicle Inspection Reports |
| <input checked="" type="checkbox"/> Affidavit of Good Moral Character | <input checked="" type="checkbox"/> Grievance Process/Records | <input type="checkbox"/> Visitation Logs |
| <input checked="" type="checkbox"/> CCC Reports | <input type="checkbox"/> Key Control Log | <input checked="" type="checkbox"/> Youth Handbook |
| <input checked="" type="checkbox"/> Logbooks | <input checked="" type="checkbox"/> Fire Drill Log | 6 # 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 | 7 # Personnel Records |
| <input type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 9 # Training Records |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 4 # Youth Records (Closed) |
| <input checked="" type="checkbox"/> Fire Inspection Report | <input type="checkbox"/> Telephone Logs | 5 # Youth Records (Open) |
| <input type="checkbox"/> Exposure Control Plan | <input type="checkbox"/> Supplemental Contracts | 0 # Other |

Surveys

8 Youth 9 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 checked="" type="checkbox"/> Tool Inventory and Storage | <input checked="" type="checkbox"/> Facility and Grounds |
| <input type="checkbox"/> Recreation | <input checked="" type="checkbox"/> Toxic Item Inventory and Storage | <input checked="" type="checkbox"/> First Aid Kit(s) |
| <input type="checkbox"/> Searches | <input type="checkbox"/> Discharge | <input 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 checked="" type="checkbox"/> Medication Administration | <input checked="" type="checkbox"/> Staff Interactions with Youth | |

Comments

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

Rating Narrative

The Director of Adolescent Services reported reviewing all program policies within the last year; however, the cover sheet documenting the review of the policies was misplaced. After a review of all the policies it appeared to the review team they had been reviewed and updated in the last year as the policies reflected recent changes made to Quality Improvement Indicators.

Strengths and Innovative Approaches

Rating Narrative

The shelter is currently in the process of moving. The agency's Tiger Bay Facility has been renovated and will be the new home for all residential and non-residential services. The non-residential counselors and services have already moved to the new location. All residential services should be moved within the next two months.

The agency has added several new positions since the last review. Most of the new positions were at the Executive Management level. A Clinical Director position was added at the program level to oversee the residential counseling services. An Adolescent Activities Coordinator is going to be added once the agency moves the shelter to the new location.

Standard 1: Management Accountability

Overview

Narrative

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

The SMA Company operates the SM Act Behavioral Health Center, a temporary youth shelter. The agency has a capacity of twenty beds. A total of ten beds are designated for youth that meet the eligibility requirements of CINS/FINS services. The SMA Company has been a Safe Place member and continues to be an official Project Safe Place site.

The management team consists of A Director of Adolescent Services, an Assistant Program Director, two Residential Shift Managers, three CINS/FINS Service Managers, one full-time Counselor, one part-time counselor, ten Youth Specialists, an Administrative Assistant, one Case Manager, one Clinical Director, and two Outreach Specialists.

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

1.01 Background Screening

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy titled Background Screening of Employees/Volunteers. (The effective date of the policy was July 1995.) The purpose identified for the policy is to ensure all employees and volunteers are properly screened before having access to youth.

Program procedure requires the background screening process be completed prior to hiring an employee or utilizing the services of a volunteer. The procedure also requires that employees and volunteers are rescreened every five years of employment. The procedure requires an "Annual Affidavit of Compliance with Good Moral Character Standards" be submitted to the Department's Background Screening Unit by January 31 each year. (Note: the form has been updated to "Annual Affidavit of Compliance with Level 2 Screening Standards".)

Five newly hired staff and one staff who was transferred within the provider's agency to a Department funded position were reviewed for initial background screening. An initial background screening was completed prior to the date of hire/start date for all six staff. Two staff required a five-year rescreening, which was completed prior to and within one year of the anniversary of hire date for each staff. The provider submitted, by email, an Annual Affidavit of Compliance with Level 2 Screening Standards to the Department's Background Screening Unit on January 12, 2017.

There were no exceptions to this indicator.

1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy titled Provision of an Abuse Free Environment. (The effective date of the policy was July 1995.) The purpose identified for the policy is to ensure the program provides an environment in which youth, staff, and other feel safe, secure, and not threatened by any form of abuse or harassment. The program manual also includes a youth grievance process, which provides a means for youth to address staff with concerns if they feel their rights have been violated.

The procedure states staff adheres to a code of conduct that prohibits the use of physical abuse, profanity, threats, or intimidation. Youth are not to be deprived of basic needs such as food, clothing, shelter, medical care, and security. The procedure addresses mandatory reporting of suspected abuse, stating any person who knows or suspects a child is being abused must report it to the Florida Abuse Hotline. The procedure states management takes immediate action to address incidents of any form of abuse.

The grievance process includes informal, supervisor, and program director phases. The informal phase is for youth to try to resolve their complaint or condition by speaking to the staff on duty. If not resolved at the informal phase, youth write a grievance for the supervisor phase. The supervisor has 72 hours to investigate and render a decision regarding the grievance and inform the youth. If the youth disagrees with the supervisor, the grievance is elevated to the program director phase. The program director has 72 hours to review the grievance and issue a decision. The procedure is included in the youth handbook.

There have not been any abuse allegations made against any program staff since the last annual compliance review. The program has contacted the Florida Abuse Hotline to report suspected child abuse based on reports/allegations made by youth about care takers or other adults. The provider keeps a record of incidents, which includes all reports/calls made to the Florida Abuse Hotline. Staff are trained on abuse reporting procedures upon hire. Nine staff were surveyed. All nine staff understood child abuse reporting procedures and reported they have never observed a co-worker tell a youth that they could not call the Florida Abuse Hotline. The nine staff also reported they had never observed staff using profanity, threats, intimidation, or humiliation when interactive with youth.

Grievance forms are available to youth in a binder in the hallway just outside the dorm area. Two written grievances have been completed by youth since the last annual compliance review. Both were addressed within one day of the grievance being completed. In one case, the youth agreed with the resolution and signed the grievance to acknowledge her complaint had been resolved. In the remaining case, the youth was not satisfied with the resolution and refused to sign the grievance form, which was documented by staff. This grievance was elevated to the program director phase, but the youth was released a day later and there was no time for the program director to meet with her.

Nine youth were surveyed. None of the youth reported they had made an attempt to report suspected abuse or been delayed or stopped from reporting suspected abuse. All nine youth reported that staff were respectful and that they had never heard staff use profanity or threats when speaking with youth. All nine youth reported they felt safe at the program. When asked what to do in case they had a complaint about the shelter or staff, six youth stated they would talk to staff and/or use a grievance form; three youth did not identify how they would respond. When asked to rate the grievance process, two youth rated it as good, four rated it as very good, and three youth did not respond.

There were no exceptions to this indicator.

1.03 Incident Reporting

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy titled Incident Reporting. (The effective date of the policy was July 1995.) The purpose identified for the policy is that the program will properly notify the Department in regards to

incidents.

The procedure states the program will notify the Department's Central Communications Center (CCC) within two hours of a reportable incident or becoming aware of the incident.

The program reported six incidents to the Central Communications Center (CCC) in the past six months. Five of the incidents were related to medication errors. The remaining incident was the program temporarily closing due to Hurricane Matthew. All six incidents were reported within the required time frame. The CCC reports showed follow-up information was provided to the CCC as needed. All six incidents were documented in the logbook and on internal incident reports. A "Supervisor's Occurrence Response" form was completed for each incident, documenting the supervisor's review and actions taken for the incident.

Documentation showed one youth was taken to the emergency room on 1/27/2017 for an asthma attack and on 1/31/2017, by EMS, for a severe allergic reaction. The CCC was called in each case, though neither call was accepted due to the incidents occurring at school. The program documented the calls to the CCC in the logbook.

There were no exceptions to this indicator.

1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy titled Training Requirements. (The effective date of the policy is July 1995.) The purpose identified for the policy is that staff receive training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions.

The training procedure reflects the requirements listed in the indicator, identifying the required number of hours for staff. The procedure identifies required trainings be completed within 120 days for pre-service training.

The program had four direct care staff hired since the last annual compliance review, two of whom are no longer with the program. Training documentation for the remaining two staff were reviewed. One staff, who was recently hired and has been employed just over a month, had completed 94 hours of training. This staff had documentation of completion for all required training topics with the exception of confidentiality and understanding youth/adolescent development. This staff is still within 120 days of hire and has time to complete these two trainings.

The second staff was hired in May 2016. This staff did not have a training file, though training documentation was provided to show she had completed 69 hours of training. The staff was certified in First Aid and CPR and had received training in suicide prevention, managing aggressive behavior, behavior management, child abuse reporting, fire safety, ethics, and cultural diversity. This staff did not have documentation of training in Title IV-E, confidentiality, information security awareness, trauma informed care, PREA, and serving LGBTQ youth. Based on annual training requirements in place at the time of her hire, this staff still has approximately three months to complete these required trainings.

Training files for five staff in subsequent years of employment were reviewed for in-service training. Four of the five staff completed over 40 hours of annual training; the remaining staff completed 36 hours. All five staff completed training in suicide prevention. Four of five staff had current First Aid and CPR certifications; the certification for the remaining staff expired on 2/9/2017. Four of five staff had documentation of training in Fire Safety and PREA in the last two years. One of the five staff had documentation of training on managing aggressive behavior in the last two years.

Exceptions:

One staff had less than 40 hours; he had 36 hours.

Four staff did not have documentation of training on managing aggressive behavior in the last two years.

1.05 Analyzing and Reporting Information

Satisfactory Limited Failed

Rating Narrative

The program has a policy titled Analyzing and Reporting Information. (The effective date of the policy is July 2012.) The purpose for the policy states the program collects and reviews several sources of information to identify patterns and trends.

The procedure identifies eight different reports to be completed, which include monthly, quarterly, and annual reports required by the indicator. The findings of the reports are to be reviewed by management and communicated to staff. Improvements and/or modifications are to be made based on the reports and staff are to be informed and involved in this process.

Documentation showed case record reviews are routinely completed for each youth. A form is completed for the case reviews, documenting compliance with various requirements or need for correction or updates. Staff meeting minutes showed incidents, grievances, outcome data, and NetMIS data are shared with staff on a monthly basis. The staff meeting minutes identified when improvements were necessary based on the review of incidents or data. The program has youth and parents/guardians complete surveys upon discharge. Results from the surveys are totaled by the provider and shared with the program.

There were no exceptions to this indicator.

1.06 Client Transportation

Satisfactory Limited Failed

Rating Narrative

The agency has a policy that addresses client transportation. The policy addresses youth safety during transport. Staff transporting a single client must have supervisory approval prior to transport and consent is documented.

All staff are required to transport and must have a valid Florida drivers license and clean driving record as a condition of employment. When one on one transport occurs, supervisory approval is obtained and noted/highlighted in logbook.

A transportation log is used noting date, driver name, destination/purpose mileage, time in and out and vehicle performance.

Policy, transportation logs, and logbooks were reviewed. Supervisory approval of solo transports are documented and highlighted in logbooks. Transportation log does not have a space noting the number of passengers. This was corrected on site during the review.

There were no exceptions to this indicator.

1.07 Outreach Services

Satisfactory Limited Failed

Rating Narrative

Agency has policy addressing interagency agreements and outreach with additional objectives to present information and serve on appropriate committees.

A binder is kept with all interagency agreements, safe place monthly statistics, events attended, cosponsored and sponsored and agendas for meetings attended.

The agency employs an Outreach Coordinator. The Program Director is the designated staff attending local and circuit Department of Juvenile Justice meetings.

Outreach binder was reviewed containing numerous interagency agreements, documented meetings, and events. There was documentation the Program Director attends the local DJJ Board and Council meetings.

There were no exceptions to this indicator.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

Stewart Marchman ACT Behavioral Healthcare (SMA) provides an array of services including Centralized Intake and Non-Residential Counseling services. The non-residential staff members include three CINS/FINS Service Managers. Non-residential services are provided to program participants and their families.

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

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

2.01 Screening and Intake

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy titled "Screening and Intake", effective date July 2001, for the BEACH House and CINS/FINS services.

There is a standard screening form for both residential and non-residential services. Centralized intake services are available twenty-four hours a day, seven days a week. The screening must occur within seven days of referral. Families will receive service options, rights and responsibilities, and information on grievance process.

There were five residential files reviewed. Intakes were all completed within twenty-four hours of screening.

There were four non-residential files reviewed. Out of the four referrals, three were screened within seven days of referral, one non-residential file was completed after the seven days.

Florida Network rights and responsibilities were given and signed for by staff, youth, and parent in all nine files.

For the residential files, the staff and youth sign off on the orientation once the youth is given the grievance information. A "welcome booklet" is given to each youth during intake and a second one is offered to the parents. The grievance information is outlined in the handbook.

For the non-residential files, parents and youth are given handbooks that contain information about the grievance process during intake.

Each of the nine files reviewed contained the NetMIS screening form completed.

Exception:

One non-residential file was not screened within seven days of the referral.

2.02 Needs Assessment

Satisfactory Limited Failed

Rating Narrative

The agency has a policy titled "Psychosocial Assessment", effective date of February 2001 for BEACH House and CINS/FINS services.

Each youth entering the residential program will have a Psychosocial Assessment initiated within 72 hours. A full assessment will be completed if the last date of admission is older than six months.

For non-residential services the Psychosocial Assessment must be initiated in the first face-to-face session and completed within three face-to-face sessions. Referrals are to be documented in the Psychosocial.

There were five residential and four non-residential files reviewed. The Psychosocial Assessments were completed within 72 hours of admission for shelter care and were completed during intake for the non-residential files. The Psychosocial Assessments were all signed by the counselor and the supervisor.

There were no exceptions to this indicator.

2.03 Case/Service Plan

Satisfactory Limited Failed

Rating Narrative

The agency has policy titled "Case/Service Plans", effective March 1999, for BEACH House and CINS/FINS services.

The policy states that a formal Service Plan is to be developed within seven working days of completion of the Psychosocial Assessment. The Service Plan should be completed with the youth and/or parents. The plan should be targeted with specific needs of the youth and family, time-frames for completion, responsibilities of the program and youth/family to complete goals, and measurable objectives.

There were five residential and four non-residential files reviewed. All the files had a case/service plan. All case/service plans were completed within the seven days after completion of the Psychosocial Assessment. The goals are identified clearly. There is an open date and a target date. The goals are broken

down by interventions. The interventions were detailed with measurable indicators. The staff responsible for the intervention is noted. The problems and goals on the treatment plans are individualized. The interventions on the residential files are the same, with each youth participating in one individual and one family session, and five weekly group therapy sessions.

There is a specific page for the youth, counselor, and licensed professional to sign explaining the treatment plan agreement. There is another page that the youth, parent, supervisor, and counselor sign verifying treatment plans were explained to all parties.

Exception:

There was one non-residential file that was missing the sixty-day treatment plan review, but did have the thirty-day treatment plan review.

2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy titled "Case Management and Service Delivery", effective March 1999, for BEACH House and CINS/FINS services.

The policy states that the Service Manager will review and update the Service Plan at 30, 60, and 90 days after initiating the Service Plan. The Service Plan is then reviewed every six months thereafter for status of achieving goals and objectives. The Service Plan can be reviewed at any "major key decision points".

There were five residential and four non-residential files reviewed. There were copies of referral forms in each of the non-residential files. The referrals were based on the needs of the youth and the family. Three of the five residential files had referrals for the families. The referrals were completed during the treatment team meetings and copies given to the families.

There were no court hearings for any of the nine files reviewed. One of the non-residential files had a CINS petition filed but was dropped due to the youth having an accident.

There are two binders with thirty and sixty day follow-up surveys, for youth in the shelter for the past twelve months. They are divided by month. Non-residential youth also receive a thirty and sixty day follow-up survey as well. They are located in the same binder as the residential and completed by the BEACH House case manager.

There were no exceptions to this indicator.

2.05 Counseling Services

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy titled "Counseling Services", effective February 2001, for BEACH House and CINS/FINS services.

The policy states that youth and families receive counseling services, including at least five group counseling sessions a week. For the non-residential program, services provided are community-based to stabilize the families in the event of a crisis and keep families intact. Counseling services reflect coordination between presenting problem, biopsychosocial, case/service plan, reviews, case management, and follow-up. All files adhere to laws regarding confidentiality, maintain chronological case notes on youth's progress, and maintain an on-going internal process for clinical review of files.

There were five residential and four non-residential files reviewed. All nine files reflect coordination for presenting problems, psychosocial assessments, service plans, and referrals.

The (residential) youth are receiving at least 5 groups a week, documented on the "group documentation" form in each of their files.

The agency has an internal review process for the review of case files. For residential, there is a daily log from the licensed Counselor that is sent to the Clinical Director updating on youth in shelter. The licensed Counselor signs off on his biopsychosocials, treatment plans, and any notes in each youth's file. There were two files that had treatment team reviews that had the families involved with referrals discussed. The third shift supervisor reviews files after intake and at closure. There is a form that was created for each file, when closing, of any missing pages and/or signatures in the file. The supervisor initials once each line is completed.

For non-residential services, there is a monthly staff meeting where service managers discuss any issues and reviews cases.

There were no exceptions to this indicator.

2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy titled "Adjudication /Petition Process", effective in February 2001 for BEACH House and CINS/FINS services.

The policy states that services managers can use Case Staffing Committee for cases that cannot be resolved. The service managers will notify all parties within five working days (this includes family, youth, guardian, school personnel and any/all providers). The notification will be sent out via certified mail to the guardian. If a guardian makes a written request for case staffing, then service manager has seven days to convene a meeting. The case staffing's will be recorded.

At the case staffing, representatives are required to attend (school district, DJJ, or a member of the agency's CINS/FINS program). The Case Staffing Committee may also include anyone recommended by the guardian, youth or CINS/FINS program, mental health, representative of state attorney. The service manager can arrange a meeting with the Case Staff Committee if the family or child have not demonstrated sufficient progress, have not addressed one of the problems listed or they will not participate in services. If guardians are not provided the plan, then it can be mailed to the family, along with reasons for a petition being filed.

There were four non-residential files reviewed. Two of the files had a case staffing. The parents were

notified via certified letters, which were documented in the file. The parents were notified more than five days in advance. The Case Staffing Team also had more than five working days notice. The parent in one of the files that went to the staffing had requested the case staffing. The case staffing was not held in the seven days but in nine days. That particular case had a CINS petition filed as well. That petition was dropped due to the youth's accident. This was documented in the file.

Each of the three non-residential service managers has a binder for case staffings. This maintains the list of the youth that went to case staffing and email correspondence to the case staffing team. It is divided by months.

Exception:

One case staffing requested by the parent was held two days late.

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy title "Youth Records", effective February 2001 for BEACH House and CINS/FINS services.

All records are to be marked confidential in a secure room or locked cabinet. Youth records are maintained neat and orderly manner so staff can have easy access.

Eight of the nine files reviewed each had confidential marked on the front of the files.

Current files are locked in a room that has a lock only staff can access. The shelter holds one year of files on campus. The files are securely stored in several locked cabinets which are also in a locked office. The files are found to be neat and orderly. The non-residential files are located on the agency's other campus.

Exceptions:

One file reviewed did not have confidential marked on it.

The agency does not own an opaque file container that locks and has "confidential" on it.

The policy is not up-to-date with Florida Network Standards regarding the opaque file container.

Standard 3: Shelter Care

Overview

Rating Narrative

The SM Act Behavioral Health Center serves both CINS/FINS and DCF referral populations in the residential environment. The youth shelter provides residential services twenty-four hours a day, 365 days per year. The youth shelter operates three work shifts and is staffed with both male and female staff members on each shift. At the time of the review the shelter had six CINS/FINS youth. The shelter has not had any Staff Secure or Domestic Minor Sex Trafficking youth since the last on-site review; however, has served Domestic Violence and Probation Respite youth.

3.01 Shelter Environment

Satisfactory
 Limited
 Failed

Rating Narrative

The agency has a written policy and procedure that addresses key components of the indicator.

The program's procedure and policy requires that the shelter will remain in good repair and maintained to include the inside and outside of the building. Issues will be documented by staff and notated in the shift review. Safe sleeping quarters will be provided as a part of residential services - adequate lighting; provision of bed coverings and pillows; individual beds for each youth; and windows, vents, and sprinkler heads are free covers, wire mesh, and etc.

The annual fire inspection was reviewed and everything appeared to be in compliance - sprinklers and fire extinguishers included. Health inspection was reviewed and was in compliance. Fire drills and mock drills are conducted and appears to be in accordance with policy and procedure. The agency has a disaster plan that is updated and includes all components consistent with FNYFS policy and procedure manual requirements. The program has a current DCF Child Care License displayed in the building. The grounds appear to be well kept and maintained - liter free. The bathroom and shower areas have minor issues. Bedrooms of youth also appear overall to be organized and clean. All doors were secure at the facility. Evacuation maps were located throughout the facility. All chemicals were maintained in a secured cabinet. The washer and dryer was operational and free of debris in surrounding areas. Grievances were accessible to the youth. Daily activity schedules are posted in multiple areas and provide for a variety of activities. The program appears to be free of insect infestation. The program is equipped with knife-for-life, first aid kits, wire cutters, and bio-hazard bins.

There were no exceptions to this indicator.

3.02 Program Orientation

Satisfactory
 Limited
 Failed

Rating Narrative

The agency has a written procedure "Program orientation" that addresses key components of the indicator.

The policy requires that during the admissions/orientation process each youth be provided with an orientation to the program. Orientation should occur within twenty-four hours of admission and rules are

to be explained by a program staff. Each youth will receive an Orientation Booklet and Client & Family Rights & Responsibilities Booklet that the youth can keep for future reference.

There were eight files reviewed, four open and four closed, to ensure the orientation procedures were followed as outlined in Policy and Procedure. All eight files documented an orientation handbook was received by the youth within twenty-four hours of their intake. The handbook informs/provides youth with a list contraband items, disciplinary actions, program dress code, about access to mental and medical health services, and the grievance procedure. Each file contained an orientation check list where staff and the youth signed that the orientation process occurred. Layouts of the facility are visible throughout the shelter and shown to youth during the orientation process. The alert board appeared to be up-to-date (open files). All documentation for the intake process had necessary parental signatures and youth signatures.

There were no exceptions to this indicator.

3.03 Youth Room Assignment

Satisfactory

Limited

Failed

[Rating Narrative](#)

The agency has a written policy and procedure that addresses key components of the indicator.

The program's procedure and policy requires youth to be interviewed to determine the most appropriate sleeping arrangement. Staff utilize the CINS/FINS Intake Assessment form to assist with determining appropriate room placement.

There were two open and two closed youth files reviewed. All youth appeared to be identified by their age, gender, history status, and exposure to trauma. Youth alerts were documented throughout the files. All alerts that were written in the intake files were on the alert board for open files reviewed. There is a color-coded system by risk factors that is used to identify issues on the client board.

There were no exceptions to this indicator.

3.04 Log Books

Satisfactory

Limited

Failed

[Rating Narrative](#)

The agency has a written policy and procedure that addresses key components of the indicator.

The program's procedure and policy requires the logbook to be used to document information about the operations of the program this excludes clinical documentation. Shift leader is responsible to ensure that the information recorded in the log as outlined in the log (guidelines identified in procedure manual).

Logbooks for the previous six months were reviewed. The ?Logbook?s ?were legible,? ?color- ?coded? ?to? ?identify? ?shift? reviews,? ?maintenance? ?issues,? ?safety and? ?security? ?concerns,? ?supply? ?needs,? ?and? ?log? ?book? ?reviews. Staff consistently documented safety and security issues, medication related items, youth counts, shift reviews, intakes, and communications pertaining to potential intakes. Supervisor reviews were present and within the time-frame outlined in the procedure manual.

Visitations in shelter and home visits were also consistently and correctly documented in the logbook. There was no evidence of eraser or whiteout errors that were documented as in adherence with policy and procedure.

There were no exceptions to this indicator.

3.05 Behavior Management Strategies

Satisfactory

Limited

Failed

Rating Narrative

Agency has policy in place describing their behavior management system. This policy describes the level system, expected behaviors, rewards and consequences.

Agency has three levels in behavior management system: Orientation, VIP and Super VIP. Orientation occurs for the first 24 hours until behaviors are evaluated and a request is made to move to the next level. VIP level requires appropriate behavior for five consecutive days and Super VIP level is the final level that a youth may remain until discharge with demonstration of appropriate behaviors. A clear description of the behavior management strategy is included in the youth handbook and described during orientation. Staff are trained in the behavior management system on the job while shadowing seasoned staff.

Policy and youth handbook were reviewed. Program staff were interviewed. Behavior management system is easily understood and a large part of daily interaction. Daily point sheets are used and each evening an evaluation of each youth's point status is done in a group setting. Re-direction and de-escalation techniques are used. The Agency has a "hands off" policy. Loss of level is the primary consequence of misbehavior.

There were no exceptions to this indicator.

3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy addressing staffing and youth supervision. Minimum staffing as required by F.A.C is required. Two staff are required for overnight and efforts are made to have both male and female staff each shift. Staff are required to observe youth at least every fifteen minutes while sleeping.

Minimum staffing levels described in agency policy are scheduled and delivered consistently with the exception of the overnight shift. (Agency currently has two staff vacancies that are in process of being filled.)

The policy and staff schedule were reviewed. While it appears that in most instances two staff were scheduled for the overnight shift, many times one staff was actually left to work alone due to staff illness, holidays, or other events. There were some small pockets of overnight shifts that were originally scheduled with only one staff.

Interviews with staff report having limited on-call back up for the overnight shift. Video was reviewed for bed checks. Bed checks occurred regularly for each date selected.

Exception:

There is limited on-call back up for overnight shift which results in one staff present during the overnight shift.

3.07 Special Populations

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that addresses key components of the indicator.

The provider's procedure requires Domestic Violence Respite youth to have a pending DV charge and be screened by DJJ. Length of stay is not to exceed twenty-one days and all data entry is to be completed within designated time frames. If applicable, documentation of transfer to CINS/FINS placement must be completed and youth must have a case plan that reflects goals for aggression management, family coping skills, or other interventions to reduce propensity for violence in the home. Probation Respite youth are to have a referral from DJJ Probation and allow for youth with DCF involvement eligible. Admission criteria to be met (i.e. approval from the Florida Network). Assessment of length of stay and appropriate placement to be assessed upon criteria being met. Domestic Minor Sex Trafficking are to be approved by the Florida Network with a stay of up to seven days. Allowing for additional days with approval on a case by case basis.

The program has not had any Staff Secure or Domestic Minor Sex Trafficking youth since the last review.

Three closed Domestic Violence Respite files were reviewed. There was a domestic violence request for each youth. Each youth had their face sheet in file and a JJIS Youth identification number was assigned as required. It was noted on the screening, case plan, and the assessment that the youth had a DV charge. The case plan goals targeted appropriate issues relating to Domestic Violence Respite youth. None of the files reviewed exceeded the twenty-one days and none required transitions to CINS/FINS.

One open probation respite file was reviewed. The requirements for accepting the youth were adhered to and services are being delivered in accordance with procedure and policy.

There were no exceptions to this indicator.

3.08 Video Surveillance System

Satisfactory

Limited

Failed

Rating Narrative

Agency has a Video Surveillance System policy. This policy requires a twenty-four hour, seven days a week video surveillance system that can capture and store images for a minimum of thirty days. Supervisory review of the video must be conducted and documented a minimum of every fourteen days.

The agency has a video surveillance system with cameras located in hallways, common areas and outdoors. Images are stored for a minimum of thirty days. Cameras are operable during a power outage for a brief period of time. Supervisory review of video is done regularly and documented in logbook.

Written notice of surveillance is located on doors. Logbooks were reviewed for supervisory review of video documentation. Supervisory reviews were completed within the fourteen day time requirement. A third party review of video recordings can be completed by copying requested video to disc. There are two staff that have access to the recorded video.

There were no exceptions to this indicator.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The SMA agency provides screening, counseling, and mental health assessment services. The agency has two counselors providing clinical services to the residential youth, one is a full-time Licensed Mental Health Counselor (LMHC) and the other is a part-time registered mental health intern. These two staff are overseen by a licensed Clinical Director. The shelter has staff members that are trained to screen, assess, and notify all staff members of conditions and risks of all youth admitted to both residential and non-residential CINS/FINS programs. The shelter staff provides risk screening and identification methods to detect youth referred to the program with mental health and health related risks. Specifically, the shelter utilizes a screening 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 shelter also screens for the presence of acute health issues and the agency's ability to address these existing health issues. The shelter uses a general alert board and colored dot system to inform all staff members on each shift of the health and mental health status of all youth in the residential youth shelter.

The shelter staff also assists in the delivery of medication to all youth admitted to the residential youth shelter. The shelter operates a detailed medication distribution system. Certain staff are designated to distribute medication. The agency uses the Pyxis Med-Station 4000 Medication Cabinet. All youth medication is stored in the Medication Cabinet. The agency provides medication distribution training to all direct care staff members, as well as, first aid response, CPR, fire safety, emergency drills and exercises, and training on suicide prevention, observation, and intervention techniques. Staff members are also required to notify parents/guardians in the event that a resident has a health injury.

4.01 Healthcare Admission Screening

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy on Healthcare Admission Screening. The policy has an effective date of July 1995 and was last reviewed within the last year by the Director of Adolescent Services.

The History Health Questionnaire shall be completed on all youth entering the residential program. Guardians and referral agencies shall be consulted regarding health status, if available, in conjunction with the youth. Staff will make every effort to complete the Health History Questionnaire within four hours of admission.

Staff will ascertain if youth is on any medication, if they are staff must obtain the name of medication, the dosage and frequency of medication, the condition the medication is prescribed for, the name of the physician who prescribed the medication, and when the last dose was taken. If the medication is to be taken while in residence, the guardian must sign the Release to Take Medication form.

Staff shall notify the Program Director if a youth is admitted with any chronic or acute health condition. The parents will be notified if any youth is determined to have physical health problems through the health screening. Staff will encourage the parent or legal guardian to seek medical advice for a youth not being followed by a physician for a health issue.

The shelter uses the Physical Health Screening portion of the CINS/FINS Intake form to screen youth at admission. This is completed by the intake staff and signed by the Assistant Program Director. Within one to two days of admission, the Biopsychosocial is completed which includes a more in-depth health screening section. This portion is completed by the Residential Shift Manager and reviewed by the Registered Nurse (RN) within five days. If the youth is on any type of medication or has any physical health condition the RN will also interview the youth for further information. In addition, a Tuberculosis and Lice Screening is completed on each youth. A body chart is completed to note any scars, pain, or tattoos.

There were six youth files reviewed. All six files documented the CINS/FINS Intake form was completed at admission. None of the youth had any chronic or acute health conditions. There was one youth taking medications and the medications as well as the reasons for them were documented. The health screening portion of the Biopsychosocial was also completed in all six files within one to two days after admission. This was reviewed and signed by the RN, in five of the six files, within two to three days after completion. There was one file that did not document a review of the health screening by the RN. The Tuberculosis and Lice Screening, and body chart were completed in all six files.

Exception:

There was one file that did not document a review of the health screening by the RN.

4.02 Suicide Prevention

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place for Suicide Prevention. This policy was effective in July 1995 and reviewed within the last year by the Director of Adolescent Services.

The policy states the shelter will use the EIDS to screen youth at admission for suicide. In practice, the shelter uses the six questions on the CINS/FINS Intake form as the initial screening for suicide. The EIDS is no longer used; however, the policy had not been updated.

The shelter uses two different levels of supervision, with the most intense level being One-to-One Supervision. This level is used for youth while waiting for removal from the shelter by law enforcement or the guardian for the purpose of Baker Act assessment. The second level of supervision used is Constant Sight and Sound Supervision. This level of supervision is for youth who are identified as being at risk of suicide but are not expressing current suicidal thoughts or threats.

The shelter has clinical staff on-site seven days a week. There are two counselors, one full-time and one part-time, who are supervised by the Clinical Director. The full-time counselor is a Licensed Mental Health Counselor (LMHC) and the part-time counselor is a registered intern. The Clinical Director is also a LMHC.

There were three youth files reviewed and all three files documented the CINS/FINS Intake Assessment form was completed during the initial intake and screening process. All CINS/FINS Intake Assessment forms were signed by a supervisor. Two of the three files documented an assessment of suicide risk was completed by a LMHC immediately. The LMHC cleared both youth for admission to the shelter and the intake process resumed. The youth were not placed on constant sight and sound supervision due to the LMHC completing the assessments immediately during the intake process. There was documentation in the log book each time, by the LMHC, stating the assessment was completed and the youth was cleared for intake.

The third file documented the youth was placed on sight and sound supervision at admission due to "hits" on the CINS/FINS Intake form. This youth was seen and assessed the next day by the LMHC using a suicide risk assessment, and was placed on standard supervision. There were thirty minute observations of the youth while on suicide precautions. This was documented in the logbook and on the shift review form for those days.

Exception:

The procedures outlined in the current policy do not reflect the actual practice of the shelter.

4.03 Medications

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place for Medications. The policy was effective in July 1995 and was reviewed and updated within the last year by the Director of Adolescent Services.

There are procedures in place for storage of medication, verification of medication, steps of medication distribution, refills of medication, and disposal procedures.

The agency has a Registered Nurse (RN) who is on-site Monday through Friday from approximately 6am to 7am. The RN will distribute all the morning medications when on-site. The RN then goes off-site to the school, run by the agency that all the youth attend. The RN stays there with the youth during the school hours and will assist to the youth's medical needs if needed.

The agency provided a list of thirteen staff who are trained to supervise the self-administration of medications. There are five Super Users listed and the RN is one of them.

The RN trains all staff on the use of the Pyxis Med-Station and the medication administration process at hire. There is a Skills Checklist completed with the RN and newly hired staff during the training process. The checklist is signed by the staff and RN and dated when completed. All staff must complete this training with the RN before they are authorized to distribute medications. Once the staff has completed the training the RN will come on-site during the staff's shift to observe them give the medications for the first time. The RN also completes on-going trainings with staff on various health topics. On Wednesdays, the RN will come back to the shelter after school and complete a health education group with the youth.

All medication is stored in the Pyxis Med-Station, including over-the-counter (OTC) medications which are stored in drawer one of the Med-Station. Controlled medications are stored in drawer two. Prescription medications are stored in the third drawer of the Med-Station. There was nothing in drawer four. Drawer five is used for over-sized medications, liquid medications, and topical medications. At the time of the review this drawer was empty. Medications are verified at admission using one of the four approved methods by the Florida Network.

There have been thirty discrepancies in the last thirty days. Out of those thirty discrepancies eighteen were not closed out by the end of the staff members work day, they were closed anywhere from one to seven days later. All discrepancies involved inaccurate counts and were easily fixed.

Trained direct care staff complete an inventory every shift of all the controlled substances. This inventory is documented on the youth's individual controlled medication inventory sheet and also in the logbook and highlighted in yellow. A perpetual inventory is maintained on the youth's Medication Distribution Record (MDR) each time a medication is given. Non-controlled medications are inventoried by maintaining a perpetual inventory each it is given. However, there is no process in place to complete a weekly inventory of non-controlled medications.

The shelter has a system in place for refrigeration of medication if needed; however, there was no medication that required refrigeration during the time of the review.

The shelter has various sharps located throughout the facility. These sharps were inventoried each week for the month of February 2017. There were no further inventories of the sharps documented during this review cycle. There was a knife-for-life and wire cutters located on a shadow board in the file room.

The shelter has five OTC's: Tums, Tylenol, Pepto-Bismol, Ibuprofen, and Allergy Relief. There was documentation these OTC's were inventoried weekly during the month of December 2016 and one week in February 2017. There were no further inventories for these OTC's during this review cycle.

The shelter is not currently utilizing the Knowledge Portal to print or review reports. The RN reported not knowing how to run the reports.

The shelter has a process in place for refills of medications as they get low. The RN will call the youth's parent once the medication has approximately five days remaining and request them to bring in a refill. The shelter has had to dispose of one medication since the last on-site review. Documentation of the disposal was reviewed. The medication was listed, as well as, three witnesses, and the disposal procedures. The medication was dissolved in a cup of bleach and then flushed down the toilet. These are not the disposal procedures outlined in the agency's policy. The policy states the shelter will bring the medication to a

pharmacy and dispose of it there.

There was one youth in the shelter currently on medications. This youth was on multiple medications. There was documentation the medications were verified at admission. The MDR is maintained in a binder in the staff work area. All the MDR's reviewed documented the youth's name, date of birth, physician, allergies, medication the youth was taking with dosage, times to be given, common side effects, reason, and the full printed name of each staff administering medication, as well as, the youth. A picture of the youth is located in front of the MDR in the Medication Log Book. All MDR's reviewed on site document that perpetual inventory counts with running balances are being maintained on each medication. All MDR's reviewed for the youth also documented that all medications were given at prescribed times. Staff also document in the shelter log book when medications are given. Medications are also documented on the Shift Review form under each applicable youth.

There have been five CCC reports in the last three months relating to medication errors. One report involved a staff giving a medication too early. This staff received a verbal reprimand. There was documentation the pharmacy was contacted and there were no adverse side effects to this. The second report involved five missed doses of medication over several days. There were two staff members involved in this report. The first staff member received a verbal reprimand. The second staff involved was the RN. A youth's topical antibiotic ointment was missed for four days during the morning medication pass due to the RN not realizing the youth had received this ointment. There was no disciplinary action available for this staff. There were no adverse reactions from any of these medications being missed.

The last three reports all involved missed doses of medication and all involved the same staff member. This staff member received a verbal reprimand, then a written reprimand, and then was put on a sixty-day suspension from medication administration and required to complete training again with the RN. One of the missed doses of medication caused an adverse reaction in the youth and required the youth to have a breathing treatment at 3:45am. The other two missed medications did not cause any adverse reactions.

Exceptions:

There was documentation for one month out of the past six months of weekly inventories of the OTC's.

There was documentation for one month out of the past six months of weekly inventories of the sharps.

There was no documentation that non-controlled, prescription medications were being inventoried weekly.

The Knowledge Portal is not being utilized by the agency to run reports.

There have been thirty discrepancies in the last thirty days. Eighteen of those discrepancies were not closed out by the end of the staff members shift.

There have been five CCC reports in the three months relating to missed medications or medication errors.

The agencies medication disposal procedures outlined in the policy are not the procedures that were recently used to dispose of medication.

4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy on the Medical and Mental Health Alert Process. This policy was effective in July 1995 and reviewed within the last year by the Director of Adolescent Services.

The agency has a written procedure to address the medical and mental health alert process for all youth admitted to the youth shelter. The shelter utilizes a large dry erase board located in the Youth Specialists'

office and is concealed from plain view. The shelter uses a color-coded alert system with each color identifying a different alert. The applicable color-coded dots are placed next to the youth's name on the alert board. The colors used are: dark green for a suicide history; dark blue for mental health; orange for substance abuse; yellow with black dot for runaway behaviors; red for medical and allergies; pink for sexual issues; yellow for out of shelter; light green for no razors; and brown for no outings.

All alerts and allergies are also documented on the Shift Review form that is completed each shift and reviewed at each shift change. A SANS note is completed on each youth after admission that will document all alerts, allergies, and medical conditions that were identified during the admission process. This note is placed in the youth's file. The "Alert" sticker on the front of the youth's file is checked "yes" if there were alerts identified during admission and "no" if not. An orange "allergies" sticker is placed on the front of the youth's file, if any allergies are identified, and the allergy is documented on the sticker. All food related allergies are also documented on a form located in the kitchen.

A review of seven open youth files was conducted. All applicable alerts were documented in the youth's file. All files also had a sticker on the front of the file checked "yes" for alerts if applicable. If the youth had any allergies then they were also documented on the front of the file. Alerts were also documented on the Shift Review Forms. These forms were reviewed to indicate staff were provided sufficient information and instructions regarding the youth's medical conditions, allergies and information to allow them to recognize and respond to the need for emergency care and treatment. All alerts were also appropriately documented on the large dry erase board in the Youth Specialists' office. There were no dietary alerts or food allergies at the time of the review but an alert form was observed hanging on the refrigerator in the kitchen to be used if needed.

There were no exceptions to this indicator.

4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy on Episodic/Emergency Care. This policy was effective in October 1998 and was reviewed within the last year by the Director of Adolescent Services.

All direct care staff are required to have current CPR and First Aid Certification. A "knife for life" and wire cutter is to be mounted on a board inside the medication room. First aid kits are to be located in the staff office, in the medication room, and in each vehicle. The first aid supplies will be examined every month for replacement supplies, potency of sterile items, and expiration dates. Basic first aid must be logged on the episodic/emergency care log in the staff office. Medical drills will be conducted monthly on various shifts to prepare staff for emergency situations. Emergency situations are reviewed monthly at staff meetings in order to keep all staff informed of incidents.

If a youth needs emergency medical attention, staff will call the Program Director or designee to staff and make a determination on means by which youth shall be transported for emergency care. Staff will then call the legal guardian, Program Director, and on call supervisor for notification. Upon discharge from the hospital should youth return directly to the shelter, the legal guardian must provide discharge instructions and any prescribed medications.

There have been three instances of youth being transported to the hospital for emergency medical care. All three instances were logged on the Episodic Care Log. In one incident, the youth hurt her foot. The youth's parent was contacted and transported the youth to the hospital. An incident report was completed and there was documentation the supervisor and Program Director were notified. The youth's parent returned the youth to the shelter with discharge instructions and follow-up care.

The second incident involved a youth having an asthma attack while at school. The youth was given their inhaler and seen by the RN. The RN recommended the youth be transported to the hospital. Staff transported the youth and the notified the youth's parent who met them at the hospital. The youth was

treated and returned to the shelter. The parent kept the discharge instructions; however, a very detailed note was found in the youth's file stating exactly what happened, who was notified, and what the discharge instructions were. The incident was reported to the CCC; however, was not accepted due to it happening at the school and not at the shelter. An internal incident was completed.

The third incident involved a youth having an allergic reaction to something she ate. Staff had to administer her Epi-pen and emergency services were called to transport the youth to the hospital. The youth's parent was notified right away and told to meet the staff at the hospital; however, never showed up. The staff transported the youth back to the shelter after the hospital visit and the youth's parents met them there and took the youth home. The discharge instructions were given to the parent since the youth left the shelter immediately upon returning. There was a very detailed note in the youth's file documenting the whole incident. It was reported to the CCC; however, was not accepted due to the incident occurring at the school and not the shelter. An internal incident was completed.

The shelter has adequate first aid kits, a knife for life, and a pair of wire cutters. There was no process in place to review the first aid kits for expired contents or for replenishing.

The shelter conducts three medical emergency drills each month, one on each shift. The drills cover an array of emergency medical situations to include: sprained ankles, head trauma, and eye trauma. All staff have current CPR and first aid certifications.

Exception:

There is no process in place currently to review first aid for expired items or for replenishing.