Florida Network of Youth and Family Services Quality Improvement Program Report

Review of YFA-RAP House

on 01/20/2016

CINS/FINS Rating Profile

Standard 1: Management Accountability	
1.01 Background Screening	Satisfactory
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Satisfactory
1.05 Analyzing and Reporting Information	Satisfactory
1.06 Client Transportation	Satisfactory
1.07 Outreach Services	No rating

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

Standard 2: Intervention and Case Management	
2.01 Screening and Intake	Satisfactory
2.02 Needs Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management and Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petitiion Process	Satisfactory
2.07 Youth Records	Satisfactory

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

Standard 3: Shelter Care	
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

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%

Overall Rating Summary

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

Rating Definitions

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

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

Review Team

Members

Ashley Davies, Lead Reviewer and Consultant, Forefront LLC

Kent Rinehart, DJJ, Central Regional Supervisor

Teresa Clove, Thaise Educational and Exposure Tours, Executive Director

Mandy Kumrits, Family Resources SafePlace2b Clearwater, North Residential Supervisor

Kristi Castenada, Boys Town of Central Florida, Director of Program Support

Persons Interviewed

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

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

0 Maintenance Personnel
3 Program Supervisors
0 Other

Documents Reviewed

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

5 Health Records
5 MH/SA Records
11 Personnel Records
9 Training Records/CORE
5 Youth Records (Closed)
3 Youth Records (Open)
0 Other

Surveys

4 Youth | 5 Direct Care Staff | 0 Other

Observations During Review

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

Comments

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

Strengths and Innovative Approaches

Rating Narrative

The shelter has had a Nurse on staff since July 2015. The Nurse is also a CPR and First Aid instructor and completes trainings for staff. She conducts a three-hour medication training. It includes an exam at the end of the course in which staff must pass in order to assist in the medication process. The Nurse works one-on-one with staff who are having issues and offers these staff more technical assistance.

The shelter is also using their Medication Cart to store sharps, company credit cards, and keys to vans and restricted areas of the facility. The agency reports this has helped keep strict control over these items as staff must log into the Medication Cart to retrieve the items and to return the items.

The agency was able to make some updates to some items in the shelter including the television, couch covers, and updated the living room due to receiving a monetary gift over the summer from a civic organization.

A local Fraternity adopted the shelter and have volunteered as positive male role models for the youth. They also produce events and BBQ's for the youth.

The agency broke ground during the week of the review on a new pavilion. This was made possible from a local Rotary Group and some private donations. This is expected to be completed by the end of March 2016.

The agency is in the process of trying to raise money to add on an additional sunroom and porch to the shelter and also to renovate the youth bedrooms.

Three staff members were sent to MAB training.

The non-residential program did not have any drastic changes since the last review. One Counselor was promoted to a Senior Counselor and a new Counselor began in December 2015; however, this person has been with the agency for years.

Standard 1: Management Accountability

Overview

Narrative

At the time of this onsite program review, the YFA Residential program employs a Residential Director, an Office Specialist, two Youth Development Specialist (YDS) Team Leaders, two Residential Counselors, and fifteen Youth Development Specialists, both full-time and part-time. At the time of the onsite Quality Improvement program review, the position vacancies included three vacant YDS part-time positions, one vacant Life Skills Educator position, and one vacant Outreach Worker position. 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

The program had eleven new hires since the last review. Each staff has been screened through the Department of Juvenile Justice's Background Screening Unit. Ten of the eleven staff's results came back before their date of hire. The remaining staff's result was dated nine days after their hire date. Each staff's screening documentation had been returned with an eligible rating. There were no staff requiring a five-year rescreen at this time.

The Annual Affidavit of Compliance with Good Moral Character Standards was completed January 19, 2016.

1.02 Provision of an Abuse Free Environment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

All staff members sign several acknowledgements upon hire. These include ACA Code of Ethics, Employee Affidavit of Agency Policies and Procedures, Child Abuse and Neglect Reporting Requirements, Reporting Abuse, Neglect, and Exploitation of Children, and Vulnerable Adults, and Receipt of the Employee Handbook.

The program has a written grievance procedure that provides an avenue for youth to address their complaints in a positive manner. There were three grievances in the youth grievance folder. Each grievance was addressed and resolved to the youth's satisfaction within one day.

There were no documented incidents of staff using physical or psychological abuse, verbal intimidation, profanity, or excessive force during the review period.

All four youth surveyed reported they know the number to the abuse hotline and have never been denied access to call if needed. All four youth also reported staff are respectful when talking with the youth and they have never heard staff use inappropriate language or threats when speaking with the youth.

All five staff surveyed reported they have never seen another staff member deny a youth access to call the abuse hotline. All five staff members also reported they have never heard a staff member use profanity, threats, or intimidation when speaking with the youth.

1.03 Incident Reporting

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a written policy and procedure for incident reporting. The policy requires DJJ funded programs to comply with Chapter 63F-11 Florida Administrative Code for the Central Communications Center (CCC). All qualifying incidents are to be reported within two hours of knowledge of the incident. There were fifteen reports made to the CCC in the last six months. Each report was made within the required two-hour time-frame.

1.04 Training Requirements

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has training requirements for new employees and for staff continuing in service beyond a year. The training documentation of four first-year staff documented the staff far exceeded the required eighty hour of training. The program's on-site orientation training requirements included seventy-two of the required eighty hours. The average of documented training hours for new staff was 172 hours per staff. The documentation detailed the staff were trained in the required topics.

Training requirements were in place for staff requiring annual training beyond their first year of service. The training documentation was reviewed for five staff. These staff also far exceeded the mandatory forty hours of annual training. The staff averaged a total of ninety-nine hours of annual training. The documentation indicated the staff had received training in the required and suggested topics.

1.05 Analyzing and Reporting Information

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program conduct peer reviews of the residential and non-residential program. The reviews generate corrective action plans for issues identified during this process.

The agency has a comprehensive continuous quality improvement process that is established in policy for identifying patterns and trends across the agency. The CQI plan has been revised beginning this year.

A number of committees have been established and meet regularly to review different aspects of the quality environment. Incident reports are reviewed as they come in and data is compiled on a month to month basis. QI staff and management staff review the data monthly and the QI Council reviews it quarterly.

Customer satisfaction data is reviewed at least once a year as part of the strategic planning process. Outcome data is reviewed monthly and is compiled for review by the management team and the QI Council. This data is also compiled for the board at least once a year. Program management reviews monthly NetMIS data and clearly knows where the agency is in terms of objective achievement at all times.

The agency has instituted a feedback process for peer review. CQI plans involve staff that coordinate the QI process, monitor compliance, and follows up to see if improvements have had the desired result. This information is shared freely with program supervisors. Subcommittees of the QI Council keep detailed minutes of their meetings and plans and results are tracked.

There is documented evidence of training related to issues identified through the QI process and the review of incidences to monitor its success. The committees have identified two areas of concern within the shelter and developed CQI Worksheets to address the issues. The worksheets identify the issue and desired outcome. There were several issues identified during an audit of the residential charts. A CQI worksheet was put into place to correct issues found in the charts. Corrective action plans have been put into place and a follow-up will be scheduled to ensure recommendations are implemented.

Supporting documentation from the file reviews was attached to the CQI Worksheet. The second CQI worksheet reviewed identified several issues found during the chart audit of the non-residential charts. Again all files were reviewed and issues were identified. Supporting documentation was attached to the CQI Worksheet and a follow-up review was scheduled.

1.06 Client Transportation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policy in place for Client Transportation. Per the procedure, Human Resources approve staff drivers. The policy does state the program will make every attempt to avoid single party transport situations. Drivers will have a valid driver's license and are covered by program's insurance.

In the event a third party cannot be obtained for transporting a youth, the Program Director and/or the Team Leader look at who the youth is and their history and recent behavior to pair them with a staff of the same gender or with a staff that has a good rapport with the youth. In these cases the staff has an agency phone with them are in constant contact with a staff member that is back in the program. Van logs were reviewed from September through December 2015 and there were nine single client transports in the Dodge Caravan and 24 single client transports in the Chevy Uplander. The majority of the single client transports were for school drop offs, pickups, or hospital visits.

There are binders for each van that have eighteen approved routes. The routes were approved by the Program Director and have varied destinations such as schools, medical center, hospital, and the court house. This is used to check that the mileage of the trips match the MapQuest directions in the binder.

There is a log for each van that has columns for date, driver, safety equipment in van, number of clients transported, purpose, stops, odometer start, odometer stop, and comments or notes. There is no column for start and end time or a column for supervisor acknowledgement or consent in case it was a single client transport. The start and end times and approval for single client transports are being recorded in the logbook.

It was recommended to add a column for start and end times and a column for supervisor acknowledgement or approval for single client transports.

1.07 Outreach Services

☐ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policy for Outreach Services. There is documentation the Program Director attends the quarterly DJJ Advisory Board meetings. Meeting minutes for October and December 2015 were provided for review. The program has a separate binder for all community outreach meetings, presentations, events, and activities. The program had 67 outreach events from 8/2/15 to 1/15/16. They also have 16 interagency agreements with community partners.

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

A written policy was in place for Screening and Intake. There were five non- residential files reviewed (four closed and one open) and three residential files reviewed (two open and one closed). The agency has a twenty-four hour, seven days a week Central Intake process at the shelter for residential and non-residential youth. All eight files reviewed were screened for eligibility within one to two days. There was documentation in all files the written Rights and Responsibilities were given to and signed by the parents and youth. A brochure that includes the Grievance Procedure is included in the YFA brochure and is given to the parent at intake.

2.02 Needs Assessment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

A written policy was in place for the Psychosocial Assessment. There were five non-residential files reviewed (four closed and one open) and three residential files reviewed (two open and one closed). The Psychosocial Assessment for all the files were started on the day of admission and completed within two to three face-to-face contacts. There were no indications of suicide tendencies on any of the files. A Master's level counselor completed the Psychosocial Assessments and the Suicide Screening and it was reviewed and signed by the supervisor.

2.03 Case/Service Plan

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

A written policy was in place for Case/Service Plans. There were five non- residential files reviewed (four closed and one open) and three residential files reviewed (two open and one closed). Overall, the agency was in compliance with this indicator for the 30, 60 and 90 day service plan reviews. The reviews were being completed in the appropriate time-frame, reviewed with the youth, and signed by the counselor. It was recommended that these reviews also be signed by the parent or document in the case notes if the parent is unavailable to sign.

The three residential case files were not due for reviews but the counselor reported that they review with the youth and the parent, then document it in the case notes if the parent is not available to sign the review form.

2.04 Case Management and Service Delivery

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

A written policy was in place for Case Management and Service Delivery. There were five non-residential files reviewed (four closed and one open) and three residential files reviewed (two open and one closed). Each youth had a counselor assigned to their case that delivered services pursuant to the Psychosocial Assessment. The counselors provided support to the youth and the family and made recommendations and referrals as needed.

2.05 Counseling Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

A written policy was in place for Counseling Services. There were five non- residential files reviewed (four closed and one open) and three residential files reviewed (two open and one closed). The counselors assigned to the case provided counseling to the youth and the family addressing their presenting problems as stated on their individual Service Plan.

The non-residential counselors had monthly reviews with the youth but did not meet or review with the family as required. The supervisor met with the counselor and reviewed their cases on a

monthly basis and notated it in the file. The counselor's notes were in chronological order and the overall files were neat in appearance. The residential case files were recently opened and were not due for reviews.

2.06 Adjudication/Petitiion Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

A written policy is in place for the Adjudication/Petition Process. There were two non-residential files referred to the Case Staffing Committee by the Counselor and the Counselor's Supervisor. Both families were notified in writing within seven days of the decision to send the case to the Case Staffing Team and were notified by phone within five days of the meeting. Each family received a copy of the committee's recommendations at the Case Staffing Committee Meeting or it was mailed to the home and documented in the case notes. In attendance were a DJJ Representative, Law Enforcement, School Board Representative, YFA Director, and the YFA Counselor.

The agency has an established Case Staffing Committee which is scheduled to meet monthly unless there are no youth referred. An email is sent out to the committee members monthly when the meetings are cancelled.

During the Case Staffing Committee meeting, the team makes recommendations for the youth to follow. The agency uses these recommendations as their Service Plan goals which is excellent but on the plans they are leaving out the frequency, location, time-frame, and responsible person for each intervention/goal or objectives. The policy requires that these items are added to the service plan.

2.07 Youth Records

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

A written policy is in place for Youth Records. There were five non- residential files reviewed (four closed and one open) and three residential files reviewed (two open and one closed). Each file was marked/stamped "confidential". The non-residential files were kept at a different location and reported by the Director to be kept in a locked file cabinet. The residential files were kept at the facility in a locked room inside a locked file cabinet. When having to transport files away from the facility they have a small key, locked, black opaque carrying case that could carry a few files and two large combination lock roller cases that could carry multiple case files. All files were maintained according to the indicator—neat and orderly, and easy to access.

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 five CINS/FINS youth in the shelter. Youth in the shelter at the time of this onsite review responded to an online survey. These residents reported that they feel safe and that they had not witnessed or experienced any adults threatening any residents. The shelter has a grievance process and grievance forms are available to the youth in common areas. The agency accepts grievances directly from residents and checks the grievance box on a routine basis to address resident concerns.

3.01 Shelter Envonment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Upon review, the facility appeared well-kept and in working order both inside and out. The grounds are very clean. The facility appears free of graffiti and all furniture appears in operational order. Schedules are posted clearly in several places throughout the facility. The schedule does meet all contractual requirements for physical activities, faith-based, education and quiet time. The youth rooms were appropriate, containing all necessary requirements. The program inspections were visible and up-to- date. Emergency drills, as well as, fire drills were conducted on a regular basis.

3.02 Program Orientation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in regards to Program Orientation. Upon review, youth files, the Log Book, and other additional documentation reviewed demonstrated appropriate requirements for fulfilling this indicator.

A review of five youth files revealed all the youth received an orientation to the shelter upon admission. All files contained a completed orientation form that covered all requirements and was signed by the youth and staff. The parent also received information regarding the program and signed forms indicating they had received it.

3.03 Youth Room Assignment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place regarding Room Assignment. Upon review of five files, it was apparent the program has been following proper protocol when implementing room assignments.

There were five youth files reviewed. There is documentation within the youth files that clearly capture all the youth's history (i.e. medical, mental or physical disabilities, sexual aggression, and suicide risk) that staff use to determine what room to place the youth in. If a youth comes into the shelter with special needs and such risk like suicide, mental health, substance abuse, physical health or security risk factors, an alert system is enacted. That alert is placed on the youth's file, in the program log book, and on the alert boards placed throughout the facility (behind blinds to help maintain privacy for the youth).

3.04 Log Books

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

After a review of the log books, it is apparent that staff and supervisors review the log books on a regular basis. Staff review the previous two shifts. The Program Director reviews the logbook at least weekly and makes recommendations as needed. The oncoming supervisor reviews the logbook at the beginning of each shift. Overall, appropriate dates and times are visible and entries are legible and initialed once completed. Errors appear to be handled correctly. A signature page was provided so names could be recognized. The program is currently working on implementing a color coded system for the log book. Some colors have already been implemented.

3.05 Behavior Management Strategies

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a detailed policy which explains their Behavior Management System (BMS). The last time this policy was revised was 11/1/11 and the training they refer to in the policy is outdated. They have had a certified trainer in Managing Aggressive Behavior (MAB) since March 2015. This training needs to be added to the policy as it is their practice.

The shelter has a Youth Development System with levels and time-frames. The three levels are Orientation (0-14 days), Educational (5 days), and Graduation (20-90 days). I spoke to three staff members about the BMS and they stated they do not punish the kids, there could be a loss of privileges but no points are given or taken away. They talked about re-directing youth and verbally escalating situations. The kids cannot go on outings until after the orientation level. Other incentives besides outings are: snacks, baking, RAP store ninja bucks, and inside activities to accommodate the kids who are not on outings.

All new staff are trained on the BMS through the Residential Youth Training section of their 72 hours of training curriculum.

The program has a Team Leader, who is on the floor observing staff interactions with youth and will intervene for training purposes around the BMS. The Team Leader holds shift meetings every two weeks and a staff meeting monthly. The Team Leader also emails information that staff may need to know on a regular basis. The staff interviewed discussed the "fish philosophy"—where they can cut out a fish and write down a good deed done by a staff member and that staff member could receive a gift card or something for the program's appreciation. This helps with a positive environment for staff and that can flow into the positive culture for the kids.

The program embraces the six pillars of character and developmental outcomes. Many times the group sessions tie the lesson back to these staples in the program. Six pillars of character are responsibility, respect, caring, citizenship, fairness and trustworthiness. There are 12 developmental outcomes: safety and structure, self-worth, belonging and membership, mastery and future, autonomy and responsibility, self-awareness and spirituality, physical health, mental health, intellectual ability, employability, civic and social ability and cultural ability.

3.06 Staffing and Youth Supervision

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has two policies (Staff Levels/On-Call and Youth Supervision) to cover the requirements of this indicator.

The program has staff schedules posted in a binder. This binder is kept in the room where the medication cart and alerts are located. The staff take a picture of the schedule to keep with them. There are highlights on the staff schedule to show assignments and training requirements: pink= staff meeting mandatory, purple= medication training, orange= employee assigned to intakes, yellow= employee assigned to supervise medications, and blue= training shifts.

In the program's policy they strive to maintain one male and one female on duty at all times. The Program Director reported they have had a hard time recruiting and sustaining males in the Youth Development Specialist position. Currently, there are only two full-time and two on-call male Youth Development Specialists. The Program Director provided documentation of recruitment efforts of male staff. They are using "Indeed" which funnels to "Paycom". They also advertise job positions on their programs website under "Careers".

The shelter has video cameras throughout the facility and the backup tapes capture 7-9 days back. The time on the video is off by approximately three minutes from the clock they have where the staff are doing 15 minutes overnight bed checks. The video was also approximately three minutes off from the time on the phone system that was observed in the Program Director's office where the video panel is located. Staff has tried over and over to reset the clocks but they never seem to sync exactly with the time on the video cameras. The overnight bed checks were observed through video on Wednesday, January 13th; Friday, January 15th; and Monday, January 18th and all were completed within three minutes of the time recorded in the logbook.

3.07 Special Populations

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy on Special Populations.

There were five Domestic Violence (DV) files reviewed. In all five cases, the youth were pending a DV charge and had either a Face Sheet from DJJ or a copy of the arrest report to show this. The longest length of stay in all five cases was five days. Only one case was closed and transferred into a CINS case. There was only one youth with a service plan and that was the youth who transferred over to CINS. All files were consistent with all the same sections and required documents.

The shelter has not had any Staff Secure or Probation Respite youth since the last on-site Quality Improvement review.

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 and Ongoing Monitoring last reviewed and updated on September 13, 2013. Upon admission to the shelter, Youth Development Staff (YDS) use the CINS/FINS Intake Assessment Form, the Health Screening Form, and the Tuberculosis Symptom Assessment Questionnaire, to screen youth for medical, mental health, and substance abuse concerns. Staff will 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.

In addition, the nurse also completes a thorough Nursing Intake Examination on each youth that covers twenty-four different areas of the body and includes a body chart. The nurse also does a thorough examination on each youth for Lice. Whenever possible, the youth's parent/guardian or caseworker will be actively involved in the youth's medical condition and scheduling of follow-up medical appointments or care if needed. However, if the youth's guardian or caseworker is unable or unwilling to provide for the youth's medical appointments, the shelter will ensure the youth's needs are met.

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 five files, there was documentation the youth had asthma. One file documented the youth only used the inhaler as needed and there was no further information in the file concerning the youth's asthma. The second file documented the youth had asthma, there was documentation the parent was present for the intake, but there was no other documentation concerning the youth's asthma. Three of the five youth were on medication and the type of medication as well as the reasons for the medication were documented. Two youth documented allergies and those were documented and entered into the alert system.

All five files also documented the nurse completed a thorough Nursing Intake Examination on each youth that included a body chart. The nurse also completed a thorough examination on each youth for Lice.

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 September 13, 2013. 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 if 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 youth files reviewed (two open and three closed) 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 four of the five files the youth was removed from suicide precautions and placed on standard supervision. One file documented the youth was to remain on constant sight and sound supervision and assessed again at a later date. There was documentation the next day that the counselor completed another suicide assessment and talked to the LMHC and the youth was removed from suicide precautions. All five files documented five minute observations of the youth were maintained the entire time the youth was on precaution.

There was documentation in the log book when three of the five youth 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.

4.03 Medications

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place for medication storage, access, and inventory. The policy was updated 12/21/2015 to include use of the Pyxis Med-Station 4000 Medication Cabinet.

The shelter has hired a Registered Nurse (RN) who has been employed at the shelter since July 2015. The RN is on-site at least 20 hours a week at various times depending on the need of the shelter, the population and time of day/year. The RN limits her time in the shelter during school hours since the youth are not on-site and tries to be at the shelter during hours the youth are present. The RN's hours are very flexible and she is able to be on-site whenever needed. She is on-call 24/7 to help staff through any issues they may run into when she is not there. She completes trainings with staff on using the Pyxis Med-Station and anytime a discrepancy is found or an error occurs, she re-trains the staff to ensure they fully understand where the error was so that it does not happen again. The RN has an extensive four-hour training all staff must participate in before they are authorized to administer medication. The training covers all aspects of the medication distribution process, as well as, how to operate the Pyxis Med-Station. There is currently twenty-one staff members in the shelter trained to administer medications and there are four Super Users.

All youth medication is stored in the Pyxis Med-Station. After the youth's information is entered into the Pyxis Med-Station, a bin within the machine is assigned to the youth. Each medication is stored in its own separate bin within the Medication Cabinet, so topical medications are always stored separately. The youth's medication is placed in that bin and once it is closed it can only be opened during assigned medication times or for inventory purposes. Staff using the Pyxis Med-Station have to enter a password as well as their fingerprint to gain access. 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.

All medications in the shelter are inventoried once per week by the RN. All medications are also inventoried at admission (when given) by maintaining a perpetual inventory with running balances and at discharge. Staff are required to count the medication and enter the beginning amount into the Pyxis machine each time they give a medication and this is documented on the youth's Prescription Medication Log Sheet. The RN maintains all weekly inventory sheets in a separate binder. The inventory sheets are actual print-outs from the Pyxis computer and list every medication in the Pyxis Med-Station and the count. The RN then inventories each medication and documents the physical count on the inventory sheet next to the applicable medication and ensures the two counts match. There was no documentation of controlled medications being inventoried shift-to-shift. These medications are inventoried as given, by maintaining a perpetual inventory with running balances, at admission, and at discharge.

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 sharps in the shelter, as well as, all keys and company credit cards are also stored in the Pyxis Med-Station. These items are stored in the first drawer on the machine and are inventoried weekly. The Program Director reported this is done to have better control over these items, as staff are required to sign into the machine and pick which item they are removing. In case an item is missing or not returned into the Pyxis machine it is easy to verify through the computer who was the last person to sign the item out.

The only over-the-counter (OTC) medication given at the shelter is non-aspirin pain relief. Only youth in the shelter who are not on any type of prescription medication are allowed to have an OTC. Youth on prescription medications cannot receive the non-aspirin pain relief unless it is prescribed by a doctor. This is for safety purposes as some types of prescription medications may have adverse effects if mixed with other OTC medications.

There were six youth currently in the shelter on medication. The agency still 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, side effects, 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.

The RN print-outs all discrepancies from the Pyxis computer and maintains them in a binder once they are resolved. Most discrepancies were due to staff inputting the wrong medication count due to staff just not paying attention and pressing the wrong button.

There have been two incidents in the last six months, accepted by the CCC relating to medication errors. The first incident was a missed dose of medication. A youth was not given a morning medication. This error was discovered on the next shift when the staff went to administer the youth's next dose. The incident was reported to the CCC and the pharmacy was contacted, who reported there would be no adverse side effects. The staff member involved was re-trained by the RN and a memo was signed by the staff and placed in the staff members personnel file. The incident was successfully closed out with the CCC.

The second incident was also a missed medication. Staff on another shift noticed a youth did not receive a medication earlier in the day. It was reported to the CCC and there was supporting documentation to show the staff responsible for the error was re-trained by the RN. In response to this error the program also implemented a process in which each shift must sign a log sheet stating all medications on that shift were dispensed. The outgoing staff and oncoming staff must sign the log. This form was observed and reviewed and has been in practice since October 29, 2015. There was documentation the case was successfully closed out with the CCC.

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 September 13, 2013. The policy in place has not been updated to reflect the current alert system. The policy does not address the alert codes A-H the shelter is currently using. The policy also refers to one alert board located in the medication room. This alert board only lists youth on medication. There are two additional alert boards located in the hallway in the administrative area and the other board is located in the dorm area. These alert boards list all alerts the youth have.

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. 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.

4.05 Episodic/Emergency Care

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy on the Episodic/Emergency Care System that was last reviewed and updated in September 2013. 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 eight instances in the last six months of youth being transported off-site for emergency medical. The incident, notifications, and any follow-up care needed.

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 behind two locked doors (laundry room and storage closet). First aid kit/supplies are located throughout the shelter and in the vans. These kits are inventoried weekly, as evidenced by review of the Facilitation Verification Checklist. The shelter utilizes Zee Medical Services to restock the first aid kits as needed. Program Director reports that a representative from Zee Medical comes out at least 4-5 times each year to replenish all first aid kits.