Florida Network of Youth and Family Services Quality Improvement Program Report

Review of CHS West Palm Beach

on 10/04/2017

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 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	Limited
3.07 Special Populations	Satisfactory
3.08 Video Surveillance System	Satisfactory

Percent of indicators rated Satisfactory:87.50%
Percent of indicators rated Limited:12.50%
Percent of indicators rated Failed:0.00%

Standard 4: Mental Health/Health Services	
4.01 Healthcare Admission Screening	Satisfactory
4.02 Suicide Prevention	Satisfactory
4.03 Medications	Limited
4.04 Medical/Mental Health Alert Process	Satisfactory
4.05 Episodic/Emergency Care	Satisfactory

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

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

Rating Definitions

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

Satisfactory Compliance	Non-systemic exceptions that do not result in reduced or substandard service delivery; or exceptions with corrective action already applied and demonstrated.
Limited Compliance	Exceptions to the requirements of the indicator that result in the interruption of service delivery, and typically require oversight by management to address the issues systemically.
Failed Compliance	The absence of a component(s) essential to the requirements of the indicator that typically requires immediate follow-up and response to remediate the issue and ensure service delivery.
Not Applicable	Does not apply.

Review Team

Members

Marcia Tavares, Lead Reviewer, Consultant Forefront LLC Ashley Davies, Consultant, Forefront LLC Raymond Ballinger, Shelter Manager, Lutheran Services Florida Southwest Ashton Howell, CINS/FINS Coordinator, Mount Bethel Human Services Corporation

Persons Interviewed

- [ ] Chief Executive Officer
- [ ] Chief Financial Officer
- [ ] Program Coordinator
- [ ] Direct-Care On- Call
- [x] Clinical Director
- [ ] Case Manager
- [ ] Nurse
- [ ] Executive Director
- [x] Program Director
- [x] Direct- Care Full time
- [ ] Volunteer
- [ ] Counselor Licensed
- [ ] Advocate
- [ ] Chief Operating Officer
- [x] Program Manager
- [ ] Direct-Care Part Time
- [ ] Intern
- [ ] Counselor Non- Licensed
- [x] Human Resources

0 Case Managers
1 Program Supervisors
0 Health Care Staff

0 Maintenance Personnel
0 Food Service Personnel

0 Clinical Staff
2 Other

Documents Reviewed

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

3 # Health Records
3 # MH/SA Records
13 # Personnel Records
7 # Training Records
2 # Youth Records (Closed)
4 # Youth Records (Open)
0 # Other

Surveys

3 Youth 3 Direct Care Staff

Observations During Review

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

Comments

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

Strengths and Innovative Approaches

Rating Narrative

Children's Home Society (CHS) is a statewide agency with programs located in 15 divisions throughout the state. The agency's headquarters is located in Winter Park, Florida. CHS employs more than 2,000 employees. Since 1982, CHS of Florida has continuously maintained accreditation through the Council on Accreditation (effective until June 30, 2021).

CHS Safe Harbor Shelter is located at 3335 Forest Hills Boulevard in West Palm Beach, Florida. The shelter is licensed for 10 beds by the Department of Children and Families effective through January 23, 2018. The shelter facility is located in the rear of a large campus that includes its administrative offices housed in a separate building. The Safe Harbor program is the agency's Children In Need of Services/Families In Need of Services (CINS/FINS) program which is sub-contracted with the Florida Network of Youth and Family Services (Florida Network) to provide temporary residential and non-residential services to youth and families in South Palm Beach County. Services are provided to male and female youth under the age of seventeen.

CHS has successfully supplemented its services to the youth in the CINS/FINS program by offering life skills training, educational, and career coaching. Additionally, the program provides structured enrichment activities for the youth through the Choices program. The Choices program is fully supported by volunteers who offer a variety of services such as: theatre improvisation, theater writing, art, soccer, and potting. The program also offers additional recreation activities such as: drug prevention, music, yoga, broadcasting, sewing, and a tennis clinic. All of these services are provided onsite and the shelter also converted one of its bedrooms into an indoor game room where youth are encouraged to earn privileges to play video games. The program uses a hallway closet for its Point Store where some of its donations are used as incentives for youth, in exchange for points earned.

During the past year the program obtained funding between $4,000 to $5,000 through Great Give to update the program with new therapy games and tools for the counseling staff.

The shelter has been remodeled during the past year with new furniture in the living room and a new mural painted by a local artist and the youth in the kitchen/dining room. These additions have improved the overall aesthetics and home-like environment of the facility.

Staffing changes for the shelter include the hiring of a new Residential Program Manager in May of 2017. The new manager has experience working with the agency/program and was formerly employed as a Youth Care staff prior to transferring to a Quality Management position. In addition to the hiring of the Residential Manager, new Shift Leader positions were added to the shelter program.

Standard 1: Management Accountability

Overview

Narrative

CHS Safe Harbor is under the leadership of a management team that consists of an Executive Director, a Director of Program Operations, a Clinical Supervisor, a Residential Program Manager, a Data Management Supervisor, and an Administrative Secretary (vacant). In addition to the Residential Program Manager, the residential component of the program is staffed by three Residential Shift Leaders (two of which are new positions), five fulltime Youth Care Workers (YCW), and three relief YCWs. The program has 8-hour shifts with variations of 6am-2pm/7am-3pm, 2pm-10pm/3pm-11pm, and 10pm-6am/11pm-7am.

The agency's Clinical Supervisor is a licensed mental health counselor (LMHC) who oversees the agency's counseling services. The clinical component of the program includes four (4) fulltime counseling positions that are designated as Residential/Non-Residential Counselors. The program also utilized the services of several volunteers during the review period.

The agency has employees in outreach positions that are grant funded. The outreach staff conducts presentations to the community at parks, schools and other community functions.

At the time of the onsite visit there was one vacant position for an Administrative Secretary.

1.01 Background Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The provider has a policy and procedures for Background Screening of Employees and Volunteers (CHS/7101) that was last updated on 7/1/2017 and reviewed on 10/2/17.

CHS policy #7101 requires all staff and volunteers to complete a Level 2 Background Screening that includes good moral character documentation, employment history checks, employment screening, criminal record checks, and juvenile record checks. Prior to hire, the provider also conducts a background check with the Department of Motor Vehicles and local City/County law enforcement screening. Per the agency's procedures, employees who receive a promotion must be re-screened before the promotion is effective.

Additionally, per the provider's policy, personnel will be re-screened during the fifth year of their employment and every 5 years thereafter.

A total of thirteen background screening files were reviewed for 7 new staff, 1 staff promoted, 4 volunteers, and 1 staff eligible for a 5-year re-screening. All 7 new employees were background screened prior to hire date and e-verified. Similarly, all 4 volunteers were background screened with eligible results prior to their start dates. A 5-year re-screening was completed prior to the 5 year anniversary for the one eligible staff. The provider completed the annual Affidavit of Good Moral Character and submitted it to the Department of Juvenile Justice Background Screening Unit via email on November 22, 2016, prior to the January 31, 2017 deadline.

During the review period, one of the agency staff was promoted from Quality Management to Residential Program Manager on 5/18/17. Documentation in the employee's file shows an eligible DJJ background screening prior to his original hire date and a timely 5-year re-screening; however, the employee was not re-screened before his promotion and the most recent screening was completed on 6/12/17, after the promotion date.

Exception:

One eligible agency staff who was promoted during the review period was not re-screened in accordance

with the provider's policy that states promoted personnel will be re-screened prior to their promotion date.

1.02 Provision of an Abuse Free Environment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a current policy and procedure in place for the Provision of an Abuse Free Environment and Grievance policy CHS/7303. The policies were last updated on 7/1/2017 and reviewed on 9/27/17.

Upon hire, employees receive the employee handbook and sign receipt of the Agency's Code of Conduct (Professional Conduct) which outlines the agency's policy against workplace violence and expectation regarding the provision of a safe environment. During orientation, staff receive training on child abuse reporting mandate and the reporting procedures. Employees are required to report all known or suspected cases of abuse and/or neglect and youth have unimpeded access to self-report. Abuse reports are maintained in the youth's file and are entered in the provider's AirsWeb incident reporting database.

The Florida Abuse Registry Hotline number, rights and responsibility, and other relevant numbers are visible posted in the hallway on the Resident Corner board. Youth are also informed of these procedures during program orientation and the abuse hotline number is included on the orientation checklist and in the Resident Handbook.

The grievance procedure is also reviewed with the youth during intake and the program has a grievance box with forms accessible to youth in the dormitory lounge adjacent to the staff desk. Per the provider's grievance policy, youth will personally handle their grievance documents unless a request for staff assistance is made by the youth.

A total of 5 abuse allegation incidents were reported and reviewed during the onsite visit for the review period; copies of the reported incidents are on file. None of the abuse allegations were institutional. There were no reported incidents of youth being deprived of basic needs or physical abuse by program staff was reported during youth surveys conducted during the review or observed during the visit.

Training files for three new staff were reviewed. All three staff received training in child abuse reporting during program orientation.

During the tour of the facility, posting of the Florida Abuse Registry Hotline number, rights and responsibility, and other relevant numbers were observed to be visibly posted in the hallway on the Resident Corner board. Youth are also informed of these procedures during program orientation and the abuse hotline number is included on the orientation checklist and in the Resident Handbook.

The grievance procedure is also posted and the program has a grievance box with forms accessible to youth in the dormitory lounge adjacent to the staff desk. Grievance procedures are reviewed with the youth during intake and verified during the review of the three residential files reviewed.

A review of one grievance that occurred during the review period was related to staff name-calling youth. The Program Manager (PM) met with the staff to address the grievance and the interviewed youth. The staff denied the allegations and the youth indicated s/he could not recall what took place and agreed to respect staff and follow directives. The youth accepted the resolution and signed off on the grievance.

Per the DPO, the program has not taken any disciplinary actions against for abuse behavior toward youth including verbal or physical abuse staff during the review period.

No exceptions noted.

1.03 Incident Reporting

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a Risk Management and Incident Reporting policy and procedures (CHS/7102) that were updated on 7/1/2017 and reviewed on 9/27/2017.

Children's Home Society has a written risk management plan that identifies and addresses significant changes in the number/severity of incidents via the accident reporting process. Safe Harbor program staff takes immediate action to address incidents by documenting incident reports and following the incident reporting process. Staff member involved, witnessing, and/or having knowledge of an incident are required to immediately contact his/her supervisor who will determine if the incident is reportable to DJJ CCC. If reportable, staff is required to make the call to CCC and document a CHS Incident Report in the provider's incident database called AIRSWEB by the end of the shift. AIRSWEB is used as a paperless system which provides security and confidentiality of incidents reported. The completed report is then forwarded by staff to the supervisor(s) for review and approval. Supervisory notification is documented on the AIRSWEB report and signatures are recorded under a "Sign Off" section of the report which is entered by the respective supervisory staff including the DPO and ED. Program staff/supervisor will complete follow-up communication/tasks as required by the CCC.

A review of the program's CCC reports made during the reporting period was conducted. The agency had four incident reports that were called into the CCC hotline during the last six months. Three of the four calls were accepted by CCC and all three were related to medication counts (1) or missed medication (2). Two of the three incidents called in to the CCC were reported within the two hour time frame. Follow-up communication as requested by CCC was completed by program staff who documented the communication via email.

Exception:

One of the three reportable incidents was not called in to CCC during the 2-hour time frame. Staff became aware of the error in medication count while distributing medication on May 30, 2017. The count was off by ½ pill. The incident was not reported to the CCC until 6/1/2017.

1.04 Training Requirements

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has current policy and procedure CHS/7105 to ensure that all direct care staff is appropriately trained within the first year of hire to adequately meet the needs of sheltered youth. CHS/7105 was last updated on 7/1/2017 and reviewed on 9/27/17.

The agency's policy and procedures include training required within the first year of hire and the minimum 80 hours of training as well as mandatory training to be completed within the first 120 days of hire. However, two of the required training topics were not listed on the provider's policy and procedures as required during the first 120 days, namely Understanding Youth/Adolescent Development and Universal Precaution. In addition, the training of non-licensed mental health clinical shelter staff was not listed as a topic to be completed during the first year for applicable staff.

Training files are maintained in a binder for each staff. The respective program supervisors are responsible for maintaining the training files and monitor the training records on a regular basis.

CHS/7105 does not include procedures to address how/by whom trainings are provided or how training files are maintained as required by Indicator 1.04. In practice, the program supervisors maintain individual training binders for staff that include a complete training plan and log. Mandatory training is listed in the training plans and includes training required internally, for CINS/FINS and DCF. Sources of training

included in the file vary from the provider's online Relias Training system, the Florida Network's Katniss system, and local providers.

A total of six files were reviewed for three staff in their first year of employment and three in-service staff. All three (3) new staff had surpassed the first 120 day period and had completed all of the mandatory trainings required during this timeframe. It was observed that the majority of trainings required during the first year were also completed by the three staff with the exception of EEO (3 staff) and PREA (1 staff); however, the staff has ample time to complete these training during the current year. Two of the three staff have exceeded the 80 hours required and the remaining staff, date of hire 4/10/17 had completed 40.5 hours and is on target for meeting the 80 hours annually.

Three (3) training files reviewed for in-service staff employed for more than one year demonstrated two of the three had exceeded the 40 hours required annually and staff member is on track to complete the hours required. The three staff have completed all of the mandatory training required during their current training year.

Exceptions:

Upon review, two of the required training topics were not listed on the provider's policy and procedures as required during the first 120 days, namely Understanding Youth/Adolescent Development and Universal Precaution. In addition, the training of non-licensed mental health clinical shelter staff was not listed as a topic to be completed during the first year for applicable staff.

CHS/7105 does not include procedures to address how/by whom trainings are provided or how training files are maintained as required by Indicator 1.04. The DPO promptly addressed these findings upon notification and updated the agency policy and procedure CHS/7105 to include the missing elements effective 10/5/17.

1.05 Analyzing and Reporting Information

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a written policy and procedures (CHS/7112), updated on 7/1/2017, for analyzing and reporting data for case record reviews, incidents, accidents, grievances, customer satisfaction, outcome data, and monthly review of NetMIS data reports. In addition, there is a comprehensive CHS Quality Management Plan for the current FY 2017 that describes the agency's philosophy, Quality Management Structure, CQI strategies, strategic planning, management/operational plans, program results/outcomes, monitoring and evaluation of performance, data collection, and communicating results.

The program has a designated Quality Management Manager (QMM) who is responsible for the implementation and oversight of its CQI program in Palm Beach, Inter-coastal, and Southwest Florida. In practice, the program's CQI program includes many activities that are conducted by all staff to ensure all aspects of analyzing and reporting data are consistently implemented and documented.

The program's non-residential clinical staff as directed by the program supervisor, along with QM for the residential files, conducts quarterly case record reviews. Upon completion of each record review, the QM Specialist aggregates the results and provides a copy of the aggregated Quality Management Division Evaluation report with corresponding graphs to the DPO and Program Managers. Themes, trends, and areas of concerns are discussed monthly during team meetings and data analysis meetings. Program supervisors discuss the aggregated data with direct support staff to ensure appropriate areas are addressed and responded to in a timely manner. The QMS also follows up at a later date to spot check specific files to verify completion of the corrective actions.

The program's Safety Committee is facilitated by the QM Specialist and includes participation of the designated shelter staff (RSL) and non-residential staff. The committee is responsible for reviewing incidents and accidents, performing safety checks and fire drills and making recommendations to

management on a monthly basis. Each program and site has a representative who sits on the Safety Committee. The safety committee meets on the third Thursday of each month and if unable to attend, can appear by phone. The QMS facilitates the call and meeting minutes from each meeting are produced and provided to committee members (including the QMS), Program Managers, and the Executive Director (ED). The Division Safety Committee Coordinator discusses safety concerns and suggestions with the ED monthly and follows up with the QMS as needed. The QMS will follow up with the ED and program supervisors as needed to ensure division safety. Consumer grievances are submitted to program supervisors and reviewed weekly by the QM Specialist.

Consumer surveys are administered twice a year during the second and fourth quarters. The QMS addresses consumer surveying via email and at management team meetings and notifies the program supervisors of the outcome of the surveys. The surveys are aggregated by the QMS and provided to supervisors, DPO, and ED. The provider also has a Data Analysis Committee comprised of the Director of Program Operations (DPO), Program Manager, Clinical Supervisor, QMM, QMS, and Data Specialist that meets monthly to review findings of the peer reviews, grievances, incidents/accidents, satisfaction survey results, outcome data, and NetMIS data reports. Strengths, weaknesses, and goals are reviewed and documented in the minutes and discussed by QM at team meetings.

Outcome data is reviewed monthly, quarterly, and annually. Each program documents outcome data monthly into a Program Performance Report. QM updates the DQPR monthly and data is entered into the agency's Division Quality Performance Report (DQPR) into the following areas: program performance, program team minutes, safety, record review, consumer satisfaction, and outcomes.

NetMIS data is emailed from the Florida Network to the agency ED who sends it to the DPO for review. The DPO shares information from the report card with staff during staff meetings. Evidence of staff meeting discussion was found on the agenda for one applicable meeting during the review period that was held in June 2017.

A review of peer record reviews for the 4th quarter FY 16-17 and 1st quarter of FY 17-18 was conducted. A total of 12 files were reviewed from the residential program for the two quarters. For the 4th quarter, Safe Harbor achieved 97% overall compliance and 5 areas were identified as needing improvement. During the 1st quarter of FY 17-18, Safe Harbor achieved 98% overall compliance and 2 areas of improvement were identified. The Non-residential program also completed peer record reviews for the same periods. The program achieved 99% compliance for each quarter reviewed. The non-residential program completed peer record reviews for a total of 36 files. Detailed reports of the case record reviews include: ratings of the review, significant findings, data analysis, and report summary/recommendations.

Monthly meeting dates and/or minutes for the period April-September 2017 were provided demonstrating Safety Committee meetings held to discuss trends and patterns in incidents, accidents, safety inspections, and fire drills. The Safety Committee conducts monthly analysis of the data and submits the necessary recommendations to the ED for approval. Grievances are reported to the QMS on a monthly basis via the Program Performance Report and are discussed at the monthly Data analysis meetings when applicable.

A copy of the most recent Consumer Satisfaction Survey Result for the 2nd period of FY 2016-2017 was reviewed. Survey results are compiled for the shelter and non-residential clients separately. A total of 55 surveys were completed; the surveys resulted in a 92% satisfaction rate for Safe Harbor and 98% satisfaction rate for the non-residential program.

Program outcomes data are documented monthly by each program, incorporating the contract, NetMIS, and program outcomes required by the Florida Network and DJJ QI. A copy of the Florida Network Agency FY 2016-2017 Contract and Benchmarks was reviewed on site. Reports of the outcomes data were reviewed for the current FY to date demonstrating 100% compliance with outcomes indicators for both the residential and non-residential program.

Monthly minutes for the period June-August 2017 were reviewed and found to have documentation of discussion by QM or staff of data being discussed regarding FN NetMIS data, QI activities, QM reports, and areas identified as needing improvements or changes needed from analysis.

A copy of the most recent FN Report Card was submitted by the provider for review. The report included

data for the current FY for the month of July 2017. The report was reviewed by the Non-Residential program team in August 2017.

No exceptions noted.

1.06 Client Transportation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The Client Transportation Policy CHS/7116 that addresses the transportation of youth was last updated on 5/18/17 and reviewed on 9/27/17. The policy and procedure outlines the safe transportation process for the direct care staff and clients in their care, as well as striving to follow best practices.

The policy outlines the agency's protocols regarding requirements and usage of a 3rd party passenger; prior approvals required for single client transport; approval of agency drivers; and the maintenance of current list of approved drivers. Per the policy, the agency will strive to have a third party present in the company vehicle when performing client transport. The third party can consist of other direct care staff, volunteers, interns, clinical or administrative staff, and other youth. Current procedure requires the use of a vehicle travel log that includes information required by the indicator.

Before approving a single transport, the Residential Program Manager will consider the client's recent behavior, background history, and recent behaviors as well as the employee's work performance. Staff is required to document approval by the supervisor in the program logbook. Employees will maintain an open phone line with the Residential Manager or designee upon arrival and departure during the approved trip and every fifteen minutes should the travel time take longer than thirty minutes.

There is a current list maintained of thirteen agency staff approved and monitored periodically utilizing DMV Motor Vehicle Reports. The agency has two vehicles that are used to transport youth. A review of the agency's transportation logs showed use of a travel log that documents: date and time of travel; destination; purpose of travel; beginning and ending number of clients; mileage; initials of staff/driver; initial for supervisor's approval; and use of open line if needed for single client transports.

The transportation log clearly documents instances where single youth transport occurs. The general practice is to document single transport approvals both the transportation log including initials of supervisory approval and in the program logbook; however, there were 2 instances noted 6/2/17 and 8/16/17 where the permission/approval by the supervisor for single youth transport using the Chevy van was not entered in the program logbook.

Exceptions:

The transportation log clearly documents instances where single youth transport occurs. The general practice is to document single transport approvals in two places: 1) the transportation log (including initials of supervisory approval), and 2) in the program logbook; however, there were 2 instances noted 6/2/17 and 8/16/17 where the permission/approval by the supervisor for single youth transport using the Chevy van was not entered in the program logbook.

Supervisory approval was missing on the Chevy van transportation log for a single client transport on 8/4/17; the transport was also not documented in the program logbook.

1.07 Outreach Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The provider has a policy (CHS 7104) that establishes outreach activities, written agreements, and informal

linkages with community based service providers targeting at risk youth. The policy and procedure was updated on 5/18/17 and last reviewed on /27/17.

The provider has a policy (CHS 7104) that establishes outreach activities, written agreements, and informal linkages with community based service providers targeting at risk youth. The policy and procedure was updated 5/18/17 and last reviewed 9/27/17.

CHS Safe Harbor has established interagency agreements with various local organizations. These agreements include service providers from the following sectors: prevention/early intervention programs; medical; educational; mental health and/or substance abuse; and recreation. Copies of the agreements are kept in a binder with a master list that shows the name of the agency, effective date, and expiration date.

Various staff are involved in providing outreach services. The DPO, licensed Clinical Supervisor, and/or Residential Program Manager will conduct educational and informational activities to target and high risk audiences in the community. CHS participates in the national Safe Place program and the DPO is responsible for the maintenance of the established sites. All staff are trained in Safe Place procedures. The DPO or designated staff will participate in community coalitions, forums, and advisory councils. Outreach activities are documented in NetMIS and agendas from activities conducted are maintained.

The provider participates in the Juvenile Division meetings and DJJ Advisory Board meetings. Documentation of minutes of the meetings was provided for the months attended in May, June, and August 2017. September's meeting was cancelled due to Hurricane Irma.

No exceptions noted.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

CHS Safe Harbor is contracted with the Florida Network of Youth and Families to provide both shelter and non-residential CINS/FINS services for youth and their families in West Palm Beach, Florida. The program provides centralized intake and screening twenty-four hours per day, seven days per week, and every day of the year. Trained staff are available to determine the immediate needs of the family and youth. Each youth at the program receives an initial eligibility screening, CINS/FINS Intake Assessment, a needs assessment, and a service plan. The counseling component consists of a total of four (4) counseling positions and a LMHC supervisor. The counselors are responsible for completing assessments, developing case plans, providing case management services, and linking youth and families to community services. Additionally, case management, individual, family, and group counseling services, substance abuse prevention education, and referrals to local community agencies are provided as needed.

The shelter program provides critical temporary shelter care services to youth meeting the criteria for CINS/FINS, DV and Probation Respite, Staff Secure as well as Domestic Minor Sex Trafficking (DMST). Two of the shelter beds are reserved for Probation Respite youth due to the demand for the services in the county. During the review period, the program did not serve any youth meeting the criteria for DMST.

The program meets the needs of the youth while in care with the ultimate goal of reunification with their families. The facility has ten beds available for both male and female youth in the CINS/FINS program and twenty-four hour awake supervision is provided for youth residing in the shelter.

As needed, CHS Safe Harbor coordinates the Case Staffing Committee, a statutorily-mandated committee that develops a treatment plan for habitual truancy, lockout, ungovernable, and runaway youth when all other services have been exhausted or upon request from the parents/guardians. The Case Staffing Committee can also recommend the filing of a CINS Petition with the court. Non-residential counseling services are provided by qualified Master's level staff who are under the supervision of a licensed Clinical Supervisor. Case file reviews revealed that the counselors monitor the youth's and family's progress in services, provided support for the families, and monitored out-of-home placement as applicable. Additionally, the program has many outside agencies with which to refer youth and families and makes multiple referrals to meet the needs of the families it serves.

2.01 Screening and Intake

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a Screening and Intake policy, CHS/7201, which meets and exceeds indicator 2.01 and was last updated on 7/1/2017 and reviewed on 9/27/2017.

The agency's procedure captured on Policy Number CHS/7201 includes the following:

1. The CINS/FINS initial screening form is to be completed within 7 calendar days of referral to the program.

2. During regular business hours clinicians will gather information consisting of, but not limited to, demographics, presenting problem(s) emergency and/or immediate needs and eligibility for services. During weekends and evening hours the shelter staff will gather this information. This information is documented on the intake screening form.

3. All screening/referrals are reviewed by the Program Supervisor or designee and assigned to the appropriate Counselor.

4. The Data Supervisor or designee enters all referral and admission information into NetMIS within 72 hours of completion.

5. Staff will gather specific client documents (i.e., birth certificate) and submit to Florida Network so that Title IV-E eligibility can be determined.

6. An Auxiliary Aids and Services for the Deaf and Hard of Hearing' screening assessment is required to be completed at intake and the client's preferred method of communication will be recorded in the clients file if necessary.

Six (6) files were reviewed, 3 non-residential cases and 3 residential cases. Agency CHS/7201 was followed for all 6 files. Screenings and intakes were done accordingly. All documents were signed by the designated staff. The screening was completed within 7 calendar days in all 6 files reviewed. Similarly, all six files demonstrated youth/parent received a copy of the consumer handbook, providing information regarding available service options, rights and responsibilities, and grievance procedures. Possible actions occurring through involvement with CINS/FINS is provided via the Florida Network CINS/FINS parent booklet.

No exceptions to this indicator were found as of the date of the onsite QI review.

2.02 Needs Assessment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There is a written Policy, CHS/7201, which provides the procedures addressing the Needs Assessment which the agency completes for each incoming youth receiving services. The policy was last updated on 7/1/2017 and last reviewed on 9/27/17.

The agency's procedure that is outlined in Policy number CHS/7201 includes the following:

1) For residential services, the Needs Assessment must be initiated within 72 hours of admission. For non-residential services, the Needs Assessment must be initiated within the first face-to-face session and be completed within three visits/sessions.

2) During completion of the Needs Assessment, staff will obtain information regarding the youth's current situation, presenting problems, immediate family, and medical and health needs.

3) The process of assessing youth is ongoing while services are being provided and more intensive assessments will be conducted however necessary.

4) Readmitted youth will have their Needs Assessment reviewed but if the Psychosocial Assessment is over 6 months old, a formalized Needs Addendum will be completed and include a comprehensive review.

5) The Needs Assessment will be completed by a Bachelors or Masters level staff and signed off by a Supervisor.

Six files were reviewed for three non-residential cases (2 open, 1 closed) and 3 residential cases (2 open, 1 closed). The needs assessments were completed in all six files, within the required time for completion, by a Bachelors or Masters level staff with a supervisor’s review upon completion. All six files included Needs Assessments completed with a risk assessment for suicide indicators.

No exceptions to this indicator were found as of the date of the onsite QI review.

2.03 Case/Service Plan

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There are written policies CHS 7202 (Service Plans) and CHS 7203 (Service Plan Implementation, Review, and Revision) that address the procedures for Service Plans. Both policies were updated on 7/1/17 and last

reviewed on 9/27/17.

The agency has a Procedure that is outlined in Policy number CHS/7202 as follows:

1. The Counselor assigned to the youth/family will schedule a session within seven (7) working days after the completion of the Needs Assessment in order to develop a service plan. The Needs Assessment contains relevant information regarding the youth's social, emotional, educational, health, employment a Service Plan. In the event the Service Plan is not completed within the allotted time frame, the notation will be made on the Service Plan checklist.

2. Service Plans contain specific needs of the youth and family, time frames for completion responsibilities of the youth/family in goal completion are listed. The Service Plan also includes measurable objectives that address the identified problems or needs. The services and treatment to be provided include; type of services or treatment, a frequency of service or treatment, location, and responsible service providers or staff. The Service Plan is developed with and signed by the youth, family, and Counselor.

3. Discharge Planning is incorporated in the Discharge Summary/Aftercare Plan Form developed at the time the Service Plan is completed and signed by the youth/family and Counselor. Achievement of goals will lead to the completion of services and discharge.

4. A formal review of the service plan will be made every 30 days for the first three months and every six months thereafter. Once a client achieves a goal or another goal is added the family is involved in the review of the Sevice Plan as evidenced by their initials on the appropriate review dates. This process is appropriately documented in the Services Plan Checklist and any review involving the family/youth is also documented in the Progress Notes.

5. If the service plan signature/initials are unable to be obtained, documentation within the file should clearly indicate the reason as well as all attempts made in obtaining the signature.

Six files were reviewed for 3 non-residential cases (2 open, 1 closed) and 3 residential cases (2 open, 1 closed). The six Service Plans reviewed included: individual goals; service type, frequency, and location; persons responsible; target and completion dates; plan initiation date; and signatures of the youth, counselor, and supervisor. Three files did not include parent signatures. However, a note was made at the bottom of the signature page that parent/guardian was available by phone and participated in creating the case plan. The activity notes also reflect the parents/guardians involvement.

Service plan 30 and 60-day reviews were done and documented and provided details with regards services the youth and family are receiving.

No exceptions to this indicator were found as of the date of the onsite QI review.

2.04 Case Management and Service Delivery

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

CHS Safe Harbor has several policies and procedures that address case management and service delivery standards: CHS/7111, CHS/7204, and CHS/7206-7207. All of the policies were last updated on 7/1/17.

The program has many collaborative community agencies with which to refer youth and families and makes referrals accordingly and tracks them on their service plan. Clients are assigned to a designated clinician who provides case management services throughout service delivery. Case management services include but are not limited to: service referrals, completing an assessment of needs, coordinating service plan implementation, monitoring and documenting client progress. Counselors make extensive efforts to engage the families and others in case planning activities. Referrals to outside agencies may be appropriate based on assessment information and family resources. Policy CHS/7204 provides the procedures for family involvement and referrals for services.

Six files were reviewed for three non-residential cases (2 open, 1 closed) and three residential cases (2

open, 1 closed). All of the files had coordinated service plans implemented and corresponding progress notes which reflected that the counselors monitored the youth and family's progress in services and provided support for families as well as monitored out-of-home placement as applicable. The program makes referrals using a referral form, "Referral for Concurrent Services". The program also provides follow-up services after discharge.

No exceptions to this indicator were found as of the date of the onsite QI review.

2.05 Counseling Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

CHS policy 7208, "CINS/FINS" Services, ensures the provision of an array of services but does not identify an actual policy to provide counseling services. The policy was last updated on 7/1/17 and last reviewed on 9/27/17.

The Agency has a procedure in place outlined in Policy number CHS/7208. The Counselor, in participation with the youth and family, will develop a service plan including but not limited to the following areas:

a. Intensive crisis counseling

b. Parent training

c. Individual, group or family counseling

d. Community mental health services

e. Prevention and diversion services

f. Services provided by volunteers or community agencies

g. Runaway center services

h. Special educational, tutorial, or employment services

i. Recreational job training, or employment services

j. Recreational activities

k. Homemaker or parent aide service

The Program Supervisor/Licensed Clinical Supervisor will review the plan and continue to follow-up monitoring the progress made in the service plan, suggesting any needed revisions during regularly scheduled supervision meetings.

Once a youth is adjudicated, the CINS/FINS Non-Residential Counselor will add any goals specified by the courts.

The Agency also has a Procedure in place outlined in Policy number CHS/7204 that states:

1. Counselors make extensive efforts to engage the families, guardians, and significant others in case planning activities. Completed service plans will be signed by the youth and family.

2. A family conference will be held in the family's home or in the Counselor's office to examine the family system's operations and difficulties. Every effort will be made to engage a family in the face-to-face meeting is not possible. Missed meetings will be documented and rescheduled when possible

3. All family contacts or attempts to contact (whatever nature) will be documented in progress notes

4. Referrals for service to outside agencies may be appropriate as based on assessment information and family resource.

5. Through outreach services, families will become aware of the availability of counseling services.

Case notes were relative to the youth needs and provided clear and concise details regarding progress and service activity. Counseling services were provided as needed to all youth reviewed. Needs assessments and case plan reviews were held timely and addressed the youth and the family needs.

All files reviewed received counseling services in accordance with the case/service plan.

Group counseling was observed in the files of 3 applicable residential cases. The program provides a variety of group sessions at least 5 times per week.

No exceptions to this indicator were found as of the date of the onsite QI review.

2.06 Adjudication/Petitiion Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

CHS has a policy that addresses Case Staffing and Adjudication. CHS/7206 effective 1/01/2003 was last updated on 7/1/17 and last reviewed on 9/27/17. The policy addresses all of the requirements of Indicator 2.06.

The Agency has a procedure in place outlined in Policy number CHS/7205 as follows:

The Counselor will schedule a Case Staffing Committee review for those youth/family that are not in agreement with services or treatment, if youth/family will not participate in the services selected is not making progress towards completion of Services Plan goals or upon request of the parent.

2. When the Counselor schedules a Case Staffing Committee, the youth, family, and staffing committee is contracted with five (5) working days prior to confirm scheduling times of the meeting.

3. A meeting of the Case Staffing Committee is convened within seven (7) working days after the receipt of a written request from a parent/guardian

4. The Case Staffing Committee will invite a representative from the Department of Juvenile Justice, the contract provider for CINS/FINS, school representative, youth and parent/guardian.

5. Other interested/involved parties that may attend:

a. Representative(s) from the area of health, mental health substance abuse, social, or educational services

b. A representative of the state attorney's office

c. The Alternative sanctions coordinator

d. The youth, parent/guardian and other persons as recommended by the youth, family or CINS/FINS program

6. The Case Staffing Committee is a standing committee, which meets on a regular basis.

7. When a parent/guardian is not able to attend the Case Staffing, a written copy of the Case Staffing Recommendations is sent to the parent/guardian outlining the reasons for or against a petition being filed within seven (7) days of the Case Staffing meeting.

CHS will hold a case staffing review for those cases documented as having insufficient progress or at the request of a parent/guardian. All of the requirements of the indicator are addressed in the policy and procedures. It appears that the provider's schedule for case staffing is fluid and they are scheduled as needed.

The case staffing was initiated by CHS staff in the two cases reviewed. The attendance record did not show participation/attendance by a school board representative, a CINS/FINS provider, or a member from DJJ;

however, staff was present for case staffing and the client files clearly show that notification was sent to all parties via certified mail.

No exceptions to this indicator were found as of the date of the onsite QI review.

2.07 Youth Records

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There is a written policy CHS/7111 that aligns with the indicator that was last updated on 7/1/17 and last reviewed on 9/27/17.

The policy and procedure address how records are maintained and the levels of security required for files marked confidential. The procedure in place is outlined in policy CHS/7111 as follows:

1. A Confidential case record is created and maintained for each youth upon admission the Safe Harbor and Non-Residential Programs.

2. A case file will be opened when youth are admitted into the shelter or after an initial face-to-face contact for non-residential clients.

3. All closed youth records are marked confidential and kept in a secured room and in a locked file cabinet centrally located and accessible to program staff.

4. All active residential youth records are maintained in a locked room behind the Youth Care Worker station.

5. All active non-residential youth records are marked confidential and kept in a secured cabinet in each therapist's office.

6. Maintenance of the official case record in the nation-residential program is the primary responsibility of the assigned Counselor. In the residential program, the case record is divided between the youth Care Workers admission and daily documentation section, and the medical section. The assigned Residential Counselor maintains the clinical section.

7. Case records are systematically organized as evidenced by the file checklist.

8. All cases are given numbers according to the residential or non-residential programs. If a youth is readmitted they are reassigned their previous case number with a suffix.

9. All closed case records are filed in a closed file cabinet and are placed in alphabetical order.

10. All closed case records are filed in a closed file cabinet and are placed in alphabetical order.

11. Opaque locked boxes are used when files are transported out of the office.

All open Non-Residential youth records are stored in locked file cabinets in locked offices. The staff has keys to their offices as well as their file cabinets. All records are transported via a zipped binder that each counselor owns.

It was observed that all records reviewed were marked “Confidential” and transported in locked, opaque containers also marked confidential. Each binder is locked. Closed cases are maintained in a locked storage room inside locked cabinets.

Active/open residential records are maintained on a metal cart behind a locked door only, adjacent to the residential hallway and not in a locked cabinet.

All records reviewed we labeled confidential. All records are maintained in a neat, orderly manner.

No exceptions to this indicator were found as of the date of the onsite QI review.

Standard 3: Shelter Care

Overview

Rating Narrative

CHS Safe Harbor Shelter program provides temporary residential shelter care for male and female youth identified to be at-risk. The program has adequate space for all indoor and outdoor activities and is equipped with one dormitory for youth of both genders. The dormitories, kitchen, restrooms and common areas were observed to be clean during the visit. Each bedroom is furnished with two beds with separate pillows and bed covering and a closet for youth belongings. Youth have access to a large yard with tennis and basketball courts for outdoor activities.

All youth who are admitted to the program receive a copy of the Consumer Handbook and an orientation to the facility. During the admission's process, each youth receives a new CINS/FINS intake screening to identify any medical, mental health, and/or substance abuse condition and this information is provided to the assigned clinical staff. The program provides individual, group, and family counseling, as needed. Group sessions are scheduled at least five times per week. The program also has a Comprehensive Master Plan for Access to Mental Health and Substance Abuse Services in place. Interagency Agreements have been established for the provision of health education, leadership development, and substance abuse, mental health, and medical services.

The Department of Children and Families has licensed Safe Harbor as a Child Caring Agency, with the current license for ten (10) beds, effective until January 23, 2018.

In addition to the Residential Services Manager, the shelter has three Shift Leaders who are responsible for the operation of their assigned shift. Counseling services to youth in the Residential program are provided by a Master's level Counselor under the supervision of a licensed Mental Health Supervisor. College Interns are also utilized by the program to assist with delivery of services.

3.01 Shelter Envonment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policies and procedures, CHS/7302 and CHS/7311 that address all of the key elements of this indicator regarding maintaining a safe, clean and neat shelter environment. The policies were last reviewed on 9/27/17.

The agency has a policy to maintain all buildings and grounds in a manner that is clean, landscaped and free of hazards and unsafe conditions. CHS/7302, Shelter Environment, requires the buildings to be inspected weekly by the Residential Program Manager, Residential Shift Leader, Data Management Staff, Facility Operations Person or designee. The inspections include verification of current health and fire inspections as well as valid inspections and the fire safety equipment. Needed repairs and unsafe conditions are identified during the inspections. Repairs will be requested within 24 hours and logged to identify staff responsible for the repairs.

During the tour of the facility, an inspection of the shelter environment was conducted. The facility appeared to be clean overall, neat, and well maintained. The Agency is in compliance with all health and safety and fire inspections. All health and fire safety inspections are current as of 11/3/16 when the Department of Health completed the last health inspection and the Fire Department completed the Annual Fire Safety inspection on 3/3/17. During on-site inspections all identified repairs were taken care of prior to the conclusion of the inspection and as a result compliance was maintained.

Agency has a current Satisfactory Food Service inspection report from the DHF effective 11/3/17. A menu is posted and signed by licensed dietitian annually. There is a separate fridge for youth to store leftovers and youth are able to access at any time. All fridges/freezers are equipped with thermometers and are maintained at required temperatures. All food is properly stored, marked, labeled and pantry area is clean.

Agency has a current DCF Child Care License for 10 beds, which is displayed in the facility, effective through 1/23/18.

All furnishings are in good condition and provide for a home-like environment. The facility is free from any apparent insect infestation and the agency maintains scheduled pest control service. The grounds of the facility are well maintained and afford residents ample space and opportunity for physical activities. The interior of the facility is well maintained and is free from graffiti. Each youth room was well maintained and youth have sufficient bedding and linen.

The program's daily schedule includes structured activities that are both educational and recreational. Youth are engaged in meaningful, structured activities seven days a week during wake hours. Some of the activities include but not limited to: improvisation, sewing, painting, writing, fitness, green market, community service, large muscle activity (LMA) and exercise, bible study, yoga, and career development/job applications. Idle time is minimal. The daily schedule reflects at least one hour of physical activity is provided daily and notated in the logbook on each occurrence listed as fitness or LMA.

Daily programming includes opportunities for youth to complete homework and access books in the facility library that have been approved by the agency. Daily programming schedule is publicly posted in two areas (dining area large dry erase board/words of motivation and resident board daily schedule) accessible to both staff and youth.

Youth are provided the opportunity weekly to participate in faith-based activities. Non-punitive structured activities such as reading, journal writing, tutoring, board game and counseling are offered to youth as an alternative to youth who do not choose to participate in faith-based activities.

No exceptions noted.

3.02 Program Orientation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has written policies and procedures, CHS/7313 (Program Orientation) and CHS/7301 (Classification) that address all of the key elements of this indicator. The policies were last reviewed on 9/27/17.

The agency has a policy which provides all youth the opportunity to learn about the program and expectations through a positive orientation process. During the orientation process, the program's philosophy, goals services and expectations are discussed. At that time youth are given a list of contraband items, informed of disciplinary actions. Each youth is made aware of the dress code, how to access medical and mental health services. The process allows for youth to gain understanding of visitation and mail privileges. Also, bullying and bully prevention will be discussed and youth's property will be inventoried. Youth are introduced to program staff during a tour of the facility. Documentation of each component of the orientation is outlined on the Admission/Client Orientation Checklist signed by staff and client and kept in the client file.

There were four residential files reviewed for Program Orientation. Orientation provided an opportunity for youth to learn about the program's philosophy and expectations as the agency policy calls for. In all four of the files reviewed, orientation was conducted on the same day of intake and there was a corresponding Orientation Checklist signed by youth and staff. The orientation checklist includes: receipt of Consumer Handbook; explanation of disciplinary action; grievance procedures; emergency/disaster procedures; contraband rules; layout of the facility; room assignment; and suicide alert notification.

No exceptions noted.

3.03 Youth Room Assignment

☒ ☐ ☐

Satisfactory	Limited	Failed

Rating Narrative

The agency has detailed policy and procedures, CHS/7301, for classification of youth to ensure the most appropriate sleeping room assignment. The policy was last reviewed on 9/27/17.

The agency has a policy to assure the most appropriate unit assignment and sleeping room assignment to all youth being admitted to residential programs for the purpose of the youth's protection from threats of harm or violence. During the intake process all youth will be interviewed and assessed to determine the most appropriate room and bed assignment. When determining whether a youth is placed in a single or double occupancy assignment, all of the available information about the youth's history, status and exposure to trauma will be reviewed. A process is in place that includes an initial classification of the youth's room assignment on the CINS/FINS Intake Form during admission for safety and security concerns. The agency also has a practice of utilizing a color coded alert system to notify staff of youth with special needs and/or risks.

The agency has a five bedroom shelter with a total of 10 beds that are available for youth. There were four residential files reviewed for current youth for room assignments. All of the files reviewed contained documentation indicating the youth's room assignment. All files contained information obtained during the intake process to support the appropriateness of room assignments. In all files reviewed, the information available at intake included age, gender, height, weight of client as well as any known criminal offenses, assault or aggressive behavior and gang involvement.

No exceptions noted.

3.04 Log Books

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure, CHS/7109, that address all of the key elements of the indicator for Log Books. The policy was last reviewed on 9/27/17.

The agency has a logbook policy to maintain a permanent, bound logbook that records all routine information, emergency situations and incidents pertinent to shelter activities. Entries that impact the security or safety of the program and the welfare of youth are highlighted. Logs will be kept at a minimum of three (3) years. Other information may be maintained in binders.

The agency has procedures in which logbooks and/or binder will be created, labeled and maintained in each area of the facility and is appropriate to that area and log so as to document activities taking place in that area. Documentation involving safety and security or emergency situations will be highlighted. Documentation will be simple, clear, brief legibly written in ink. The use of white out is prohibited. A residential log is kept in the youth care staff area. This log contains documentation of all activities that have taken place in the facility.

The agency has a logbook policy in which safety and security issues are documented. The agency uses a highlight system which is consistent and easy to follow. The highlight system helps to track significant activity. The occurrence of fire drills, youth movement and critical incidents were documented and highlighted throughout logbook. Log books were reviewed from April 4, 2017 through October 4, 2017. The logbook is used to track daily activity within the facility. The occurrence of youth movement, critical incidents, staff signing in and out was documented and highlighted throughout logbook. Supervisory review was done consistently over the review period using red ink.

No exceptions noted.

3.05 Behavior Management Strategies

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a detailed written description of the Behavioral Management Strategies (BMS) and it is explained to youth at program orientation. The policy, CHS/7304, was last reviewed on 9/27/17.

The agency has a policy that implements a Behavior Management Strategy designed to encourage accountability and provide positive reinforcement for compliance with the program's rules and expectations. The goals of the behavior management program are to increase positive interactions between the staff and the program residents and to shape appropriate behavior through these interactions. The program provides structured daily opportunities for residents to earn points that may be redeemed in the point store. There are also levels each client can attain to increase privileges.

Upon admission to the program, each youth is given a copy of the resident handbook in which the behavior management system is described. All Staff will be trained in NAPPI behavior management training. During the Orientation process the behavior management program will be reviewed with youth by the staff person conducting the intake. The youth will discuss their understanding of the system in their own words.

All staff are trained in theory and practice administering rewards and consequences. This will assure rewards and consequences are administered fairly and consistently by all staff. Supervisors are trained to monitor the use of rewards and consequences and all evaluations include an evaluation of the skill. The system is based on positive reinforcement.

Levels that are earned are never taken away from a youth. Inappropriate behavior results in the youth being frozen on their level and unable to advance between program levels. If the youth's level is frozen, they are still able to earn points, however they are not allowed to spend earned points until they speak with program supervisor regarding their behavior and a plan to change that behavior. The program has a detailed written description of the Behavior Management System which is explained during program orientation. Youth and staff sign the orientation check list at intake indicating the BMS has been explained. Additionally, youth receive a copy of the system during orientation which outlines all aspects of the behavior management system. The BMS utilizes a points system for rewards and consequences.

There are three different levels which make up the Behavior Management System. All residents begin at the level one until they show a general understanding of program rules and expectations as well as their own interpretation of the poem "growing up isn't always easy" which is on page two of the resident handbook. During level two of the program, youth show the ability to not only describe program expectation but also the ability to demonstrate program expectation. During level three of the system, there are elevated expectations for youth. Youth are expected to combine an understanding of the system gained on level one with the ability to demonstrate the necessary behaviors to advance to level two. In order to advance to level three, the highest level of the system, youth are expected to utilize the skills used in level one and two in order to mentor and serve as role models for youth new to the program.

Staff is trained in the practice of administering the behavior management system which promotes skill-building for the youth. Staff training on the behavior management system is documented in training files.

No exceptions noted.

3.06 Staffing and Youth Supervision

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure, CHS/7306, that addresses all of the key elements of this indicator. The policies were last reviewed on 9/27/17. The policy ensures adequate staffing is provided for the safety and security of youth and staff. Safe Harbor ensures that all staff understands the requirements regarding supervision of youth, including youth on constant sight and sound and overnight supervision of youth.

The staffing schedule is completed by the Residential Manager. The agency strives to ensure that there is at least one staff on schedule the same gender as the youth. Staffing ratios are 1:12 during hours of sleep and 1:6 during awake hours. Youth are observed at least every 15 minutes while youth are in their room. Youth Care workers/shift leaders will ensure that 10 minute are conducted for youth identified with risk of suicide or identified as needing constant sight and sound supervision are completed as required.

The program has 8-hour shifts with overlapping time on each shift: 6am-2pm/7am-3pm, 2pm-10pm/3pm-11pm, and 10pm-6am/11pm-7am. The schedule book is located in the Program Manager's office and in the youth care staff office and is visible for all staff. The agency maintains a list of full time and relief staff with their contact information in the schedule binder. The agency is equipped with surveillance cameras, well positioned with back up cameras which captures coverage for at least 30 days. Random samples of surveillance footage reviewed from 9/17/17, 9/26/17, 9/30/17, 10/1/17 and 10/2/17 show staff conducting bed checks in 15 minute increments during the overnight shift.

Exception:

During the review period, the agency has not met the standard for having a staff person on duty the same gender as the youth on the overnight shift. Throughout the review period, there is only a male staff scheduled on the overnight shift two days per week.

3.07 Special Populations

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has three policies pertaining to special populations: 1) Staff Secure- The agency provides higher level of security for staff secure youth and strategies in place to reduce runaway incidents; 2) Domestic Violence and Probation Respite which outlines the agency's policy procedures for both respite programs. 3) Domestic Minor Sex trafficking- The agency has a policy to provide services to youth who are suspected or confirmed survivors of sexual exploitation for financial or material benefit of a third party as determined on a case by case basis by the Florida Network. The Staff Secure policy was last reviewed on 9/27/17 and the Domestic Violence /Probation Respite policy was last reviewed on 10/5/17.

The provider has one bed for staff secure services. When there is a staff secure youth at the facility, the difference in staffing will be documented and clinical services are enhanced by having multiple service plan goals. Domestic Violence Respite referrals are obtained from the JAC Center/Detention Center. Youth will be admitted as a DV Respite client for 14 days and the service plan will have goals that will reduce violence in the home. Probation Respite referrals come from DJJ Probation and are submitted through the Florida Network Probation Respite Referrolator. Youth must be on Probation with Adjudication withheld.

During the review period, the agency did not serve any Staff Secure, Domestic Minor Humans Sex Trafficking or Domestic Violence Respite Youth. However, during the review period, the agency served Probation Respite youth. Three probation respite files were reviewed. In all three files reviewed, there was evidence of the referrals coming from the probation officers as there was email correspondence in all files. All three files contained documentation that the FNYFS was contacted for approval prior to admission. In two of the three cases reviewed the length of stay was 14 days or less and in the third case the length of stay was under thirty days. In all three case reviewed, referrals were provided for identified service needs.

No exceptions noted.

3.08 Video Surveillance System

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure, CHS/7117, that addresses all but one of the key elements of this indicator. The policy does not require the video system to enable facial recognition. The policy was last reviewed on 9/27/17. The policy is to ensure overall safety and personal accountability while acquiring activities of all youth, staff and visitors.

The program has a surveillance system that can attain and retain video feedback and be stored for a minimum of 30 days. The system will reflect date, time, and location and is able to operate on a generator if there is a loss of power. Cameras are not located in client bedrooms or bathrooms but are visibly located by the facility main entrance and lobby area and in the common areas such as the living room, back lounge area, laundry room, kitchen and hallways with a posted written notice. Camera feedback is accessible to and reviewed by Residential Program Manager, Director of Program Operations or Executive Director a minimum of every 14 days and documented in the log book. During the review, activities and random overnight shifts will be assessed.

The program has cameras on the interior of the facility. The system can record footage for 30 days with date and time indicated. Program Supervisor conducts reviews of the cameras on a bi-weekly basis and the review is documented on a log which is attached to the front page of the daily logbook. The review log indicates date/time review was conducted date/time reviewed as well as any comments or issues from the designated review person. A review of the cameras on five dates from September 17, 2017 through October 2, 2017 revealed the room checks were being conducted in 15 minute increments. Also, the checks are being documented in the logbook. The practice of conducting room checks in 15 minute increments is in compliance with agency policy.

Exception:

Video surveillance did not include cameras with view of the parking lot, backyard, and front yard.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

Children's Home Society Safe Harbor shelter has written policy and procedures related to the admission, interviewing and room assignment of youth admitted into the program. Upon admission program staff completes the intake via an individual interview with the youth. An initial intake assessment is completed to determine the most appropriate room assignment in relation to the youth's needs and issues, the current population of the facility, the physical space available, and staff's assessment of each youth's ability to function effectively within program rules and expectations. When making youth room assignment, consideration is given to each youth's physical characteristics, maturity level, history (including gang or criminal involvement), propensity towards aggression, and apparent emotional or mental health issues.

Staff receiving the youth at the time of admission notifies the program manager, counselor and/or director of program operations of any youth admitted with special needs, mental health issues, substance abuse issues, medical needs or security risk factors as well as those at risk of suicide.

At the time of this QI review the part-time licensed registered nurse (RN) position was vacant. The position was vacated in June 2017 and the DPO stated it's been difficult recruiting a nurse, despite their efforts, due to the part-time status of the position.

The program began utilization of the Pyxis Med-Station system in August 2016 and it is stored in the locked medical room adjacent to the staff work station on the facility dormitory. Topical and injectable medications are stored separately from oral medications. A locked refrigerator is maintained in the medical room for the sole purpose of storing medication requiring refrigeration. Medication distribution records for each youth are maintained in a binder which is stored in a locked medication cabinet in the locked medical room. The shelter does not maintain any medical or hygienic sharps in the residential quarters.

4.01 Healthcare Admission Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place for Healthcare Admission Screening. The policy number is CHS 7401. The policy was last updated on July 1, 2017 and last reviewed on September 27, 2017.

During the admission process, staff will complete an intake assessment form with the youth. If scheduled during an intake, the agency nurse will conduct the health screening. Staff completing the intake will review with the youth his/her past and current medical/mental health history. Parents will be required to ensure that their child with a chronic medical condition receive the necessary treatment to ensure their medical needs are met. If the parent is unwilling to ensure this medical care is provided, the staff will ensure the youth receives the necessary treatment.

There were four youth files reviewed for Healthcare Admission Screening. In all four files the CINS/FINS Intake Assessment Form was completed at admission. All four files documented the youth were either on medication, had allergies, or had current mental health or substance abuse issues. None of the youth had any type of chronic health condition that required monitoring or follow-up care but there are procedures in place if it is needed. All four files also had body charts that were completed. None of the files reviewed documented a review of the healthcare screening by the Registered Nurse (RN) due to the shelter not having a RN during that time frame. Two additional closed files were reviewed for documentation of the RN reviewing the healthcare screening and both these files were reviewed by the RN on the day of admission.

Exception:

The program policy does not state that the healthcare screening will be reviewed within five business days by the RN if the RN is not present during the intake.

4.02 Suicide Prevention

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place entitled Suicide Assessment, policy number CHS 7403, that was last updated on July 1, 2017 and last reviewed on September 27, 2017. In addition, there is a Comprehensive Master Plan for Access to Mental Health and Substance Abuse Services, to meet the requirements for this indicator.

The Comprehensive Master Plan addresses the Suicide Prevention procedures including: screening, identification and monitoring, mental health consultation, suicide risk assessments, referrals, staff training, and on-going staff communication. Youth are screened at admission for suicide risk factors using the CINS/FINS Intake Assessment and then, if warranted, are referred to a mental health professional for in-depth suicide risk assessment. Youth are placed on constant sight and sound supervision until this assessment is completed. This assessment is completed by a qualified professional within twenty-four hours. If he youth engages in suicidal/homicidal gestures, repeatedly states he/she wishes to harm themselves or others, and/or states a specific plan for suicide, the youth will be placed on one-to-one supervision, and will be referred immediately to law enforcement for a Baker Act.

There has been one new mental health counselor hired since the last on-site review. This person was grandfathered into the training requirements for new mental health staff due to the fact they had previously been an intern with the shelter and had already completed the training previously. An email documenting this decision made by the Florida Network was provided and placed into the file for supporting documentation.

There were three applicable files of youth placed on suicide precautions that were reviewed. The CINS/FINS Intake Assessment form was completed in all three cases and required the youth to be placed on constant sight and sound supervision until the youth could be seen and assessed by a mental health professional. All three youth were seen by either the LMHC or an unlicensed mental health counselor working under the supervision of the LMHC, within twenty-four hours. An Assessment of Suicide Risk was completed in all three cases and the youth were removed from constant sight and sound supervision and placed on standard supervision. Ten-minute observations of the youth were maintained the entire time the youth were on suicide precautions.

Exception:

The Suicide Precautions Observation Log for one youth did not have a shift supervisor's signature for third shift one day and the following day for first shift. In addition, one of the log sheets for the same youth was not signed by a mental health clinical staff person.

4.03 Medications

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

The agency has a policy in place for Medications. The policy number is CHS 7405. The policy was last updated on July 1, 2017 and last reviewed on September 27, 2017.

The policy has detailed procedures for admission, verification of medication, administration of medication, storage of medication, inventories, and refusal. The program's written procedures require the program to: verify and document the verification of prescription medication with the pharmacy; store all medications, including controlled medications, in the Pyxis med-station which should be inaccessible to youth; maintain a minimum of two super users for the med-station; store oral medications separately from injectable and topical medications; maintain a perpetual inventory for OTC medication which must be inventoried at least weekly; inventory narcotics and controlled substances weekly; utilize a secured refrigerator only for the storage of medication with storage temperature requirements; allow only staff designated with user permissions to have access to secured medication and allow only limited access to controlled substances; inventory and count controlled substances daily with witnessed shift-to-shift counts; secure syringes and sharps with documented weekly inventory counts; utilize the Medication Distribution Log form to document distribution of medication by all staff; have the registered nurse conduct all medication related processes and procedures when the nurse is on site; and conduct a review of medication management practices at least monthly via the knowledge portal or med-station reports

When the Registered Nurse (RN) is on-site, he or she will conduct all medication related processes and procedures. The RN will train all non-licensed staff in accordance with the DJJ Health Services Manual.

The shelter has not had a Registered Nurse for approximately three months prior to the onsite Quality Improvement review. The shelter received notice on Wednesday, June 14, from the contracted nursing agency that the RN would not be returning to work. Documentation was provided to show that the agency had already posted the vacancy on the company's website on June 12, 2017. The shelter is also working with the contracted nursing agency in addition to posting the position on their website. At the time of the on-site review, the shelter had not had any luck hiring a RN due to the number of hours being only part-time.

A list of staff designated as a Regular User or Super User was provided. There were four staff designated as Super Users and four staff designated as Regular Users.

The RN was training all new hires on using the Pyxis-Med Station prior to leaving. Since the RN has left the Director of Program Operations has been providing this training for any newly hired staff.

All medications are stored in the Pyxis Med-Station. Drawer one is over-the-counter medications and drawer two is prescription medications. Drawers three, four, and five are empty. There is a refrigerator with a lock on it located in the same room as the Pyxis Med-Station. At the time of the review there were no medications requiring refrigeration. The temperature of the refrigerator was 36 degrees.

All controlled and non-controlled medications are inventoried each shift. The inventories documented by only one person doing the count, so the controlled medications were not inventoried with a second person or witness present. The shelter only has three over-the-counter medications that are given out: Ibuprofen, Non-Aspirin, and Aleve. The weekly inventory was reviewed for these three medications for the last six months. During the month of May 2017 there was only one weekly inventory documented. During the month of June 2017 there were only two weekly inventories documented. During the month of July 2017 there were only three weekly inventories documented. The remaining months documented all required inventories.

The shelter does not maintain any sharps. All razors were disposed of after the last on-site Quality Improvement Review in December 2016.

The shelter uses a Medication Distribution Record (MDR) for each youth on medication. The MDR documents the youth's name, a picture of the youth, allergies, diagnosis, physician information, date of birth, date started, if it is a controlled medication, the medication, directions, possible side effects, signatures and initials of staff.

There were three youth files reviewed, one open and two closed, to verify medication administration. The two closed files documented the medications were verified by the RN. The one open file documented the medication was verified by a staff member by observing the bottle, its contents, and talking to the parent. This method of verification can only be used by an RN. All three files had MDR's for each medication the youth was taking. The MDR's were filled out completely and documented all medications were given at

prescribed times.

The Quality Management Manager (QMM) is currently running reports from the Knowledge Portal. There are three separate reports automatically received by email, two of the reports are weekly reports and one report is a monthly report. The Discrepancy Report and the Inventory-Meds reports are received weekly and the Summary by Transaction Type report is received monthly. Any information from these reports is shared with the management team.

A Discrepancy Report was provided for the past six months. There have been sixty-one discrepancies in six months. All discrepancies were cleared out at the time of the review. However, an interview with one of the Youth Care Workers/Super User revealed that it is not common practice to clear out discrepancies by the end of the staff members shift and that they are usually cleared out within one week.

There have been two medication related incidents reported to the CCC in the last six months. One incident was due to a missing medication. Upon inventorying medication staff discovered half a pill was missing. The report states the pills were very tiny and when cut in half would break apart into even smaller pieces. Staff believes the pill was lost during the inventory due to the piece being so small. All prior inventories were correct. All applicable parties were notified. There were no disciplinary actions taken against the staff. The report states staff did their job correctly and all prior inventories were correct and that the small half pill must have been dropped during the inventory.

The second CCC report was due to a youth missing a medication. The error was discovered during medication administration the following day. The staff responsible for the error did receive a Medication Error Counseling note on the importance of timely medication distribution. All applicable parties were notified of the incident, including the pharmacy who said the youth should have adverse reactions to missing the medication and continue with the next scheduled dose.

Exceptions:

The program's policy does not have procedures for disposal of medication.

All controlled and non-controlled medications are inventoried each shift. The inventories documented only one person doing the count, so the controlled medications are not inventoried with a second person or witness present. In addition, there were approximately eight shifts on the Shift Change Medication Count Log that were left vacant for one youth on controlled medication.

There is no weekly inventory of all medications in the MS4000 by the RN or Super User, if no RN present, and a witness.

The weekly inventory for OTC medications revealed that during the month of May 2017 there was only one weekly inventory documented. During the month of June 2017 there were only two weekly inventories documented. During the month of July 2017 there were only three weekly inventories documented.

It is not common practice to clear out discrepancies by the end of the staff member’s shift; they are usually cleared out within one week.

One file reviewed revealed the method used for verifying the medication was an incorrect method for a staff who is not an RN to use.

4.04 Medical/Mental Health Alert Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place for the Medical and Mental Health Alert Process. The policy number is CHS 7406. The policy was last updated on July 1, 2017 and last reviewed on September 27, 2017.

The youth is screened for any alert identified on the General Alert Sheet in the intake packet. If an alert is

noted two copies of the General Alert Sheet are made. The original copy is maintained in the file, a copy is placed in the Medication Log. A General Alert Board is maintained in the Medication Storage Room. This board is color-coded to reflect the various alerts and is used as a quick look for staff to identify the clients and their alerts without having to pull the clients file. Common side effects sheets are attached to the Medication Distribution Record (MDR) for each client prescribed medication. Staff members are provided instructions on how to identify and respond to the need for emergency care and treatment as a result of medical, mental health or substance abuse problems.

There were four open youth files reviewed. All alerts identified during the screening process were documented on the General Alerts Sheet in the youth's file. There is an alert board located in the Medication Storage Room. All four youth were documented on this dry erase board. The applicable colored dots were placed next to each identifying all alerts documented in the youth's file. Side effects concerning medications for a medical condition are located in the Medication folder with the applicable youth's MDR's.

Exception:

There was no General Alert Sheet in the Medication Folder as required by the program's policy.

4.05 Episodic/Emergency Care

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program maintains policy and procedure number CHS 7407 to address episodic and emergency care. The policy was last updated on 8/1/15 and last reviewed on 9/27/17.

The program's written procedure for emergency medical and dental care requires the program to maintain a knife for life, wire cutters, and first aid kit on the residential unit. Episodic emergency drills must be conducted on each shift at least quarterly to focus on varying emergency situations to include detailed debriefing; critiques and corrective action follow up if necessary. All instances of the first-aid and emergency case must be documented on a running episodic or first aid/emergency care log to provide information essential for the identification of a need for additional resources and/or clinical trends.

The program had 3 instances in which youth required episodic/emergency care within the last six months requiring off-site emergency medical care and all were documented in the episodic/emergency care log. The three applicable closed files were reviewed and in the internal incident report for each documented action taken, persons notified, persons involved, the date, type and description of the incident, the date reported, and the date entered into the program status system.

No exceptions to this indicator were found as of the date of the onsite QI review.