



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of YFA-RAP House

on 04/05/2017

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	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:100.00%
Percent of indicators rated Limited:0.00%
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, Forefront LLC, Lead Reviewer/Consultant

Shelia Dixon, Lutheran Services Florida Southwest, CINS/FINS Clinical Manager

Al McCray, Boys Town, Shelter Director

Canitha Taylor, Department of Juvenile Justice, Regional Monitor

Danielle Taylor, Family Resources, Quality Improvement Coordinator

Persons Interviewed

- | | | |
|---|--|---|
| <input type="checkbox"/> Chief Executive Officer | <input 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 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 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 | 5 # Health Records |
| <input checked="" type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 5 # MH/SA Records |
| <input type="checkbox"/> Contract Monitoring Reports | <input checked="" type="checkbox"/> Table of Organization | 9 # Personnel Records |
| <input type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 6 # Training Records |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 5 # Youth Records (Closed) |
| <input checked="" type="checkbox"/> Fire Inspection Report | <input type="checkbox"/> Telephone Logs | 5 # Youth Records (Open) |
| <input checked="" type="checkbox"/> Exposure Control Plan | <input type="checkbox"/> Supplemental Contracts | 0 # Other |

Surveys

4 Youth 5 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 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 checked="" 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

Strengths and Innovative Approaches

Rating Narrative

The agency has recently purchased land across the street from the RAP House to start building affordable housing.

The Residential Director is now the Regional Shelter Director overseeing RAP House and the agency's other shelter New Beginnings located in Bartow. Each shelter now has a Residential Supervisor and Team Lead.

The shelter has recently had a local organization build a new pavilion on-site and replace the sand on the volleyball court with professional volleyball sand.

The agency is hoping to receive a grant for a chicken coop and aqua farming.

The agency recently received a grant through United Way to have a Case Manager visit the homes of habitual runaways for ten to twelve weeks after services end.

The shelter has served over 400 youth in the last year.

The agency has a full-time Registered Nurse who splits her time between RAP House and New Beginnings.

Standard 1: Management Accountability

Overview

Narrative

At the time of this onsite program review, the YFA Residential program employs a Regional Shelter Director, a Residential Supervisor, an Office Specialist, one Youth Development Specialist (YDS) Shift Leader, two Residential Counselors, a Registered Nurse, and eleven Youth Development Specialists, both full-time and part-time. The agency operates a Risk Prevention and Management Team Meeting that reviews various issues quarterly. This team is comprised of various YFA staff members. Youth and Family Alternatives, Inc. is accredited by the Council on Accreditation (COA).

1.01 Background Screening

Satisfactory
 Limited
 Failed

Rating Narrative

There is a facility operating procedure for background screening of employees and volunteers to include interns and mentors which was last reviewed in March 2017. Screenings are conducted for all department employees and contracted providers for any staff, volunteers, mentors, and interns with access to youth. All screening is completed prior to hiring an employee or utilizing services of a volunteer/mentor/intern. The procedure also outlines the process for five-year rescreens for every five years of employment. Lastly, the policy also ensure that the annual affidavit of good moral character is completed by January 31 of each year.

As required by law in Chapter 985.407 F.S. and the Department of Juvenile Justice a background screening must include a complete criminal history check and fingerprinting utilizing level 2 standards for all staff and volunteers. The process includes submitting an entire BSU packet in order to complete the preliminary screening. The program is to ensure that all items needed are provided, signatures obtained and when applicable, notarized. The provider is responsible for all costs as it relates to obtaining screenings. Screenings will be completed on all employees, interns and volunteers every five years. An annual affidavit will be completed by the human resources department in January of each year on all staff who were actually working during the calendar year no later than January 31st.

There were eight staff hired since the last annual compliance review. All eight staff had a background screening completed prior to the date of hire. All staff were screened as either eligible or eligible with charges. There was one staff eligible for a five-year rescreen during this annual review, which was also submitted before date of hire. The Annual Affidavit of Good Moral Character was submitted to the background screening unit on January 24, 2017 under Youth and Family Alternatives, Inc. as required.

There were no exceptions to this indicator.

1.02 Provision of an Abuse Free Environment

Satisfactory
 Limited
 Failed

Rating Narrative

There is a facility operating procedure for provision of an abuse free environment to ensure the environment is safe and secure which was last reviewed in February 2017. The environment for youth and staff is non-threatening and free from any form of abuse or harassment. Staff are required to adhere to a code of conduct that forbids staff from using physical abuse, profanity, threats or intimidation. Youth shall

not be deprived of any basic needs such as food, shelter, clothing medical care, sleep and security.

The procedure ensures that any person who knows or has reasonable cause to suspect abuse, neglect by a parent, legal custodian, caregiver or other person responsible for the child's welfare must report such knowledge or suspicion to the Florida Abuse Hotline. The policy and procedure provides instruction to staff with contact phone numbers and the information necessary to conduct the call. All reported incidents will document the call in the clients' file. There is a procedure in place should the victim require temporary placement. The policy also ensures cooperatively with the Department of Children and Families when indicated.

The program's code of conduct prohibits the use of physical and psychological abuse, profanity, threats and intimidation. All employees and volunteers are obligated under the Florida law to report all allegations of child abuse or suspected abuse. Postings of the CCC hotline and the Abuse Registry were observed throughout the program. All training files reviewed contained documentation to support staff are aware of the code of conduct. The program has grievance forms and two locked boxes accessible to youth. Management takes immediate action of any incidents of physical and psychological abuse, verbal intimidation, use of profanity, and/or any excessive use of force. There are no reported incidents of abuse since the last annual compliance review.

There were no exceptions to this indicator.

1.03 Incident Reporting

Satisfactory

Limited

Failed

Rating Narrative

There is a facility operating procedure for incident reporting which was last revised in October 2015 and reviewed in March 2017. The reporting process is used to identify problems, document trends and provide any necessary corrective action needed to minimize risk. The policy outlines that management is to take immediate action to address founded incidents of abuse (physical or psychological), verbal intimidation, use of profanity, threats or excessive use of force. The risk management process includes identification of any significance in the number or severity of incident types not limited to use of force, youth on youth battery/assaults, and misconduct.

All employees who have direct knowledge of an incident that constitutes a risk to the organization or to its clients must complete an incident report. There is an incident report process which includes the completion of the report, to whom provided and when. This includes a hard copy with signatures upon completion and review to the supervisor. The supervisor and/or other senior staff member conducts an investigative review of the incident and takes any necessary corrective action. The agency risk manager also conducts review of the incident to determine whether immediate response is necessary based on the severity of the incident. If so, the risk manager makes appropriate senior leadership notification. The incident reporting procedure is in accordance to the Department's Central Communication Center (CCC) guidelines and is reported no later than two hours of learning of the incident as required. The procedure provides a description of reportable incidents identified by the CCC.

There is an internal report for all incidents and those reported to the Departments Central Communications Center (CCC). Those not accepted by the CCC had documentation that the incident was not accepted by the agency and noted on the internal incident reporting form. All incident reports are reviewed and signed by the program directors. A review of reportable and internal incidents from 9/29/2016 through 4/4/2017 indicated there were nineteen incidents in the CCC database for review. All were reported within the two hour time frame. There are no reported incidents of abuse or neglect to the CCC.

There were no exceptions to this indicator.

1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

There is a facility operating procedure for training requirements. The policy stipulates that the first year of employment is a critical period for staff development and training and requires all full time staff that work directly with youth to have 80 hours of training within the first year of employment. After the first year of employment, all staff are required to maintain a minimum of 40 hours of annual training to include but not limited to refresher training in the operation of fire safety/alarm equipment, CPR and First Aid and how to recognize and respond to youth who need mental health or crisis intervention. The procedure for training includes a list of required trainings for first year employees through program orientation, annual mandatory trainings and in-service training topics all outlined in policy. The policy was last reviewed in March 2017.

There is an individual training plan and training record for each staff that specifically outlines the required training areas to meet the standards set forth by the Department of Juvenile Justice for all CINS/FINS providers. Directors and supervisors maintain individual training files for each employee and are required to review with each employee to ensure training requirements are met. Employees are expected to take an active role in their staff development and training needs and interests through communication with their supervisor. Any additional training may be added for position specific functions.

The program maintains a training record for each staff. The three training files reviewed for the required training within the 120 days contained all required training. There were three training files reviewed for one year of employment training contained over the required hours. The three training files reviewed for on-going training requirements also exceeded the required hours. The training is documented in Relias training system as well as in the individual training files.

There were no exceptions to this indicator.

1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

There is a facility operating procedure for analyzing and reporting information. The policy provides a process for each program in the agency to compose a monthly report with relevant program data which is sent to the COO by the 10th of the following month. The COO reviews this report as well as the monthly NetMIS data reports for the following: Incident/accidents and grievances, annual report which highlights specific activities, trends, successes and/or recommendations, achievement of goals, consumer satisfaction data, and client outcomes. In addition, other analyzing and reporting information includes coordination, and case record (peer) reviews and reports as outlined in policy.

All records receive a paperwork compliance review individualized for the required paperwork for that program and documentation of a record review is provided to the staff member responsible for that record. Individual staff members receiving review documentation regarding a record they are responsible for are expected to use this information in their personal assessment of their skill level and training needs

and to shape their future professional growth. The COO provides an aggregate report on the peer review activities for the directors and supervisors meeting on a quarterly basis.

The program collects and reviews several sources of information to identify incidents, grievances, customer satisfaction. There is a plan that outlines the Continuous Quality Improvement (CQI). The CQI meets quarterly to identify patterns and trends, and the effectiveness of the CQI worksheets. There is a Monthly Activity report collected from the agency's client database and NetMIS and distributed.

There were no exceptions to this indicator.

1.06 Client Transportation

Satisfactory

Limited

Failed

Rating Narrative

There is a written policy that states the agency ensures the safety and security of all youth and staff while providing transportation services at the shelter's programs. The policy was last reviewed on 2/14/2017 and approved by the Chief Operating Officer and Vice President of Prevention Services.

The program has a written procedure that indicates drivers and potential drivers are approved through human resources, have a valid driver's license, and have received approval from the agency's insurance agency.

The Monthly Trip and Mileage Log is to be completed for each trip. This includes name of driver, date and time, if safety equipment is present, client's initials, origin and destination of the trip and odometer readings for both, and tolls incurred. will be completed for each trip, regardless of if clients are being transported or not.

Drivers take the phone on all trips and use the phone to check in upon arrival to their destination. Whenever possible, an approved third party is on the transport (volunteers, staff, interns). If a third party is not available, the driver will ensure their supervisor or designee is aware and documented in the log. Client's history and recent behaviors will be considered before transporting and the client sits in the back row during the transport. The driver will maintain an open line of communication with the shelter throughout the transport if there are safety concerns during a single party transport.

The program maintains a list of all approved drivers, which includes all staff working in the program.

The program maintains a monthly trip and mileage log that is completed for each transport and includes name of driver, date and time, if safety equipment is present, client's initials, origin and destination of the trip and odometer readings for both, and tolls incurred. A list of the required safety items is shared with staff at orientation. There is a log of frequent destinations and routes which are approved by the Regional Director.

Drivers take a phone on all trips and check in upon their arrival to their destination.

The program maintains a single party transportation log that includes date, client's first name, destination and reason for the trip, whether there is a supervisor's approval and the supervisor's initials, departure and destination mileage, and driver's first name. An open line of communication is maintained for all single party transports. Single party transport are also documented in the house log, indicating the time that an open and closed line of communication are maintained.

The program has two vans, a 2016 Dodge Grand Caravan and a 2008 Chevrolet Uplander. Monthly preventative maintenance/safety inspections are conducted.

There were no exceptions to this indicator.

1.07 Outreach Services

Satisfactory

Limited

Failed

Rating Narrative

There is a written policy that states staff will seek opportunities to conduct ongoing community outreach and education to communicate the agency's mission, role, functions, capabilities, and the strengths, needs, and challenges confronting children and families. The policy was last reviewed on 3/27/2017 and signed by the Board Chair and the President/CEO.

The agency has a procedure that indicates staff at all levels are formally assigned responsibility for community education. The procedure outlines a variety of activities, meetings, councils, groups, professional organizations, and forums for staff to be involved with and indicates that information about the program will be disseminated through various means. Procedure indicates that agendas, minutes, and sign-in sheets will be maintained for DJJ Circuit meetings. Also, it is indicated that the program will maintain a record of inter-agency agreements.

The program maintains a log indicating the DJJ Board and Council meetings that includes sign-in sheets, minutes, and agendas for meetings attended. There is also a NetMIS report indicating a variety of community involvement activities and meetings.

The program maintains a log of inter-agency agreements and memorandum of understandings which include the Pasco Juvenile Assessment Center, Pasco Sheriff's Office, Pasco United Way, Pasco County Schools, and more.

There were no exceptions to this indicator.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

The agency is contracted to provide residential and non-residential CINS/FINS services to youth and families residing in mainly Pasco and surrounding counties. The Non-Residential Program employs a Program Director, a Program Supervisor, two counselors, an Office Specialist, an Administrative Specialist, and a Data Entry Specialist. The program provides non-residential services at the agency's office, local schools, and other community-based organizations. The agency has a number of innovative practices that are evident in the program. All psychosocial assessments contain a concise summary write-up that follows the psychosocial assessment form. The summary is easily read and very helpful. Evidence of focus on youth development was seen throughout the facility and is clear in the case file documentation as well.

2.01 Screening and Intake

Satisfactory

Limited

Failed

Rating Narrative

The agency has written policy and procedure that addresses the key elements of the QI Indicator. The policy was last approved on 2/14/17 by the COO and VP of Prevention Services.

The procedure indicates that Program Supervisor/Director will ensure a counselor contacts the family to conduct an initial screening and document on the Centralized Intake Screening Form. The screening may be completed by phone or face-to-face, to begin as soon as possible but no later than 7 working days from the date the youth is being referred. Screening is available to families 24 hours a day which includes presenting problems, immediate needs, and determining if a youth is eligible for CINS/FINS services which is documented on the intake screening form. If a crisis mental health or substance abuse service is determined there is support staff available to contact an on-call supervisor to assist. There are also procedures in the policy in the event that youth/parent answers that the youth is currently suicidal or homicidal. There is a procedure that outlines service eligibility for Non-Residential programs during after hour calls as well as if a family requires translation assistance.

At time of intake parent/youth are provided with available services options in the form of brochures in English and Spanish for both residential and non-residential services as well as a brochure with clients' rights/responsibility including Grievance Procedures and a Guide to CINS/FINS services which outlines possible actions through involvement with CINS/FINS. Three (3) open and two (2) closed files were reviewed for both residential and non-residential programs. For all files reviewed, there were parent and youth signatures on the Rights and Responsibilities form. The initial screening for eligibility occurred before the 7 working days for all files reviewed.

There were no exceptions to this indicator.

2.02 Needs Assessment

Satisfactory

Limited

Failed

Rating Narrative

The agency has written policy and procedure that addresses the key elements of the QI Indicator. The policy was last approved on 2/14/17 by the COO and VP of Prevention Services.

The agency policy and procedure, SH 2.02, address Need Assessments. The program will conduct a full Needs Assessment, to be initiated in timely manner for each youth and family participating in services. The assessment evaluates a variety of issues faced by the family, not just the presenting problem represented by the youth. Need Assessments are used to provide a baseline measurement for effectiveness of services and family's ability to implement skills learned through interventions. Need Assessments assist counselors in understanding a family's individual needs and strengths, determining severity of issues, and enabling counselors/case managers to make timely referrals unique to the family's needs. Need Assessments are to be initiated within 72 hours of admission and if a more intensive assessment is needed the family is to be referred in a timely manner. If a youth is admitted to the shelter then the residential counselor will work closely with the non-residential counselor to ensure continuity of care. The Needs Assessment will be conducted every six (6) months and will be completed within two (2) to three (3) face to face contacts following initiation in non-residential services. Needs Assessment are completed by Bachelor's or Master's level staff and signed off by supervisor. If a suicide risk assessment is required this will be signed off by a licensed clinical supervisor.

A total of ten (10) files were reviewed, three (3) open and two (2) closed for both non-residential and residential programs. All files reviewed contained documentation of the Needs Assessment being initiated within 72 hours. All files reviewed contained documentation of completion of the Needs Assessment within two (2) to three (3) face to face visits. All Need Assessments reviewed were completed by a Masters level counselor and signed by supervisor. Of the non-residential files reviewed one (1) was identified with needing a Suicide Risk Assessment and was signed off by Masters level counselor, supervisor, and licensed mental health professional. For the residential files reviewed that indicated suicide risk, Suicide Risk Assessment was completed by masters level counselor and signed off by supervisor and licensed provider. Suicide Assessments were completed the same day as Needs Assessment or before.

There were no exceptions to this indicator.

2.03 Case/Service Plan

Satisfactory

Limited

Failed

Rating Narrative

The agency has written policy and procedure that addresses the key elements of the QI Indicator for Service Plan Development and Service Monitoring. The policy was last approved on 2/14/17 by the COO and VP of Prevention Services.

The agency policy and procedures has key elements consistent with the QI Indicator regarding components of the service plan. Service Plans will be individualized with the specific needs identified in the Needs Assessment, collaborative, information, and screening and intake forms. Counselors will make a referral if youth/family's identified needs are beyond the scope of CINS/FINS program and copy of referral will be placed in the client's record. The Service Plan is to be developed no later than seven (7) working days following the Needs Assessment.

If the Service Plan cannot be signed due to the parent or youth's unavailability, the counselor will document the reason the Service Plan was not signed and will make efforts to review and obtain a signature as soon as possible. Service Plan goals are to be monitored and reviewed at a minimum by the counselor/therapist and parent/guardian (if available) every thirty (30) days for the first three (3) months, and every six (6) months thereafter. Reviews will be documented and highlighted in yellow in the youth's

file and if the parent/youth is not available or unwilling to review the Service Plan the counselor may review the case with supervisor. The counselor will document all efforts to engage the youth and family in review process. A new plan will be developed at the end of ninety (90) days or at any time there are significant changes.

A total of eight (8) files were reviewed, three (3) open and two (2) closed for the non-residential program and one (1) open and two (2) closed for the residential program. All files reviewed contained all components required for Case/Service Plans. For both programs, all case/service plans were signed by youth, parent/guardian, counselor, and supervisor as well as included the date the plan was initiated. One (1) shelter record did not have a parent/guardian signature; however, reasons were documented in counselor's progress notes. For non-residential program file reviews all were completed with youth and parent, per documentation, at required time frames and most file reviews were completed more than what is required. Shelter files with case/service plans were not due for reviews.

There were no exceptions to this indicator.

2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

Rating Narrative

The agency has written policy and procedure that addresses the key elements of the QI Indicator for Case Management and Service Delivery as well as Family Involvement. The Case Management and Service Delivery policy was last approved on 2/14/17 by the COO and VP of Prevention Services.

Family involvement entails that counselors will utilize diligent efforts to engage the family in the solutions of the youth's issues and may be addressed by school visits, home visits, telephone contact, correspondence or other venues. Services are strength-based and are in partnership with the family. If counselors are unsuccessful in engaging the family in services, she/he will document engagement efforts and will review the case with the Program Director.

In regards to Substance Abuse referrals, a Non-Residential counselor may use the SASSI instrument to determine if further assessment is needed by a Certified Addictions Professional or a local substance abuse assessment center. If it is determined that a substance abuse assessment is needed then the Non-Residential counselor will make a referral for an assessment within 5 working days of the identification of the need. Non-Residential counselors will monitor the family's compliance with the referral and document reasons in case file if referral is not completed. If a referral is not needed the youth will be provided with basic substance abuse education during face to face contacts as well as parents/youth are provided with substance abuse prevention and awareness during CINS/FINS assessment.

Three (3) open and two (2) closed non-residential files were reviewed. Two (2) open and two (2) closed residential files were reviewed. Counselors in both programs are making referrals when necessary, providing support for families and monitoring progress with services. A binder is kept with 30/60 day follow-ups that showed follow-ups are completed.

There were no exceptions to this indicator.

2.05 Counseling Services

Satisfactory

Limited

Failed

Rating Narrative

The agency has written policy and procedure that addresses the key elements of the QI Indicator for CINS/FINS Counseling Services and Family Involvement. The policy was last approved on 2/14/17 by the COO and VP of Prevention Services.

Family involvement entails that counselors will utilize diligent efforts to engage the family in the solutions of the youth's issues and may be addressed by school visits, home visits, telephone contact, correspondence or other venues. Services are strength-based and are in partnership with the family. If counselors are unsuccessful in engaging the family in services, she/he will document engagement efforts and will review the case with the Program Director.

A total of five (5), (three (3) open, two (2) closed) non-residential files were reviewed. A total of five (5) shelter files were reviewed (three (3) open, two (2) closed). All files reviewed demonstrated that individual/family counseling is being provided and that presenting problems are addressed in the psychosocial assessment, case plan, and notes. In non-residential files there is a chart supervision that documents clinical review of case records and staff performance. When family counseling is not provided there are documented efforts to engage the family in counseling services. There is an internal process in the form of quarterly reviews of files and peer reviews during staff meetings during months outside of quarterly review for both programs. A group counseling binder was reviewed and it is evident that group counseling is being provided more than five (5) days per week.

There are no exceptions to this indicator.

2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

Rating Narrative

The agency has written policy and procedure that addresses the key elements of the QI Indicator for Adjudication/Petition Process. The policy was last approved on 2/15/17 by the COO and VP of Prevention Services.

Families are contacted and reminded of the case staffing the day before the meeting. All contacts with the child and family are to be documented on the Chronological contact sheet. Copies of all letters mailed to the family are to be filed under the Miscellaneous/Correspondence section of the youth's case record. YFA counselors prepare all Pre-Dispositional Reports and Court Reviews. Case Staffing Committees meet at locations which are central and convenient to the families and participants. If the family attends the Case Staffing they will receive a copy of the plan. The counselor is responsible for documenting the case record that the family received the plan. If the family is not present, a copy of the plan is to the parent/guardian outlined the interventions and recommendations of the Case Staffing Committee with seven (7) working days of the Case Staffing Committee.

Three (3) files were reviewed. With all files reviewed, the CINS/FINS counselor initiated the case staffing; parent/guardian and case staffing committee were notified in required time frame; and committee included the required members who were present during meetings. None of the files reviewed had court involvement. At the meeting, families are provided a copy of case staffing recommendations which includes new or revised plan for services. Two (2) of the files documented that the counselor met with the youth the day before the case staffing and discussed the case staffing meeting. Meeting locations appear

to be convenient and centrally located; program has an established case staffing committee; and has regular communication with committee meetings via email each month. The Program has an internal procedure for the case staffing processes including a schedule for meetings.

There were no exceptions to this indicator.

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

The agency has written policy and procedure that addresses the key elements of the QI Indicator for Youth Records. The policy was last approved on 2/15/17 by the COO and VP of Prevention Services.

All records are marked “confidential” and kept in a secure room or locked in a file cabinet that is marked confidential, which is accessible to program staff. All records that are transported are locked in an opaque container that is marked confidential. Youth records are maintained in a neat and orderly manner so that staff can quickly and easily access information.

Ten (10) files were reviewed for both programs (three (3) open, two (2) closed). All were marked “confidential” and were reported to be locked in a secure room or locked in file cabinet marked confidential. Non-residential records were indicated to be stored in another building in a locked cabinet and were transported by a locked, opaque bag on wheels. It was reported that youth records that are transported are done so via a locked box on wheels marked confidential or via black carrying bags that are also marked confidential. Records are organized, neat, and information is easily accessible.

There were no exceptions to this indicator.

Standard 3: Shelter Care

Overview

Rating Narrative

The RAP House is an eighteen (18) bed crisis shelter facility located on Plathe Road approximately 2 miles West of Little Road in Port Richey. The program is operated by Youth and Family Alternatives which also operates two other CINS/FINS shelter facilities in Florida (Brooksville and Bartow). The facility is well-designed, nicely decorated, attractively landscaped, very clean and well-maintained. There were no signs of graffiti, property damage or any hazardous or dangerous conditions during this site review.

A comprehensive tour of the facility was conducted to determine the environmental conditions of the facility and the living conditions for the youth. This residential shelter operates twenty-four hours a day, 365 days a year and is licensed to serve up to twenty-four residents for runaway and emergency shelter services. The youth shelter is contracted to serve both CINS/FINS youth and children placed by the Department of Children and Families (DCF). The youth shelter utilizes effective documentation practices in the agency's program logbook. At the time of this on-site Quality Improvement (QI) review, the RAP youth shelter had six CINS/FINS youth in the shelter.

3.01 Shelter Environment

Satisfactory

Limited

Failed

Rating Narrative

The policy gave a detailed description of what is needed in a shelter environment to keep all youth safe and well maintained. Policy SH 3.01 was last reviewed on 2/15/17.

The agency has put into practice many components to ensure the safety of all individuals. All staff appears to have been trained to provide the youth with social, emotional, intellectual and physical development.

In reviewing the fire safety binder, four log books, and the daily activity schedule binder it confirms that the shelter exercises various ways of making sure the shelter is productive for all consumers.

Through observation and reviewing documents in the fire safety binder it was discovered that all fire and safety inspections are current at this time. All alarms, fire boxes and sprinkler systems appeared to be operational. During a tour throughout the facility the following was confirmed: the program was free from insect infestation, the grounds and landscape was well maintained, all areas inside the facility were clean, all youth have individual beds and all needed bed coverings.

When reviewing the log books and the daily activity schedule, it showed the children were able to have the opportunity to participate in faith-based services, non-punitive activities are offered. Also, daily programming allowed for leisure and educational time if needed. The daily activity log is also accessible to staff and youth. Through observation the kids appeared to be engaged in some type of structured activity.

There were no exceptions to this indicator.

3.02 Program Orientation

Satisfactory

Limited

Failed

Rating Narrative

This policy states that during the first twenty-four hours of admission, the program must include a process that explains and outlines the rules of the program. It must also explain what steps are put in place for the

consumer if they are not in agreement of how they are being treated. Policy SH 3.02 was last reviewed on 2/28/17.

This agency has implemented a process that gives youth and parents the opportunity to learn the expectations of the shelter program.

In the review of five intake files, it was confirmed that the staff explained in detail the different components of program orientation to youth and parents.

In each of the five files reviewed staff explained the disciplinary process along with the grievance procedures. The staff gave parent and child a form that was comprehensible. The rules of contraband were laid out in a detail to inform the parents and youth what was allowed in the facility. The physical layout of the building was explained and there are floor plans placed throughout the building to be observed if needed. There were different areas throughout the intake book that stated any suicidal alerts (some examples include: needs assessment, room assignment form, and alert tab on the front of the intake folder). It is also documented on forms that the parents and youth received orientation. This was found in all five intake files. The five files also had documentation that all youth received the abuse hotline number. Documentation of parents and child reviewing the daily activity log was also reviewed and observed in all five files.

There were no exceptions to this indicator.

3.03 Youth Room Assignment

Satisfactory

Limited

Failed

Rating Narrative

The program has implemented policies and procedures that allow for the classification of each youth according to the following: age, gender, sexual identity, sexual aggression, history of violence, gang affiliation, suicide risk, disabilities, and physical size and strength. Policy SH 3.03 was last reviewed on 2/28/17.

The program's goal is to implement procedures that maintain safety and security for each youth due to age, gender, disabilities and behaviors.

During the interview with the program supervisor, she explained and outlined in detail the process of determining how a youth is classified and what determines what room they will be assigned to. Five intake files were also reviewed and each file had accurate documentation of youth's referral behaviors and what problems they presented. The files also contained a youth's room assignment that correlated with all CINS/FINS standards.

There were no exceptions to this indicator.

3.04 Log Books

Satisfactory

Limited

Failed

Rating Narrative

This agency has implemented policies and practices regarding its logbook to ensure staff are aware at all

times of the hourly and daily routines of staff and youth. Policy SH 3.04 was last reviewed on 2/28/17.

The agency has put in place a policy to document the care and welfare of youth in the program. The policy states the direct care staff and supervisory staff are to review the book at the beginning of each shift.

Four logbooks were reviewed and the director and supervisors reviewed the book thoroughly on weekly occasions. It is also noted the staff reviewed logbooks for the two previous shifts. When the supervisor was questioned regarding the logbooks she had adequate knowledge of what the logbook protocol entailed. Throughout the logbooks, youth alerts were documented. The alerts in the logbook matched with the alerts on the intake files. It was also noted when youth came off of constant sight and sound watches. There were no signs of white out in any of the four log books reviewed. All visitations were documented in each logbook.

There were no exceptions to this indicator.

3.05 Behavior Management Strategies

Satisfactory

Limited

Failed

Rating Narrative

The program has a detailed policy of the Behavioral Management Strategies that the youth and parent are informed of during the orientation process. Policy SH 3.05 was last reviewed on 10/1/15.

The program has implemented policies and procedures needed to influence the youth to make better decisions and increase accountability and responsibility.

After reviewing five intake files, it was confirmed that staff do explain the Behavior Management System (BMS) during the intake orientation process. Parents and youth sign after being orientated on the strategies.

During the interview with the program supervisor, the BMS was explained in detail to the peer reviewer the process of implementing the Youth Development System. The program completed research from different organizations with the BMS before creating their own system. There are positive reinforcements for seeking positive attention. The shelter uses a wide variety of rewards and incentives in order to motivate the youth. The program supervisor also explained their "Ninja Room" where the youth are allowed to purchase items for being positive during their stay.

The organization also uses behavioral intervention practices to de-escalate youth verbally. They also strive to use as little physical interventions as possible. This agency utilizes a process called Managing Aggressive Behavior as a behavioral intervention. The trainer explained in detail the process. Each staff must complete two days worth of training on Managing Aggressive Behavior (MAB). The first day consist of verbal de-escalation. The second day consists of physical intervention training. Physical intervention is only used as a last resort.

There were no exceptions to this indicator.

3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

Rating Narrative

There is a written policy that states that shelter programs are appropriately staffed to ensure adequate supervision of youth, and safety and security of youth and staff. The policy was last reviewed on 2/28/2017 and signed by the Chief Operating Officer and Vice President of Prevention Services.

There is a written procedure that outlines staffing levels, ratios, on-call initiation, scheduling, requests for time off, duties and responsibilities, and youth supervision. Each includes a detailed description of roles, responsibilities, timelines, and required documentation.

The program maintains a schedule that includes the names of staff and shifts they are working and meets minimum staffing ratios. The overnight shift is staffed with two staff. The program attempts to maintain both genders on shift, however is unable to employ male staff on a consistent basis. Recruitment efforts on the agency's website and on Indeed.com reflect efforts that target males. There is a staff schedule and holdover overtime roster that includes names and phone numbers which is maintained in a log book in the file room, accessible only to staff and is emailed to the staff when there are revisions. There is documentation in the house log that bed checks and the whereabouts of all youth are made every fifteen minutes.

There are currently eight youth (six of them CINS/FINS youth) residing in the shelter. Youth were observed during indoor time having a snack upon arrival from school and during outdoor time while youth were playing basketball and relaxing. There were three staff supervising and interacting with the youth at all times.

There were no exceptions to this indicator.

3.07 Special Populations

Satisfactory

Limited

Failed

Rating Narrative

There is a written policy that states shelters shall provide services designed to provide a safe alternative to secure detention for youth with pending or adjudicated charges for domestic violence to special populations including domestic violence respite, domestic minor sex trafficking, probation respite, and staff secure for youth ages 10 - 17 which are provided primarily to youth who reside in Citrus, Hernando, Sumter, Pasco, Hardee, Highlands, and Polk counties - unless approved by the Florida Network.

Procedures for each special population includes a general description of services, youth eligibility, youth referral/determination, limits on youth to be served, and services to be provided. Each section details criteria and processes.

Three files for youth with domestic violence charges were reviewed. All youth files contained documentation that the youth had a pending domestic violence charge and evidence of being screened by JAC, but not meeting the criteria for secure detention. One youth resided in the program for a day, another for two days, and another for five days. None of the youth had a case plan developed due to their brief lengths of stay. One youth entered foster care upon release, and the others did not enter another program and were encouraged to follow recommendations of DJJ and CPI.

There were no exceptions to this indicator.

3.08 Video Surveillance System

Satisfactory

Limited

Failed

Rating Narrative

There is a written policy that states that video surveillance will be used as a means to provide a secure environment, protect its facilities, and enhance the safety of youth, staff, and visitors. The policy was last reviewed on 10/01/2015.

There are written procedures that outline the areas that will be recorded, designated staff who have access to footage, written staff acknowledgement of surveillance, requests for footage, timelines for review and maintenance of footage, and purpose of footage reviews.

Notification of surveillance is posted on the front entrance door, the side door, and the door leading to the outdoor recreation area.

There are sixteen cameras that are visible and record footage of public areas, indoors and outdoors and has battery backup. There is a list of staff who have access to footage which includes the VP of Prevention Services, Regional Director, and Residential Supervisor - with the Office Specialist and Team Lead as backup staff. The system captures and maintains video, including photographic images and facial recognition, for a month. Footage of lesser quality can be accessed beyond a month.

Documentation of reviews conducted twice per month or more often if there is an occurrence of an incident, is maintained in a log book and includes random reviews of the overnight shift.

Video images were observed and clearly recorded areas and images and were dated and time stamped.

There were no exceptions to this indicator.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

Youth and Family Alternatives (YFA) has screening systems and processes to detect general health and mental health risks presented by prospective residents. This process requires that each resident that meets CINS/FINS eligibility requirements be screened by staff members for the severity of potential health and mental health issues. Designated trained YFA residential and non-residential staff members utilize agency screening forms that include the general screening form, CINS Intake form, Psycho-Social Assessment and the Evaluation of Imminent Danger for Suicide (EIDS). The CINS intake form includes health screening section that is required to be completed by staff members.

The agency also utilizes a Suicide Risk Assessment instrument that is conducted on youth that indicate a positive response on the CINS Intake form. The agency's staff members consult directly with the Vice President for Prevention who is a licensed mental health counselor (LMHC). All YDS staff members at the youth shelter are trained on the suicide risk screening process and utilize the CINS Intake form to screen for potential risks prior to placing any youth on sight and sound supervision status. At the time of this review, the VP of Prevention services was primarily responsible for reviewing and consulting on assessments completed to determine if these youth need to stay on this status or have this level of supervision reduced.

The agency utilizes an effective color-coded, general alert system that informs direct care staff of the youth's health, behavior or mental health status. The agency also documents any youth that has received on-site or off-site first aid or medical care. Staff members are trained on safety and first aid training topics as confirmed by documentation in training files.

4.01 Healthcare Admission Screening

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy for Health Care Admission Screening last reviewed and updated on February 28, 2017.

At the time of intake/admission, Youth Care Staff are to utilize the CINS/FINS Intake Assessment form and the Health Screening Form to screen for medical, mental health, and substance abuse concerns. Staff also evaluate the youth's acute needs to determine whether the youth is suffering from a condition or contagious disease/illness that may create a risk to shelter youth/staff.

Whenever possible, the parent/guardian or caseworker is to be actively involved in the coordination and scheduling of follow-up medical appointments or care. However, if the youth's guardian or caseworker is unable or unwilling to provide for the youth's medical appointments, the shelter program will ensure the youth's needs are met. Follow-up appointments and/or emergency care are to be documented in the youth's case record and the communication log book.

There were five youth files reviewed for Healthcare Admission Screening. In all five files, the CINS/FINS Intake Assessment Form, the Health Screening Form, and the Tuberculosis Symptom Assessment Questionnaire were completed at admission. In two of the files reviewed the youth were taking medications and the medication as well as the reasons for taking it were documented. There was one youth with acute asthma documented but also noted the doctor did not prescribe an inhaler for it. One youth documented Wolff-Parkinson-White (WPW) syndrome but also noted that it was inactive. Two youth had allergies to medications and those were also noted.

Four of the five Health Screening Forms were reviewed and signed by the RN within 72 hours. The fifth was due to be reviewed the first day of the on-site review.

There were no exceptions to this indicator.

4.02 Suicide Prevention

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy for Suicide Prevention in place that was last reviewed and updated on March 31, 2017.

A suicide screening is completed during the initial intake and screening process using the six questions on the CINS/FINS Intake Form Risk Screening section. If the youth answer "yes" to any of the six questions the staff will then complete the Evaluation of Suicide Risk Among Adolescents (EIDS). A suicide assessment is then completed by a qualified professional within twenty-four hours. Youth awaiting an assessment are placed on constant sight and sound supervision. If at any time during the screening or at any time during the youth's stay at the shelter, any staff observes or believes a youth presents as an immediate threat to themselves or others, the youth will be placed on one-to-one supervision and staff will immediately call 911 and/or follow Baker Act procedures.

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 program by law enforcement or the guardian for the purpose of Baker Act assessment. One staff member is to stay within an arm's length of the youth at all times while on one-to-one supervision. 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. During both levels of supervision staff must document observations of the youth at five minute intervals. Documentation must be reviewed by a supervisory staff each shift and must be placed in the youth's file. Staff must also ensure there is communication between shifts regarding youth who are on suicide precautions through the alert system and communication log book.

There were five open youth files reviewed and all five 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. All five files also documented the EIDS was completed during the intake process and the youth were placed on constant sight and sound supervision until assessed by a qualified professional. All five files documented an assessment of suicide risk was completed by a qualified professional within twenty-four hours. All assessments were completed by a master's level counselor and a telephone conversation was documented with a Licensed Mental Health Counselor (LMHC) on each assessment and signed the next time the LMHC was on-site. In all five files, the youth were removed from suicide precautions and placed on standard supervision. All five files documented five minute observations of the youth were maintained the entire time the youth was on precautions.

There was documentation in the log book for all five youth when they were placed on suicide precautions. There was documentation found when each youth was removed from precautions and also between each shift change there was documentation of all youth on suicide precautions.

There were no exceptions to this indicator.

4.03 Medications

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy for Medication Control and Management last reviewed and updated on March 29,

2017.

The policy has detailed procedures for Intake, Verification, Storage, Assisting in the Self-Administration of Medication, Discharge/Temporary Release, Over-The-Counter Medication, Medication Side Effects, Inventory, Disposal, and Training. This policy covers the requirements for medication distribution in accordance with the DJJ Health Services Manual.

The shelter provided a list of fourteen staff who are trained to supervise the self-administration of medications. Four staff on that list were identified as "Super Users" with one of them being the Registered Nurse (RN).

The agency has a RN who works full-time for the agency and splits the hours between two of the agency's shelters. The RN is on-site at this shelter Mondays, Wednesdays, and every other Friday. The RN distributes all medications when on-site.

The RN trains all staff on the use of the Pyxis Med-Station and the medication administration process at hire. This is a four-hour training that covers all areas of medication administration and includes a written test at the end. The RN also completes on-going trainings with staff on various health related topics during monthly staff meetings. The RN completes health education groups with the youth at least once per quarter.

All medication is stored in the Pyxis Med-Station. All medications are stored in drawer two. Drawer one is used to store keys to the facility. Staff must sign the keys out of Pyxis Med-Station which keeps a detailed log in case any keys go missing. Drawer three is currently empty. Drawer four is used for thermometers, pregnancy tests, lice combs, and scissors.

There were five discrepancies in the month of March 2017, ten during February 2017, and five during January 2017. The discrepancies are generally closed out by the end of the staff members shift or within twenty-four hours at the most. All discrepancies were printed out and kept in a binder and reviewed and signed by the RN. Most discrepancies reviewed were staff inputting incorrect beginning counts. The RN reported there have not been any discrepancies involving missing 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 review.

The shelter maintains a large supply of disposable razors. These razors are given to the youth to use and then disposed of. At the time of the review the shelter had 150 razors in inventory. These razors are inventoried once a week. There have been no razors used in the past six months. The shelter has a supply of eleven scissors that are inventoried weekly. There are two nail clippers and three tweezers that are inventoried weekly. There is a sign in/out log that is completed anytime a youth uses any of the aforementioned sharps. The log documents the date, the staff initials, the youth's name, the item, the time out, the time in, and the staff initials again.

The staff must complete a Low Medication Alert Form whenever a youth has less than seven days of medication remaining. The RN maintains a Medication Disposal Log of all medications that were disposed of in the shelter.

All controlled medications are inventoried by maintaining a running perpetual balance and are also inventoried each shift. Two staff members, one from the shift leaving and one from the on-coming shift inventory the medications. One staff member counts the number of pills and the other staff member records the number, with their initials next to it. Once the staff member has finished counting the pills they also initial the count on the Daily Medication Count Log so that each count has two staff signatures verifying the amount of pills. In addition, the board and tools used to count the medication on is sanitized between each use to avoid cross contamination for youth allergic to certain medications.

The medication alert board in the medication room has all controlled medications written in blue so at a quick glance staff know which medications need to be counted each shift. At the time of the review there was one controlled medication in the shelter. Two staff members were observed counting this medication at shift change. A review of the Daily Medication Count Sheet for this medication revealed it had been

counted each shift since the youth arrived at the facility. Non-controlled medications are inventoried by maintaining a perpetual inventory each time it is given and inventoried at least one time each week by the RN sometimes more often. An Inventory by Station Report is run each time the RN completes this inventory. The inventory sheets are maintained in a binder and the actual count is documented next to each medication. This inventory includes everything that is stored in the Pyxis Med-Station. The shelter does not maintain any over-the-counter medications that would require an inventory.

The Vice President of Prevention Services and the Regional Director for the agency print out various reports from the Knowledge Portal each month. These reports are then reviewed in a meeting with them and the Residential Supervisors from each shelter run by the agency. The reports that were printed along with a sign-in sheet from the meeting are maintained in a binder. Meetings were documented for the last six months.

There were three youth currently in the shelter on medication. The agency maintains hard copies of all documents relating to the medication process, as well as, enters all information into the Pyxis Med-Station. The youth's prescription medication log sheets reviewed, documented the youth's name, side effects of the medication, dosage, instructions, Doctor, prescription number, and times to be given. Each log sheet documented when a medication was given, staff signature, youth signature, and perpetual inventory with running balance. A cover sheet was located for the youth that included a picture of the youth. The RN verifies all medications herself with the pharmacist. All prescription medication log sheets reviewed for the youth documented that all medication was given at prescribed times.

There were no CCC reports for the last six months relating to medication errors.

There were no exceptions to this indicator.

4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place for Medical and Mental Health Alert System last reviewed and updated on March 20, 2017.

Medical, mental health conditions, and allergies are documented on the CINS/FINS Intake Assessment. A "Medical Alert" sticker on the outside of the youth's file indicates the youth has a medical or mental health condition. If the youth has any allergies they will be documented on the "Allergies" sticker on the front of the youth's file. Any special dietary needs and/or food allergies are documented on the CINS/FINS Intake Assessment and also on the Special Dietary Needs/Allergy Board in the kitchen.

The alert system consists of the letters A through H with each letter representing a different alert. A form is placed in the front of each youth's file that documents each alert the youth is on and the reasons for the alert. The alerts are then documented on the outside front cover of the youth's file so it is easy for staff to glance at the file and know what alerts each youth has.

There were five youth files reviewed to ensure all alerts were appropriately documented. All five files documented all the youth's alerts on the form inside the front cover of the file coincided with the alerts documented on the outside front cover of the file. These alerts also coincided with information documented on screening and assessment forms located inside the file. All applicable alerts were also documented on the two alert boards. All dietary alerts and restrictions were documented on the alert form located in the kitchen and on the front of the youth's file. A "Shift Roster" is documented in the logbook each shift change. This documents all youth in the shelter and any alerts the youth are currently on.

There were no exceptions to this indicator.

4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy on Episodic/Emergency Care that was last reviewed and updated on March 20, 2017.

If a youth is in need of emergency care, 911 is called and the incident is reported. If the youth is transferred to an off-site facility for emergency treatment, the shift leader or designee is to record in the youth's monitoring note the hospital to which the youth is to be taken prior to the youth leaving the property. After discussion with the Program Director or Residential Supervisor, the shift leader or designee on duty is to contact the youth's parent/guardian. Upon a youth's return to the shelter from an emergency medical facility, the shelter will keep in the file a verification of receipt of medical clearance, any discharge instructions, and follow-up care that may be required.

The shelter keeps a Monthly Incident and Accident Review log that lists all emergencies/incidents that occurred which required medical attention or follow-up care, including but not limited to those incidents reported to the CCC. There have been twelve instances in the last six months of youth being transported off-site for emergency medical. All twelve incidents were reported to the CCC and also documented on the Incident and Accident Review log. The log documented a brief description of the incident, the episodic care required, and if any follow-up care was needed. The CCC reports documented all notifications to the youth's parent and to program management. The CCC reports also documented a more detailed description of the incident and care received. Seven of the twelve incidents were also documented in the program logbook.

All staff are trained on First Aid and CPR. The knife for life and two different types of wire cutters are located in the shelter. First aid kits/supplies are located in the laundry room, kitchen, file room, and both vans. These kits are inventoried weekly by the RN. The RN uses a First Aid Kit Checklist that list each item in the first aid kits and the location of the kits. During the review of the kits the RN will check off each item and document if it had to be replaced due to expiring or if it was replenished due to being used. These checklists were completed weekly for the last six months. The information from the checklist is then transferred over to the First Aid Kit Inspection Log. This log documents the date, checks off each first kit inventoried, and then documents notes.

There were no exceptions to this indicator.