



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of YFA-George W Harris

on 01/24/2018

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Standard 3: Shelter Care

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

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

Standard 2: Intervention and Case Management

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

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

Standard 4: Mental Health/Health Services

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

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

Percent of indicators rated Satisfactory: 96.30%
Percent of indicators rated Limited: 3.70%
Percent of indicators rated Failed: 0.00%

Rating Definitions

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

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

Review Team

Members

Marcia Tavares, Lead Reviewer, Consultant - Forefront LLC

Travis Scott, Residential Counselor, CDS Family and Behavioral Health Services

Janet Valdez, Program Supervisor, Children's Home Society Osceola

John Weimann, Director of Counseling Services, Crosswinds Youth Services

Felicia Wells, Program Director, Youth Advocate Programs

Persons Interviewed

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

Documents Reviewed

- | | | |
|---|--|---|
| <input checked="" type="checkbox"/> Accreditation Reports | <input checked="" type="checkbox"/> Fire Prevention Plan | <input type="checkbox"/> Vehicle Inspection Reports |
| <input checked="" type="checkbox"/> Affidavit of Good Moral Character | <input checked="" type="checkbox"/> Grievance Process/Records | <input type="checkbox"/> Visitation Logs |
| <input checked="" type="checkbox"/> CCC Reports | <input type="checkbox"/> Key Control Log | <input checked="" type="checkbox"/> Youth Handbook |
| <input checked="" type="checkbox"/> Logbooks | <input checked="" type="checkbox"/> Fire Drill Log | 3 # Health Records |
| <input checked="" type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 4 # MH/SA Records |
| <input type="checkbox"/> Contract Monitoring Reports | <input checked="" type="checkbox"/> Table of Organization | 9 # Personnel Records |
| <input type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 6 # Training Records |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 11 # Youth Records (Closed) |
| <input checked="" type="checkbox"/> Fire Inspection Report | <input type="checkbox"/> Telephone Logs | 5 # Youth Records (Open) |
| <input type="checkbox"/> Exposure Control Plan | <input checked="" type="checkbox"/> Supplemental Contracts | 0 # Other |

Surveys

3 Youth 3 Direct Care Staff

Observations During Review

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

Comments

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

Strengths and Innovative Approaches

Rating Narrative

YFA George W. Harris (GWH) Shelter is located at 1060 US Hwy 17 South, Bartow, Florida. The shelter is licensed for 24 beds by the Department of Children and Families effective through December 18, 2018. The shelter facility is located on a large campus that includes its administrative/staff offices and the residential facility. The GWH program is the agency's Children In Need of Services/Families In Need of Services (CINS/FINS) program in Bartow, Florida 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 Hardee County. Services are provided to male and female youth under the age of seventeen.

YFA George W. Harris (GWH) Shelter is affiliated with Youth and Family Alternatives, Inc. (YFA). Since its founding in 1970, YFA has helped more than 225,000 children and families in the Tampa Bay & Central Florida area. Initially, YFA served as a "drop-in" center and safe haven for youth to gather and participate in everything in games, discussion groups, or individual counseling with a trained volunteer. Currently, the agency has program operations in ten counties throughout the State of Florida and provides the following services:

- Runaway, homeless, and youth crisis shelters
- Family help
- Substance abuse prevention and intervention programs
- Child welfare case management
- Adoption services
- Family preservation and reunification

YFA earned accreditation through the Council on Accreditation and has continuously maintained COA accreditation effective through 10/31/2020.

Since the last Florida Network QI Review on 2/9/17, the program has hired a part-time Registered Nurse (DOH 8/30/17). In addition, there is a new Youth Development Specialist Team Lead (DOH 6/29/17), and another FT YDS team member that started 11/1/17. Unfortunately, the program lost two long-standing shift leaders who left the agency in the fall, 2017. Two additional staff positions, funded through the newly re-acquired Basic Center Grant are in the process of background screening (Outreach and Life Skills). The position of VP Prevention Services has been eliminated.

The Department of Health and Human Services awarded GWHYS the Basic Center Grant effective 10/1/17 for \$150k/year, renewable for a total of three years. Along with that grant, the program gained two new positions mentioned above, Outreach and Life-Skills. Interviews have been conducted and an offer was made and accepted for both positions.

Hurricane Irma caused significant damage to the grounds of the shelter on 9/10/17. Youth were evacuated to the local emergency shelter on 9/9/17 and were further evacuated to the program's sister facility, New Beginnings Youth Shelter, in Brooksville, Florida from 9/11-9/17/17 due to power loss and downed trees/unsafe conditions. Once power was restored and the immediate grounds was cleared of any safety issues, the youth were returned to resume normal operations. A total of 13 trees were significantly damaged in the hurricane, costing approximately \$6500 for removal. An advisory board member assisted in arranging for removal of six of the 13 trees.

Fundraising is still underway for much-needed furniture replacement within the shelter. They anticipate completing this project within the next six months.

Standard 1: Management Accountability

Overview

Narrative

YFA-GWH is under the leadership of Glenn Parkinson, Residential Director. The management team consists of a Non-Residential Program Director, two Non-Residential Program Supervisors, a Youth Development Specialist Team (YDS) Leader, and two Office Specialists. In addition to the Youth Development Specialist Team Leader, the residential component of the program is staffed by 2 counselors, 6 Shift Leaders, 5 fulltime (FT) YDS, 4 part time (PT) YDS, a contracted Registered Nurse, and 2 positions funded by Basic Center grant: an Outreach staff and a Life Skills staff. The program had six vacant positions at the time of the QI review for 1 FT YDS Shift Lead, 4 PT YDS, and 1 Residential Counselor. The Non-residential CINS/FINS Family Help component serves 3 counties and is staffed by a program director, a program supervisor, 6 counselors, and an Office Specialist. There were no vacancies in the Non-Residential program during the visit.

The agency's Residential Director is a licensed clinical social worker (LCSW) who oversees the Residential program and is responsible for day to day program operations and clinical oversight. The Residential Director has been Vice Chair of the local DJJ Board for over five years.

All non-residential staff training files are maintained electronically through Relias, the agency's on-line training system. All residential staff training files are maintained on Relias, as well as, hard copies are maintained in individual training files.

1.01 Background Screening

Satisfactory
 Limited
 Failed

Rating Narrative

The provider's Background Screening Policy and Procedure, SH 1.01, effective 9/13/2013 was last reviewed on 3/30/17 and signed by the COO and VP of Prevention Services. SH 1.01 meets the requirement of the indicator regarding the screening of all new employees/volunteers prior to hire/start date, 5-year re-screening of employees and volunteers, and the annual submission of the Affidavit of Compliance with Good Moral Character Standards to the Background screening unit by January 31st each year. Procedures for requesting background screening clearance from the Clearinghouse is documented separately in a Standard Operating Procedure entitled "Good Moral Character".

YFA SH 100 policy requires all staff and applicable volunteers to complete a DJJ background screening that includes good moral character documentation prior to hire or volunteer start dates. An applicant's personal information is entered into the Department of Juvenile Justice section through the clearing house and is entered again through the live scan program. Finger prints and photo are taken and transmitted to ACHA. The applicant completes DJJ BSU 003 PREA Acknowledgement form and Live scan BSU Form 002 are emailed to DJJ BSU along with a copy of the applicant's driver's license and social security card for background check. In addition to the DJJ background screening, the provider also conducts a background check with the Department of Motor Vehicles, local City/County law enforcement screening, FDLE Sexual Offenders and Predators search, and drug screening for all new hires.

A total of nine background screening files were reviewed for 4 new hires and 5 staff eligible for 5-year rescreening during the review period. All of the new employees were background screened prior to hire date and all 4 were e-verified. Four of the five in-service staff received a 5-year re-screening prior to their 5 year anniversaries.

The provider completed the annual Affidavit of Good Moral Character and submitted it to the Department of Juvenile Justice Background Screening Unit via FedEx mail on January 24, 2017, prior to the January 31st deadline.

Exception:

One of the five eligible 5-year re-screenings for a staff with DOH 11/18/12 was not conducted until 11/30/17, after the staff's 5 year anniversary.

1.02 Provision of an Abuse Free Environment

Satisfactory
 Limited
 Failed

Rating Narrative

The program has multiple policies and procedure in place for the provision of an abuse free environment (SH 1.02, revised 2/13/06) and Grievance policy (CS 495 revised 12/1/15). CS 495 is an agency wide policy that is not specific to CINS/FINS. SH 1.02 was signed by the COO and VP of Prevention and CS 495 was signed by the CEO and Board Chair.

Upon hire, employees receive and sign receipt of the employee handbook which includes the agency's Code of Conduct that outlines the agency's policy regarding behavioral expectations and provision of a safe environment. 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 documented on the Abuse/Abandonment/Neglect/Exploitation Form and maintained monthly in a binder. Abuse calls are tracked monthly along with incident reports.

The Florida Abuse Registry Hotline number, rights and responsibility, and other relevant program information are visibly posted in the great room and on each wing of the dormitory. Youth are also informed of these procedures during program orientation and the abuse hotline number is included in the Shelter Handbook. The grievance procedure is also reviewed with the youth during intake and the program has a grievance box located in the great room with forms accessible to youth in the great room and in each dormitory area. Per the provider's grievance policy SH 1.02, direct care staff shall not handle completed youth grievances unless assistance is needed by the youth. However, the youth handbook instructs youth to give the completed grievance to any staff member versus depositing it in the grievance box.

The agency is committed to upholding all laws pertaining to individual rights and forbids physical abuse, profanity, threats, and intimidation. Any deviation from the agency's policy shall be reported to the appropriate management staff and will be acted upon immediately.

A total of 8 abuse allegation incidents were reported and reviewed during the onsite visit for the current FY to date. 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.

The three youth survey indicated knowledge of the abuse hotline and location of the posting of the number in the facility. None of the youth surveyed reported being stopped from reporting abuse. The three youth surveyed also indicated that they feel safe in the program and have never heard staff use profanity, threaten them or other youth.

The three staff surveyed said they have never witnessed another staff prohibit youth from calling the abuse hotline and have never heard the use of profanity in the presence of youth or have observed staff use threat or intimidation when interacting with youth. All of the staff's training files reviewed documented staff training in Child Abuse Reporting.

Per the Residential Director the program has received one youth grievance since the last onsite review in February 2017.

During the reporting period, there were no disciplinary actions taken against staff for physical abuse, profanity, threats, and intimidation toward youth.

Exception:

Per the provider's grievance policy in the shelter handbook, youth are allowed to submit their completed grievance to any staff; however, per Indicator 1.02 direct care workers shall not handle complaints/grievance documents unless assistance is requested by youth. However, the youth handbook instructs youth to give the completed grievance to any staff member versus depositing it in the grievance box.

1.03 Incident Reporting

Satisfactory

Limited

Failed

Rating Narrative

The provider's Incident Reporting policy and procedure, RM 830 effective 4/1/04 was last revised on 10/20/15 and signed by the CEO and Board Chair. RM 830 meets the requirement of the indicator regarding the reporting of reportable incidents to DJJ CCC within the required 2 hour timeframe.

The procedure references reporting requirements and entities as well as notification processes and procedures. All designated incident types shall be reported to the CCC within two hours of the incident occurring or the program learning of the incident. Staff teams are identified that are responsible for reviewing incidents on a quarterly basis to determine trends, and further action to be taken if necessary. Staff must be trained no less than annually or when incident reporting requirements change.

The initial incident and any follow up of the incidents is documented on an Incident /Complaint Report form, printed and placed in an incident report binder that is maintained by the Residential Director. All incident reports are reviewed and signed by the Residential Director.

A total of fifteen CCC reportable incidents occurred within the six-month review period classified as the following types: medical (10), medication (2), program disruption (2), and youth behavior (1). The program maintains a binder chronologically with all of the incidents that were documented by staff including non-reportable incidents. A monthly log of the incidents is also maintained. Thirteen of the fifteen incidents were called in to CCC within the two hour time frame and all fifteen were signed by the Residential Director. Documentation of follow up with CCC was evident for all the relevant incident reports reviewed and all were marked as closed by CCC. Only one of the seven incidents reviewed during the past two months were documented in the House Log Book.

Exceptions

Two incidents occurring on 9/25/17 and 1/20/18 were not reported during the 2 hour required timeframe. Both incidents were related to medical conditions requiring the transport of youth to an offsite medical facility.

Six of the seven incidents reviewed during the past two months were not documented in the House Log Book.

1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that address all of the key elements of the CQI indicator. The policy manual was dated 2014 and revised by the Chief Operation Officer and Vice President of Prevention Services, dated 02/13/2014. During the QI visit the Office Specialist advised the correct date for update is 03/31/2017.

The agency's policy requires all CINS/FINS staff, who work in direct and continuing contact with youth, to complete eighty (80) hours of training during their first year of employment and (40) forty hours of training each year thereafter.

Agency's procedure offers an array of training opportunities to staff including the utilization of an online training system named "Relias". The agency also utilizes DJJ's online training system Skill Pro for additional required trainings. The agency lists 24 training topics to be completed within the first 120 days to include the agency's "Youth and Family Alternatives, Inc. Residential Shelter Site Orientation". The form requires, as part of every new employee's training, seventy-two (72) hours of on-site shelter orientation within the first 90 days of employment. The orientation schedule includes the following required following training:

- Program Orientation
- Managing Aggressive Behavior
- Behavior Management
- Title IV-E Procedures
- Fire Safety Equipment
- CPR
- Medication Distribution for Non-Licensed Staff
- Understanding Youth/Adolescent Development
- Ethics: Civil Rights, EEO and Sexual Harassment
- Confidentiality
- Child Abuse Reporting
- Information Security Awareness
- Universal Precaution

These training requirements supersede the Network's Policy and Procedures.

Staff training files are maintained that include required training by hire date, a running list of training topics completed which includes the number of hours for each training topic, and the total hours of training completed to date. The information is entered into an Excel spreadsheet and printed for each training file. Certificates of completion are maintained in the file with training topics and hours are also maintained.

The Reviewer selected six (6) individual staff training files for this section: three first year staff, two (2) training files that had exceeded the first 120 days and one (1) additional first year Youth Direct Care (YDS) staff; and three (3) in service training files. Documentation for trainings completed were found in all of the training files reviewed.

Two of the three first year employees have exceeded the 80 hours required annually and one is on target for completing the 80 hours. Although there was evidence of ongoing staff training, none of the three first year staff completed all of the mandatory trainings required during the first 90-120 days.

Three (3) files were reviewed for Annual Training Requirements: file number 1 has a total of 37 hours of the 40 training hours; file number 2 has a total of 40.5 hours of training; and file number 3 has a total of 48.5 hours of training. The staff who had not yet completed 40 hours of training still had time to complete the necessary training.

There was no eligible non-licensed clinical shelter staff hired since the last onsite QI visit.

Exceptions:

Two (2) files have been reviewed for the required training for their first 120 days of employment. One file, DOH 8/30/17, had documented 51

hours completed during the first 120 days. As required by the agency's policy certain topics are required within 90 days as well as those required by the Florida Network within 120 days. The staff did not complete nine (9) of the twenty-four (24) combined required trainings during the required 90 and 120-day timeframes. The second file (DOH 6/29/17) documented 56.5 hours completed during the first 120 days. Similarly, this staff did not complete twelve (12) of the twenty-four (24) trainings required during the required timeframes. This staff's seventy-two (72) hours of on-site shelter orientation did not have a Supervisor's initials documented for several trainings on page 3 of the document which includes portion of Tier 5 totaling 8 hours for entire section, all of Tier 6 totaling 8 hours for this Tier of training and parts of Tier 7, total tier is 8 hours of training. A third first year training file (DOH 11/21/16) has a total of 134 hours; however, the file was missing three (3) of the twenty-four (24) training topics required by the end of the first 120 days. In addition, one of the first year staff did not have current CPR certification as it was out dated; the training date on certificate is dated 05/20/2015 and is valid for 2 years, making a renewal on or before 05/20/2017 within the staff's 1st year of training. This training was completed on 01/17/2018.

Three (3) files were reviewed for Annual Training Requirements. File number 1(DOH 11/18/12) was missing three (3) of the six (6) required training. One required training (MAB) was not completed as part of the bi-annual date. The CPR recertification was out dated; the training date on certificate is dated 06/15/2015 and is valid for 2 years, making a renewal on or before 06/15/2017. The training log has the CPR training documented as being completed on 06/15/16. Managing Aggressive behavior was completed on 09/17/15 making its renewal date by the staff's 2017 anniversary date of 11/18/17. File number 2 (DOH 11/16/15) was missing one (1) of the six (6) required trainings that were not completed as part of the bi-annual/validity date. File number 3 (DOH 3/22/10) was missing MAB, one (1) of the six (6) required trainings that were not completed as part of the bi-annual date.

1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

The program has multiple policies and procedures that outline its Continuous Quality Improvement (CQI) process (QI 275, dated 1/13/15), CQI Teams (QI 280, 9/1/16), and Data Collection and Evaluation (QI 350, 12/1/15). In addition, the agency has a comprehensive CQI Plan for FY 2017-2018 that describes the agency's CQI structure, committees, stake holders, CQI cycles, data collection and analysis, reporting, and corrective actions.

The program has a designated VP of Quality Improvement who is responsible for the implementation and oversight of its CQI program throughout the State. In practice, the program's CQI program includes many activities that are conducted using staff at various levels to ensure all aspects of analyzing and reporting data are consistently implemented and documented.

YFA appoints staff at various levels to participate in the CQI process on seven CQI teams in addition to the CQI Council. The teams are as follows: Outcomes Measurement, Risk Prevention, Training, Employee Rewards and Recognition, Stakeholder Involvement, and Information Technology. Each team has an appointed team leader who is responsible for coordinating team meetings and attending the CQI Council meetings. The CQI council and CQI teams meets quarterly. The Director of QI and Risk Prevention maintains a calendar and a log of all team meetings. Agendas for all team meetings are maintained respectively along with meeting minutes. The CQI teams are responsible for providing updates and recommendation to the CQI Council on a quarterly basis regarding areas outlined in the purpose and goals for each team. Quarterly reports are to be written for each team. Annual reports are also required from each CQI Team and are due by July 31 for the FY activities.

CQI Council meetings were held 7/14/2017, 10/20/2017, and scheduled for 1/26/2018. Evidence of meetings held is maintained in a binder. The meeting minutes and agendas were reviewed and include attendees and reports from the following CQI teams: Peer Review, Outcome Measurement, Training, Risk Prevention and Management, Safety, Employee Retention, and Stakeholder Involvement/Client Services.

The VP of QI and QI Coordinators are responsible for coordinating case record reviews for all of the agency's programs statewide. Due to the size of the agency, number of programs (12) and number of youth served, the CINS/FINS program has a formal case record review and follow up within 90 days only once per year. Upon completion of case record reviews, the results are aggregated and a report is submitted to the VP of QI to be presented at the CQI Council meeting.

A review of the FY 2017-2018 peer record review conducted for Q1 showed a total of 81 files agency wide. A summary of the findings is documented on an excel spreadsheet entitled YFA Peer Review Scoring Tool and includes metrics of performance for key indicators reviewed in the case records. The report will be accompanied by a cover page that documents deficiencies based on the criteria of falling below 85%.

Incidents, accidents, and grievances are reviewed quarterly by the Risk Prevention Committee and Safety Committee. The committees are responsible for reviewing incidents, accidents, and grievances for each program and report to the CQI council. The Risk Prevention Committee is facilitated by the VP of CQI and meets quarterly.

A review of the quarterly meetings held by the Risk Prevention Committee and Safety Committee was conducted onsite to support evidence of practice. Both committees meet on a quarterly basis and provide evidence of agendas and minutes to supporting their meetings. The Incident Report Rollup was reviewed for the current FY to date containing the aggregated monthly report of incidents, accidents, and grievances (if applicable) for the agency's programs. Evidence of shelter staff meeting agendas showed discussion of Florida Network/QA, incidents, grievances, and safety during the staff meeting.

Consumer surveys are administered by the program staff and entered into NetMIS as well as aggregated by the CQI team. The team meets

quarterly to review findings of the satisfaction reports and reports their findings to the CQI Council. Strengths, weaknesses, and goals are reviewed and documented in the minutes and discussed at the meetings.

Practice: The Stakeholder Involvement Team met quarterly on 7/10/17 and 10/10/17. Copies of the agendas and minutes for these dates were reviewed. The survey results for the YFA Bartow CINS/FINS program indicate 100% and 94% satisfaction of the shelter and non-residential programs, respectively for the period July through September 2017. Customer satisfaction data was also compiled for the subsequent quarter and reviewed on site.

Outcome data is reviewed quarterly by the Outcomes Committee. Quarterly data captures select outcomes for the CINS/FINS program such as elopement, average length of stay, completers, execution of 30 and 60 day follow ups, and satisfaction with the program. Benchmark outcomes data are reviewed by the Residential Director upon receipt and deficiencies are addressed immediately and communicated to staff via staff meetings as necessary. Quarterly reports are generated by the committee and submitted to the VP of QI to be discussed at the CQI Council meetings. Evidence of monthly management meeting agendas showing discussion of outcomes data was observed on site.

Practice: The Outcome Measurement Team met quarterly on 1/17/18, 9/27/17, and 6/14/17. Copies of the agendas and minutes for these dates were reviewed. The team collects outcomes data for the CINS/FINS program separately and aggregates the data in a spreadsheet monthly. The data for the current FY July-December 2017 was reviewed on site.

NetMIS data is reviewed on a monthly basis by the Residential Director and submitted to the Data Administrator (DA). Discrepancies and deficiencies are corrected.

No exceptions noted.

1.06 Client Transportation

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that address all of the key elements of the CQI indicator. The policy manual was reviewed and dated 02/14/17 and was signed by the Chief Operation Officer and Vice President of Prevention Services. The Agency's policy ensures the safety and security of all youth and staff when providing transportation at their shelter programs.

The agency's procedures include a practice, review and approval process in place regarding Client Transportation of youth assigned to the program which includes:

- Process for approved drivers
- Documentation of a valid Florida driver's license
- Approval to transport through the Agency's insurance agent.
- Utilization of "Monthly Trip and Mileage Log"
- Access to shelter phone and check procedure
- Approved third parties
- Avoidance of single party transportation with procedure addressing when this cannot be avoided
- Staff who are concerned about any safety issues during a single party transport.

Agency provided a copy of their Business Auto Coverage Declarations. The declaration page showed a policy period from 06/01/17 to 06/01/18 with policy limits required by the Network. The coverage included Hired Auto and Non-Own Auto insurance coverage. There are a total of 14 employees on the transporter list. Three MVR records were reviewed and were completed within the twelve (12) months. There are a total of three (3) vehicles for this location. There were Monthly Preventative Maintenance/Safety Inspections Reports, Monthly Trip and Mileage Logs and maintenance reports from dealership for each vehicle.

This reviewer observed documentation of log books (hand printed and electronic) of trip logs. In documentation there was evidence of supervisor being notified of single transportation.

No exceptions noted as of the date of this QI visit.

1.07 Outreach Services

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that address all of the key elements of the CQI indicator. There is a Community Outreach and Education Policy. The policy manual was reviewed and dated 03/27/17 and signed by the Chief Operation Officer and Vice President of Prevention Services. The policy states that staff shall seek opportunities to conduct ongoing community outreach and education to communicate the agency's mission, role, functions, capabilities, and the strengths, needs and challenges confronting children and families.

The program participates on state, county, district, and local boards; community forums; service fairs; and with various community organizations. Program information is disseminated through verbal and written means through radio, television, and newspaper media and through shelter tours. There is no designated outreach position and any staff may be used to interact with the community to provide outreach services.

The Shelter Director participates in a majority of the community meetings. If there is a development opportunity, then appropriate staff is identified to participate.

Minutes, agendas, and staff participation is maintained on NetMIS worksheet and maintained in a log book.

There is a written agreement with the US Department of Health and Human Services, dated June 9th, 2016, for the National Safe Place Network program to educate youth and adults about Safe Place services through community presentations and outreach. Evidence of participation on the DJJ Advisory Board bi-monthly (01/08/18), Homeless Collations of Polk County (HCPC) (01/17/18), United Way of Central Florida Agency Council Meeting (01/3/18) and Community Impact Cabinet quarterly meetings (January 2018) was observed. Minutes and other verification of attendance demonstrated participation as well as the Director of Residential Services is listed on the agenda to provide Board updates for the Juvenile Justice Circuit Advisory Board Meetings.

No exceptions noted as of the date of this QI visit.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

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 case management/counseling component consists of a total of 17 counseling positions (15 Non-residential and 2 Residential) and a LCSW. 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). During the review period, the program did not serve any youth meeting the criteria for staff secure, Probation Respite, or DMST.

The program meets the needs of the youth while in care with the ultimate goal of reunification with their families. The facility has 24 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, YFA-GWH 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 Bachelor and Master's level staff who have access to a licensed Clinician. 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.

The non-residential program covers three (3) counties: Hardee, Polk and Highland while YFA George W Harris residential program is located in Bartow, FL.

2.01 Screening and Intake

Satisfactory Limited Failed

Rating Narrative

The agency has a written policy on Screening and Intake named Eligibility Screening and intake. The policy is referenced as Policy & Procedure Number; SH 2.01 and is approved by the Chief Operating Officer and Vice President of Prevention Services. With an effective date of 09/13/2013 and last reviewed on February 14, 2017. The Policy and Procedures addresses all of the key elements of the QI indicator.

This policy and procedure was updated, as recommended at the last peer review, and states that upon intake the youth and families will receive available services options, their rights and responsibilities, possible actions occurring through the involvement of CINS/FINS, and a description of the grievance process. The provider's procedures require the screening to begin within seven (7) calendar days of referral by a trained staff member using the NetMIS screening form. Eligibility screenings are to be completed on request for services and are available to families 24 hours a day.

If a counselor is not available, the Centralized Intake Screening form will be completed by Youth Development Staff or Support Staff. If the screener determined the youth is in need of crisis mental health or substance abuse services, Youth Development Staff or Support staff will contact the on call supervisor to assist with the family's immediate need. There is a procedure in place if the youth/parent states the youth is currently suicidal or homicidal describing in detail how the designated screening person is to proceed immediately.

There were six files reviewed for three open residential and three non-residential (2 open, 1 closed) files. All the files contained a completed screening form and intake form. The youth, parent/guardian received the following in writing: available service option, rights and responsibilities, and grievance procedures. The residential program provided evidence youth/family receive possible actions occurring through the involvement with CINS/FINS services by signing the Admission and Discharge Form and indicating "parent received parent handbook".

Exception:

In the Non-residential files there is no acknowledgement by the parent of receipt of the "Parent Brochure" in writing. However, the progress note developed for the initial visit states "Provided family with information regarding the CINS/FINS program, including the case staffing process.

2.02 Needs Assessment

Satisfactory Limited Failed

Rating Narrative

The agency has a written policy on Needs Assessment entitled Needs Assessment. The policy is referenced as Policy & Procedure Number SH 2.02, approved by the Chief Operating Officer and Vice President of Prevention Services, with an effective date of 09/13/2013 and last reviewed on February 14, 2017. The Policy and Procedures address all of the key elements of the QI indicator.

The policy and procedures indicated a youth shall have a needs assessment to be initiated within 72 hours of admission. An updated needs assessment shall be conducted every six (6) months or when otherwise indicated. The needs assessment will be completed within two to three face-to-face contacts following the initial intake if the youth is receiving non-residential services.

All Needs Assessments are completed by Bachelor's or Master's level staff and signed by a supervisor. If the suicide risk component of the assessment is required (as a result of suicide risk screening), it must be reviewed, signed, and dated by a licensed clinical supervisor or written by licensed clinical staff.

There were six files reviewed for three open residential and three non-residential (2 open, 1 closed) files. All six of six needs assessments reviewed contained all the required information per the indicator. They were all completed within the required time frames. They were all conducted by a Bachelor's or Master's level staff member and signed by the Supervisor.

Three (3) of six (6) files indicated an elevated risk of suicide in the needs assessment and procedures were followed as described in the policies and procedures. The assessment of suicide tool was developed and signed and reviewed by a licensed clinical supervisor or by a licensed clinical staff within 24 hours of the completion of the needs assessment.

There were no exceptions noted for this indicator.

2.03 Case/Service Plan

Satisfactory
 Limited
 Failed

Rating Narrative

The agency has a written policy on Case/Service Plan entitled Service Plan Development and Service Monitoring. The policy is referenced as Policy & Procedure Number SH 2.03, approved by the Chief Operating Officer and Vice President of Prevention Services, with an effective date of 09/13/2013 and last reviewed on February 14, 2017. The Policy and Procedures addresses all of the key elements of the QI indicator.

The provider's procedures state the Service Plan and the Aftercare Plan will be developed with the youth and, if possible, the parent/guardian at the time of the needs assessment and no later than seven (7) working days following completion of the needs assessment. The Service Plan will address the specific needs identified in the needs assessment, centralized intake screening forms, intake and NetMIS documentation and any other collaborative information. Service Plan will be individualized utilizing strengths and limitations identified by the youth and family.

The plan includes: 1) identified need(s) and goal(s); 2) type, frequency, and location of service(s); 3) person(s) responsible; 4) target date(s) for completion; 5) actual completion date(s); 6) signature of youth, parent/guardian, counselor, and supervisor; and, 7) date the plan was initiated.

The case/service plan is reviewed by the counselor and parent/guardian (if available) every 30 days for the first three months, and every six months thereafter, for progress in achieving goals, and for making any necessary revisions to the case/service plan, if indicated. If the youth or family is unavailable or unwilling to review the Service Plan with the Counselor, the counselor may review the case with his/her supervisor. The counselor will document all efforts to engage the youth and the family in reviewing the Service Plan in the chronological contact sheet and progress note.

There were six files reviewed for three open residential and three non-residential (2 open, 1 closed) files. The open active files had areas listed for target dates of completion and there are still goals pending to be completed prior the completion of the case. All the closed files had all targeted completion dates filled in. All case plans reviewed indicated the identified need(s) and goal(s); type, frequency, and location of service(s); person(s) responsible; target date(s) for completion; actual completion date(s); signature of youth, parent/guardian, counselor, and supervisor; and date the plan was initiated. All treatment plans were reviewed for progress/revised by counselor and parent (if available) every 30 days for the first three months.

There were no exceptions noted for this indicator.

2.04 Case Management and Service Delivery

Satisfactory
 Limited
 Failed

Rating Narrative

The agency has a written policy on Case Management and Service Delivery titled Case Management and Service Delivery. The policy is referenced as Policy & Procedure Number SH 2.04, approved by the Chief Operating Officer and Vice President of Prevention Services, with an effective date of 09/13/2013 and last reviewed on February 14, 2017. The Policy and Procedures addresses all of the key elements of the QI indicator.

The provider's policy states each youth is assigned a counselor who will follow the youth's case and ensure delivery of services through direct provision or referral. The process of case management includes: establishing referral needs and coordinating referrals to services based upon the ongoing assessment of the youth's/family's problems and needs; coordinating service plan implementation; monitoring youth's/family's progress in services; providing support for families; monitoring out-of-home placement, if necessary; referrals to the case staff committee, as needed to address the problems and needs of the youth/family; recommending and pursuing judicial intervention in selected cases; accompanying youth and parent/guardian to court hearings and related appointments, if applicable; referral to additional services, if needed; continued case monitoring and review of court orders; and case termination with follow-up.

There were six files reviewed for three open residential and three non-residential (2 open, 1 closed) files. All the files contained progress notes, completed needs assessment, treatment plan/service plan, referral form, and case termination notes for the closed cases. The primary counselor was clearly identified in each record. The completed referrals, Needs Assessment and Service Plan indicated and show evidence of established ongoing coordination and implementation of services. The progress notes in the record serve as evidence of support for the families and youth, and the ongoing assessment of the youth's/family problems and needs. Out of home placements were monitored in 3 applicable residential files.

In two of the files the suicide risk component of the assessment was required (as a result of suicide risk screening), the Suicide Assessment form was reviewed (signed and dated) by a licensed clinical supervisor or written by licensed clinical staff.

All closed files contained completed termination summary. All closed cases had the 30/60 day follow up forms completed as needed within the allocated time frame.

There were no exceptions noted for this indicator.

2.05 Counseling Services

Satisfactory
 Limited
 Failed

Rating Narrative

The agency has a written policy on Counseling titled CINS/FINS Counseling Services. The policy is referenced as Policy & Procedure Number SH 2.05, approved by the Chief Operating Officer and Vice President of Prevention Services, with an effective date of 09/13/2013 and last reviewed on February 14, 2017. The Policy and Procedures addresses all of the key elements of the QI indicator.

The provider's procedure states youth and families will receive counseling services, in accordance with the youth's case/service plan, to address needs identified during the assessment process. Shelter programs provide individual and family counseling, as well as group counseling sessions held a minimum of five days per week, based on established group process procedures. Services are provided in the shelter. Non-Residential programs provide therapeutic community-based services designed to provide the intervention necessary to stabilize the family in the event of the crisis, keep families intact minimize out-of-home placement, provide aftercare services for youth returning home from shelter services, and prevent the involvement of youth and families in the delinquency and dependency systems. Services are provided in the youth's home, community location, or the local provider's counseling office.

There were six files reviewed for three open residential and three non-residential (2 open, 1 closed) files. YFA Counseling services: 1) Reflect all case files for coordination between presenting problem (s), needs assessment, case/service plan, case /service plan reviews, case management, and follow-up; 2) Maintain individual case files on all youth and adhere to all laws regarding confidentiality; 3) Maintain chronological case notes on the youths' progress; and 4) Maintain an on-going internal process that ensures clinical review of case records, youth management, and staff performance regarding CINS/FINS services.

Evidence of counseling services are indicated in each of the 6 youth files reviewed. All counseling sessions were properly documented in the progress notes and addressed the problems identified in the assessment and case plans.

The shelter provided group counseling held a minimum of five days per week as evident in the Harris Youth Shelter Group Sign-In Sheet binder, Harris Youth Shelter Group Notes and the Youth Development Meeting binder for the past six (6) months, July 2017-January 2018. On 09/08/2018-09/15/2017 no shelter groups were held because of preparation for Hurricane Irma and moving to Bartow High School (due to loss of power) then moving to New Beginnings the youth shelter in Brooksville, Florida. There is clear documentation stating the suspension of shelter groups during mentioned dates.

Evidence of supervisory review was observed in the 3 non-residential files reviewed. The supervisor signed off on Needs Assessment,

Treatment Plans, and Suicide Assessment and aftercare plan. Residential Case Staffings are completed monthly and the last formal meeting was held on 10/24/2017. All files were open in the month of January 2018. However, a systemic process to conduct clinical supervisory reviews was not evident for residential files.

Exception:

Although supervisory signatures were evident on the Needs Assessment and Treatment Plans in the 3 residential files reviewed, there was no evidence of a systemic process to conduct clinical supervisory reviews on a consistent basis.

2.06 Adjudication/Petition Process

Satisfactory
 Limited
 Failed

Rating Narrative

The agency has a written policy on Counseling titled CINS/FINS Counseling Services. The policy is referenced as Policy & Procedure Number SH 2.05, approved by the Chief Operating Officer and Vice President of Prevention Services, with an effective date of 09/13/2013 and last reviewed on February 14, 2017. The Policy and Procedures addresses all of the key elements of the QI indicator.

The procedures state the case staffing committee may be convened for individual cases or maintained as a standing committee, but the composition of the case staffing committee shall be based on the needs of the youth and family. Should a parent or guardian request a case staffing in writing, the committee shall convene within seven (7) working days (excluding weekends and holidays).

Case staffing committee meetings are held with the parent/legal guardian and child to review the case of any family or child who is in need of services or treatment if: the family or youth is not in agreement with the services or treatment offered; the family or youth will not participate in the services or treatment selected; the family agency counselor needs additional assistance in developing a case plan; the services or treatment selected have not addressed the problems and needs of the family or youth; and/or; the parent/guardian requests, in writing, that a case staffing committee meeting be convened. The agency is responsible for contacting the Case Staffing Committee members, the child, and family within five (5) working days of the scheduled meeting. The day before the scheduled case staffing the counselor will contact/confirm with the parent the date and time of the case staffing meeting.

Within seven (7) working days of the meeting, a written report is provided to the parent/guardian outlining the committee recommendations and the reason behind the recommendations. The counselor is responsible for documenting in the case record that the family received the plan. If the family is not present at the Case Staffing, a copy of the plan is sent to the parent/guardian outlining the interventions and recommendations of the Case Staffing Committee within seven (7) working days of the Case Staffing Committee meeting.

Three applicable case staffing files were reviewed. There was evidence of the following documentation in each file: written request from a member of the committee; progress notes in the client file documenting the events of the case staffing committee and court proceedings; copy of the case staffing meeting notes; revised plan of services; the committee's recommendation report; and the court reports developed by the case manager or counselor. Copies of the invitation letters sent to the parent/committee within the required time frame was provided by the agency. Parent invitation letters were sent by certified mail.

There were no exceptions noted for this indicator.

2.07 Youth Records

Satisfactory
 Limited
 Failed

Rating Narrative

The agency has a youth records policy entitled Youth Records, Policy number SH 2.07. The policy was last reviewed by the agency's Chief Operating officer and Vice President of Prevention Services on 02/15/2017.

The program is required to maintain confidential records for each eligible client it serves in the program. All records are required to be stamped confidential and kept in a secure room or locked in a file cabinet that is marked confidential, which is accessible to program staff. All the records that are transported are locked in an opaque container that is marked confidential.

A total of nine youth files were reviewed. Youth records are maintained in a neat and orderly manner so that staff can quickly and easily access information. All Files were marked confidential. All Files transported from the non-residential program were locked in an opaque container marked "confidential". The residential program has a black portable container marked "confidential" used to transport files. The program stores all case records in a locked room.

There were no exceptions noted for this indicator.

Standard 3: Shelter Care

Overview

Rating Narrative

YFA-GWH 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 two separate residential quarters, one for each gender. The dormitories, kitchen, restrooms and common areas were observed to be clean during the visit. Each bedroom is furnished with beds, pillows, and bed covering and storage for youth belongings. Youth have access to a large yard for outdoor activities.

All youth who are admitted to the program receive a copy of the Shelter 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. Interagency Agreements have been established for the provision of substance abuse, mental health, and medical services. Case management and counseling services to youth in the Residential program are provided by Bachelor's and Master's level counselors under the supervision of a Licensed Clinical Social Worker.

Shelter Care is designed to assure that all youth are safe and well cared for while residing in the shelter. This standard includes the shelter environment including the building, grounds and vehicles; the orientation of youth to the program including the shelter rules and regulations and their room assignment; the maintenance of logbooks for keeping a detailed description of all shelter actions and activities 24/7; the behavior management system used to both maintain a physically secure environment but to also influence youth to make healthy choices both in and out of the shelter; supervision of youth throughout the day and night within 3 daily shifts and offering a continuum of care; service delivery to special population; and finally, video surveillance for the purpose of accountability on all staff, youth, visitors and other personnel and to use in the event of allegations of mishandling of any situation. The Department of Children and Families has licensed GWH as a Child Caring Agency, with the current license for 24 beds, effective until December 18, 2018.

3.01 Shelter Environment

Satisfactory Limited Failed

Rating Narrative

The agency has a written policy and procedure, SH 3.01- Shelter Environment. The policy was last reviewed on 02/15/17 and signed by the COO and Vice President of Prevention Services.

The policy ensures that the shelter environment shall be clean, neat, well maintained, safe, and to the extent possible, reflect a home-like environment. The procedures are well documented. Highlighted practices include daily and safety inspections, cleaning and repairs, daily chores along with the documentation logs and Corrective Actions in addition to scheduling and faith-based activities. Specific procedures include discussion of the maintenance of office areas, bedroom and bathroom areas, laundry and linen area, living areas, kitchen and dining areas, public areas, grounds and pest control, and garbage disposal.

During the tour of the facility, an inspection of the shelter environment was conducted. All findings meet the requirements of Indicator 3.01. The Disaster Plan was updated July 1, 2017 for the 2017-2018 fiscal year. The Fire Safety Inspection was completed on 11/07/17 by the Bartow Fire Department which passed the inspection with no violations noted. The Fire Sprinkler System was last inspected on 10/09/17- no violation noted. The alarm system was last inspected on 01/03/2018 -no violations noted. The Residential Group Home Inspection Report was completed on 11/15/17 with two violations: Maintenance (Dirt/debris around windows/doors) and infestation/presence (wasp nest); violations were corrected as of January 18, 2017. The agency has a current DCF Child Care License that is valid until December 18, 2018.

During the tour, the furnishings were observed to be in good repair and the facility was free of insect infestation. The grounds and landscape are well maintained. Bathrooms and shower areas were found to be clean and functional and no graffiti was discovered. The lighting throughout the facility is adequate.

The program uses the Why Try curriculum and goes outside for recreation at least daily on school days and more often on non-school days. Youth are given the opportunity to participate in faith-based activities. Youth are given time to do homework and read. The daily schedule is posted and accessible to youth and staff.

There were no exceptions for this indicator.

3.02 Program Orientation

Satisfactory Limited Failed

Rating Narrative

The agency has a written policy and procedure, SH 3.02- Program Orientation. The policy was last reviewed on 02/28/17 and signed by the COO and Vice President of Prevention Services.

The policy and procedures ensure that the clients will receive appropriate and professional services and be protected in the shelter environment. The policy covers the rights as children in the State of Florida, grievance process, adequate supervision, safety of youth/staff, higher level of supervision for necessary for the youth, emergency/disaster procedures, contraband rules, and suicide prevention/alert notification, visitation schedule, telephone and mail procedures, religious activities, dress code, linen exchanged, and medical treatment procedures.

The procedures are well documented and include the following information: Client orientation is completed within twenty-four (24) hours, information on shelter admission requests, shelter admissions, abuse hotline, youth room assignment, shelter orientation, correspondence, grooming, laundry/linens/bedding, grievances, staffing levels, youth supervision and the alert system. Youth admitted to the shelter go through a new client orientation process consisting of specific 20 areas, encompassing all of the required documented on the Client Orientation Check List.

There were three residential case files (one closed and two open) reviewed for this indicator. All reviewed files met the minimum requirements for this indicator. All 3 youth were oriented within the first 24 hours of admission. This orientation included signed receipt of the handbook; explanation of disciplinary action; grievance procedure; emergency/disaster procedures; contraband rules; physical/facility layout; a room assignment; and suicide prevention and alert notification where indicated. All required signatures by youth and parent/guardian were obtained. The reviewer also interviewed a staff and a youth and both were able to articulate the policy and procedures regarding Program Orientation.

There were no exceptions for this indicator.

3.03 Youth Room Assignment

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure, SH 3.03- Youth Room Assignment. The policy was last reviewed on 02/28/17 and signed by the COO and Vice President of Prevention Services. The policy ensures that all youth shall be interviewed upon admission to determine the most appropriate unit/sleeping room assignment.

The shift leader or Youth Development Staff on duty is responsible for reviewing the youth's case record and intake packet to assess risk or special needs in determining room assignment. Youth who are determined to be a potential threat will be separated from other youth. Room assignment takes into consideration the following: behavioral history, age, maturity level, individual needs, general physical stature, gang affiliation (if applicable), any allege offense(s), level of aggression, sexual misconduct/sexual predatory behaviors, any emotional disturbances, suicide risks/ideations, medical or physical disabilities, collateral contracts, or other special needs noted.

Three residential files (one closed and two open) were reviewed for this indicator. All reviewed files met the minimum requirements for this indicator. All 3 youth's files classify youth as to review of their history, status and exposure to trauma, age, gender, history of violence, disabilities, physical strength/size, gang affiliation, risk of suicide, sexually aggressive or reactive behavior, gender identification, alerts, collateral contacts and initial interactions/observations. The reviewer also interviewed a Youth Development Staff who was able to articulate the policy and procedure regarding Room Assignment.

There were no exceptions for this indicator.

3.04 Log Books

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure, SH 3.04— Log Books. The policy was last reviewed on 02/28/17 and signed by the COO and Vice President of Prevention Services. The policy ensures that logbooks in the shelter are to document daily activities, events, and incidents in the program.

The procedures are documented for the following areas: logbook entries that could impact the security and safety of the program are highlighted, date and time of incident, event or activity, name(s) of youth and staff involved, brief statement of pertinent information, and name of person making entry with date and time of signature. The program indicates logbooks are retained for a period of no less than three (3) years. The program director or designee shall review the logbook every week and make a note in the logbook as to any corrections, recommendations,

and follow-up required. The oncoming supervisor shall review the logbook for the previous two shifts.

The shelter maintains a permanent bound logbook that records all routine information, emergency situations and incidents pertinent to shelter activities. Three (3) different types of logbooks were reviewed: one logbook is utilized for the main program documentations and procedures and the other two logbooks were used for the male and female dormitories/bed area. The logbook pages contain the date or dates of the entries on each page and each entry has a time and signature. Any entry changed or crossed markings are neat and initialed. Important documentation is highlighted and communicated effectively amongst staff and supervisor. The program director reviewed the facility logbook every week, signed, dated, and conducted any follow-up noted or needed.

The reviewer also interviewed a Youth Development Staff regarding the program logbook. The staff was able to articulate and demonstrate the procedure of documenting in the logbooks as well as identifying each weekly review by the program director.

As of July 1, 2017, the agency began using electronic logbook to document routine daily activities, events, and incidents in the program. The E-Logbook is reviewed by the direct care and supervisory staff at the beginning of each shift. After interviewing the Director of the program, the reviewer observed that the program doesn't have any policy and procedure regarding electronic log books at the time of this QI visit. Also interviewing a Youth Development Staff, the reviewer was able to witness the syncing inconsistencies and deletion of pertinent documentation regarding the electronic logbooks. The director informed the reviewer that the electronic log book hasn't been working properly due to the syncing issue and reported it to NoteActive. The agency has continued to utilize the manual logbook along with the electronic logbook simultaneously. NoteActive provided a support log that showed communication with the agency for the past 6 months. Per the log, the provider contacted NoteActive once in February 2018 regarding the syncing issue. No other calls were related to that issue; other inquiries were regarding dashboard access, login, and staff access.

Exceptions:

As of July 1, 2017, the agency began using electronic logbook to document routine daily activities, events, and incidents in the program which are reviewed by the direct care and supervisory staff at the beginning of each shift. After, interviewing the Director of the program, the reviewer was able to establish that the program doesn't have any specific policy and procedure regarding electronic log books at the time of this QI visit.

3.05 Behavior Management Strategies

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure, RM 780— Behavioral Management. The policy was last reviewed on 04/18/17 and signed by the President/CEO and Board Chair. The policy ensures that the agency use proactive behavioral management techniques that emphasizes positive and preventative measures in the management of the youth behavior. Restrictive behavior management in the form of physical restraints may be used only in an emergency and only as a means to protect the youth from self or others. Seclusions, Mechanical and chemical restraint is strictly prohibited.

The procedure reviewed identified 11 key steps in the Behavior Management Program including the introduction of the program at intake, signed acknowledgement of the system by parent(s) and youth which are placed in the file, integration of the program in order to recognize and reward for positive participation, consequences for violation that will be and will not be used, training all direct-care staff, and alerting director regarding non-routine actions and consequences. There is also a comprehensive description and procedure of the physical restraint approach.

The reviewer interviewed two of the youth care staff and they both were able to articulate the Youth Development System (YDS) to manage behavior in the shelter. This approach includes pieces of Advancing Youth Development (AYD) and Character Counts. The youth advance by levels and are positively reinforced in the shelter. In addition, staff is trained in Managing Youth Behavior (MAB). The Reviewer was able to establish that the two interviewees were also trained in WHY TRY which they utilize when interacting with the youth, although this system is not mentioned in the Policies and Procedures. The BMS uses a variety of awards/incentives to encourage participation and completion of the program. The Shift Leader provides feedback to staff and informal evaluations of their use of the BMS.

There were three residential files (one closed and two open) reviewed for this indicator, it was confirmed that staff does explain the (BMS) during program orientation and obtain receipt of acknowledgement of the consumer handbook.

There were no exceptions for this indicator.

3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure SH 520 – Staffing Levels and On-Call/Scheduling that addresses all of the key elements of the

QI indicator. The policy manual is dated 09/13/2013 and last reviewed by the Chief Operation Officer and Vice President of Prevention Services dated 02/28/17.

The procedures are divided into subtopics: Ratios, On-Call duties, and Youth Supervision. The Ratios section discusses the need for both male and female staff working at all times with a staff: youth ratio of 1:6; when to staff part-time employees; and documentation of staff in the logbook. On-Call procedures include how to reach the on-call staff and circumstances in which to contact them.

The practice in the shelter exceeds the standard in that the shelter maintains a 1:6 ratio at all times except when the census exceeds 12 at which time the director is contacted to make staffing decisions. The staff schedule is provided to staff and located on the clipboard that is used by each shift lead throughout the day and night. The staff roster is also located on the clipboard as is any phone numbers that may be needed throughout the shift. There is a list of all youth care workers' names and cell phone numbers posted to reach these staff when additional coverage is needed.

The agency is equipped with a functional surveillance system that includes 21 working cameras that are well positioned for adequate monitoring of youth whereabouts. The system's recording was functional and exceeded the data back-up for 30 days when reviewed onsite by another Peer Reviewer.

A random selection of overnight checks was conducted and verified staff's observation and documentation of bed checks every 15 minutes while the youth are sleeping times only varied by seconds as reported by Peer Reviewer.

The program meets all requirements of both staffing and youth supervision.

There were no exceptions noted for this indicator as of this QI visit.

3.07 Special Populations

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure (SH 660) that addresses all of the key elements of the QI indicator 3.07. The policy was created on 4-01-16. There has been no review since that date. The policy was signed by the Chief Operating Officer and the Vice President of Prevention Services.

The procedure states that the shelter shall provide services to special populations defined as Domestic Violence Respite, Domestic Minor Sex Trafficking, Probation Respite, and Staff Secure for youth ages 10 through 17 who have been charged with an offense of domestic violence (including youth who have previously adjudicated for other issues) specifically designed to provide a safe alternative to secure detention for youth with pending or adjudicated charges for domestic violence. The procedures describe general description of services, youth eligibility, youth referral/determination procedures, limits on youth to be served, and services to be provided for domestic violence referrals. Procedures for domestic minor sex trafficking referrals, probation respite referrals, and staff secure referrals include youth eligibility, youth referral/determination, and services to be provided. Requirements specify that youth are provided services to address their specific needs, such as Domestic Violence Referrals have service plans that identify outcomes that address ways to reduce violence in the home.

There were no referrals for either Domestic Minor Sex Trafficking or Staff Secure placements during the past year.

Three files were reviewed for Domestic Violence Respite (DV Respite). All three youth were referred for domestic violence charges by the JAC/Detention Screener. Their stays in the DV Respite placement lasted no longer than 21 days. One was able to return home in 2 days. One was transitioned to CINS/FINS shelter stay until she aged out at age 18. Other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements.

Three files were reviewed for Probation Respite referrals. The requirement for Probation Respite youth to be on Adjudication Withheld status was eliminated. Also, staff are no longer required to get Florida Network approval before accepting a Probation Respite youth. Staff are updating the youth in the Reporticator. The length of stay is determined by assessing the needs of the youth; all three youth were discharged before being in shelter 30 days. One youth was discharged the same day they were admitted. The other 2 youth's files showed evidence of case management and counseling needs being addressed. All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements.

There were no exceptions noted for this indicator as of this QI visit.

3.08 Video Surveillance System

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure, RM 660 - Video Surveillance. The policy was last reviewed on 04/07/17 and signed by the

President/CEO and Board Chair. The policy ensures that the shelter provides a secure environment, protects its facilities, and enhance the safety of youth, staff and visitors. The video surveillance is used to only meet YFA's critical goals for security and in a manner that is sensitive to interests of privacy, free assembly, and expression. Video surveillance of public area will be limited to uses that do not violate the reasonable expectation of privacy as defined by law.

The procedures outline 8 components required for the postings: usage of video recording/camera, cameras placed in general work areas (excluding bedrooms and bathrooms), limited staff access, and saving of video footage. The surveillance system is equipped with 22 cameras and captures and retains video images recorded with day, time and location in a resolution that enables facial recognition. The system has a back-up battery that is automatically utilized during a power outage. Cameras are placed inside, as well as outside the building. Video surveillance is only accessible by designated personnel and is reviewed at least every 14 days and noted in a logbook.

Observation of the video surveillance system was conducted and explored. Recording of the data was available for the period greater than 30 days required, there is a written notice displayed on the premises and the overnight staff maintains 2 logbooks: 1 for the girls and 1 for the boys. They utilize a timer to remind them every fifteen minutes to do bed checks. The bed checks are done timely and match the entries in the logbooks. Random dates were reviewed demonstrated supervisory review of a random sampling of overnights a minimum of once every 14 days. The camera system is only accessible by the program director and the Team Lead.

Exception:

The reviewer interviewed the Director and discovered that 2 of the 22 cameras are not functioning due to wiring issues. The Director also indicated there is no repair order in place at the time of this QI visit.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

YFA-GWH 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 director, counselor, or team leader 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 annual review the part-time licensed registered nurse (RN) position was filled and has been active since August 2017. The nurse works 2 10-hour days Monday – Friday each week.

The program implemented the use of the E-logbook but is still maintaining hard copies due to syncing/saving problems on the electronic devices.

The program uses the Pyxis Med-Station system for storage and distribution of medication and has 6 super users. Topical and injectable medications are stored separately from oral medications. A locked refrigerator is maintained 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.

4.01 Healthcare Admission Screening

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure (SH4.01) that addresses all of the key elements of QI indicator 4.01. The policy manual was last reviewed on 2-28-17, and was signed by the Chief Operating Officer and the Vice President of Prevention Services.

The provider's procedure requires the use of the CINS/FINS Intake Assessment form and the Health Screening Form to screen for medical, mental health, and substance abuse concerns. Youth Care Staff completing the CINS/FINS Intake Assessment form and the Health Screening Form are to inquire about, observe, and document the following client related issues: a client's mental health (including suicidal or homicidal ideation), dental, or acute and chronic medical conditions at the time of intake; whether or not a client is currently under any kind of medical treatment, or on any type of medication; evidence or observation of physical deformities or handicap and/or evidence of abuse/neglect; any issues related to medication, symptoms of tuberculosis, physical health problems, allergies, recent injuries (including head injuries occurring within the past two weeks) or illness, or any potential presence of pain or other physical distress, hemophilia, asthma, cardiac disorders, seizure disorders, pregnancy, diabetes, substance abuse and/or intoxication; difficulty moving; evidence of a history of substance abuse and/or intoxication; evidence of obvious injury, or signs of physical illness (including allergies or symptoms of tuberculosis) that require immediate medical attention; and presence of scars, tattoos or other skin markings.

Written procedures delineate use of first aid and arrangements for medical services for youth through direct contract, inter-agency agreements with medical service providers, the local health department, or the local emergency room. Procedures also describe on-going monitoring of health conditions and having, whenever possible, the active involvement of parents, guardians or caseworkers in the coordination and scheduling of follow-up medical appointments or care.

The program's policy states that during the first 24 hours of shelter stay the youth will be on Orientation status and will be closely monitored by staff for any signs of a medical condition. "In addition, if the program has a nurse the nurse will review the youth's medical history during this time."

A total of 3 Residential files were reviewed. All files reviewed indicated a health screening was accomplished at intake using both the CINS/FINS Intake and the Health Screening Form. One of the files indicated the youth has been taking prescribed medication, but the medication could not be given to the shelter because of confusing instructions on the labels. The guardian was working on getting new prescription, which were delivered to the shelter on 1-24-18. Another youth was not prescribed medication at intake, but subsequently was prescribed a medication. Medication logs were reviewed, and all entries appeared to be in accordance with policy and procedures.

Exception:

Florida Network policy states: "If present during the scheduled working hours, the agency nurse will conduct the health screening. If no nurse is present, Non-health care staff may perform this screening. In the event the nurse does not conduct the screening they will review all intakes within 5 business days." The agency policy and procedures manual states: "All youth entering shelter are placed on Orientation status for at

least the first 24 hours of shelter stay. During this Orientation period the youth is closely monitored by staff members for any signs of a medical condition. In addition, if the program has a nurse the nurse will review the youth's medical history during this time." The agency's policy does not address all of the Florida Network's policy regarding the performance of the health screening when present and review of intakes within 5 days if not present. In practice, the nurse provides a very thorough review of health screenings and documents them in the chronological notes.

4.02 Suicide Prevention

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure (SH4.02) that addresses most of the key elements of the QI indicator 4.02. The policy manual was last reviewed on 3-31-17 and was signed by the Chief Operating Officer and the Vice President of Prevention Services.

The provider's procedure requires the use of the CINS/FINS Intake Assessment form for initial screening of youth for risk of suicide. If a youth is identified as a suicide risk by virtue of answering one or more of the six risk screening questions on the CINS/FINS Intake Assessment, the Youth Care Staff completing the intake will then complete the Evaluation of Imminent Danger of Suicide (EIDS), score, and mark the score on the EIDS Summary Form. Youth Development Staff will review the EIDS with on-call if no counselor is present.

An assessment for suicide risk must then be completed by: (1) a licensed professional, or, (2) an unlicensed professional under the supervision of a licensed professional. The assessment will occur no later than 24 hours after the screening, unless the following exception exists: EXCEPTION: If the screening occurs between 5 PM on Friday and 9 AM on Monday and there is no access to staff to conduct an assessment within 24 hours, the assessment must be done within 72 hours.

Youth awaiting an assessment by a licensed professional or unlicensed professional under the direct supervision of the licensed professional will be placed on Constant Sight and Sound Supervision. Youth returning from a Baker Act facility will also be placed on Constant Sight and Sound Supervision. If at any time during a youth's stay at the shelter, any staff observes or believes a youth presents as an immediate threat to themselves or others, the youth will be placed on One-to-One Supervision and staff will immediately call 911 and/or follow Baker Act procedures.

Staff assigned to monitor the youth on either One-to-One or Constant Sight and Sound Supervision must document observation of the youth's behavior at 5 minute or less intervals using the sight and sound form. Documentation must be reviewed by supervisor staff each shift and must be placed in the youth's file. A Monitoring/Progress Note is completed for every shift.

A total of 4 residential files were reviewed. For all 4 files, the CINS/FINS Intake form was used to accomplish initial suicide risk screening. Three youth were placed on Constant Sight and Sound Observation, one of which was as a result of a positive answer to one of the suicide risk screening questions on the CINS/FINS Intake form. The other two were placed on Constant Sight and Sound Observation due to having been placed in a Baker Act facility within the past year. All three youth were documented with staff observation checks every 5 minutes, which far exceeds the required 30 minute checks. All three youth were kept on Constant Sight and Sound Observation until assessed by the non-licensed clinical professional and reviewed by the licensed clinical professional.

Exception:

Of the 4 files reviewed, all 4 CINS/FINS Intake forms were signed as completed and reviewed by the same non-supervisory staff member.

4.03 Medications

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure (RM 785) that addresses all of the key elements of QI indicator 4.03. The policy manual was last reviewed on 3-29-17, and was signed by the Chief Operating Officer and the Vice President of Prevention Services.

Upon admission to the shelter, the youth and parent will be interviewed about the youth's current medications. If the RN is on the premises, this process will be conducted by the RN. Otherwise, the interview will be conducted by authorized staff to confirm the types of medication, reasons for taking the medications, and whether or not the youth is taking the medications as prescribed.

Medication is to be accepted with a current, patient-specific label intact on the original medication container only, and the medication label must identify the medication in the container, the child for whom it is prescribed, dosage and frequency requirements, prescribing physician, and expiration date. In addition, medication accepted must be within thirty days of the date the prescription was filled. If the prescription is outside of thirty days, the guardian shall be required to refill that prescription before it will be taken into the facility.

Once the medication has been determined to be in an appropriate container with valid information and labeling, the youth/parent/guardian has confirmed the youth is taking said medication; staff may proceed to verification of the prescription if possible.

Information concerning common side effects and precautions, including allergies, of prescribed medications will be documented by the RN and readily available to the authorized staff person(s) handling medications. Allergies are documented on the youth's individual Medication Record. Allergies or medical alerts of youth are listed on the Allergy, Medical, or risk Alert Board in the medication room. A medication insert or professionally produced side effect profile sheet is to be placed behind a youth's medication record in the Medication Log.

Verification of prescriptions will be conducted by the RN when on the premises. In the absence of the RN, verification will be conducted by authorized staff designated to work with medication. If the authorized staff is unable to obtain the verification at the time of intake, verification will be obtained as soon as possible by the RN. If the RN is not available to verify the prescriptions within a reasonable amount of time, the verification will be completed by the counselor assigned to the youth. Storage of medication will be handled by the RN while on premises. If the RN is not on the premises, authorized staff will handle the process.

Medication is stored in the Pyxis Med-Station located inside the Medication Room at the shelter, including controlled medications. The medication room and the medicine cabinet are kept locked at all times and inaccessible to youth. Medication requiring refrigeration is stored in a small refrigerator located inside the medication room. The refrigerator is used for medications only.

The Pyxis Med-Station, refrigerator for storing refrigerated medications, medication logs, sharps storage and logs and medication inventories were reviewed. All medications are stored in the Pyxis Med-Station. There were no refrigerated medications on site during the review, but the refrigerator with thermometer was in working order. Medication counts/inventories appeared to be thoroughly accomplished as required. There are 4 staff members designated as Super-Users. A perpetual inventory with running balances is maintained for controlled substances. Sharps are secured properly and a weekly inventory is maintained. The agency does not store over-the-counter medications. Instead, parents are to provide a prescription labeled bottle of any over-the-counter medications they want their youth to take. If a youth complains of a medication condition, such as a headache, and there is no prescribed over-the-counter medication for that youth, the staff will call the parent to have them take the youth to a doctor. Monthly reviews of medication management practice via the Knowledge Portal or Pyxis Med-Station were reviewed. When the nurse is on duty, medication processes are conducted by the nurse. The delivery process of medication is consistent with the FNYFS Medication Management and Distribution Policy. Medication discrepancies are cleared after each shift.

There are no exceptions to this indicator as of the date of the QI Review.

4.04 Medical/Mental Health Alert Process

Satisfactory Limited Failed

Rating Narrative

The agency has a written policy and procedure (SH4.04) that addresses all of the key elements of QI indicator 4.04. The policy manual was last reviewed on 3-20-17, and was signed by the Chief Operating Officer and the Vice President of Prevention Services.

The provider's procedures require mechanisms to be in place through which staff are informed about a medical and mental health condition and allergies of youth which may require emergency medical care. These include:

- Use of the CINS/FINS INTAKE Assessment and Medical Log in the file room to document medical and mental health conditions and allergies.
- A MEDICAL ALERT and ALLERGY label will be placed on the upper left hand corner on each case record identifying each youth's medical condition or allergy.
- Staff completing the intake documentation are to post the name of the youth with a medical alert or allergy on the Allergy, Medical and Risk Alert Board in the Medication room. In addition, staff will utilize the alert codes designated in the agency procedures on the front of the file and note the codes on the census boards. Staff are to check the boards each time they come on shift so they are able to appropriately monitor youth.
- Staff are to document any special dietary needs and/or food allergies on the CINS/FINS Intake Assessment and the Health Screening Form as well as the Special Dietary Needs/Allergy Board in the kitchen.

Three files were reviewed and all three had medical/mental health or allergy alerts documented properly. The alert board was reviewed and alerts were properly documented. The alert board was located in a place that enabled staff to review it easily on a daily basis. The alert system includes precautions concerning prescribed medications, medical/mental health conditions. Staff are provided sufficient information/instructions to recognize/respond to the need for emergency care for medical/mental health problems. The alert system ensures information concerning a youth's medical condition, allergies, common side effects of prescribed medication, food and medications that are contraindicated, or other pertinent mental health treatment information is communicated to all staff.

There are no exceptions to this indicator as of the date of the QI Review.

4.05 Episodic/Emergency Care

Satisfactory Limited Failed

Rating Narrative

The agency has a written policy and procedure (SH 4.05) that addresses all of the key elements of QI indicator 4.05. The policy manual was last reviewed on 3-20-17, and was signed by the Chief Operating Officer and the Vice President of Prevention. Services.

Agency procedures require all staff to have current training in CPR/First Aid and the use of the Knife-for Life. Location for First Aid Kits and Knife-for-Life are indicated on the egress charts. Healthcare simulations are conducted on at least a quarterly basis. All instances of first aid and emergency care are documented as required. All deaths or serious adverse medical events shall undergo root-cause analysis within the risk management process of the Critical Incident Review Team. The Emergency Preparedness/Disaster Plan ensures all staff are informed of potential emergency situations. In any emergency event, the shelter will follow chain-of-command: supervisory or managerial staff delegates appropriate tasks to those on duty or otherwise available. Staff are to review television or radio news to determine any environmental stressors that might automatically render some programming unsafe. Possible stressors are to be documented in the Communication Log Book.

Staff are to contact the parent or legal guardian to make arrangements and transportation to appointments for general medical care. In the event parent/legal guardian is unable to or unwilling to transport youth to appointments for general medical care, Youth Development Staff will provide transportation.

Staff are trained to contact 911 for medical or mental health emergency situations. Medical emergency incidents are reported as required after contacting 911. On-call staff will also contact the Program Director or Residential Supervisor to inform of the incident. Parents or guardian are contacted to inform them of the emergency and the calls are documented in the Communication Log Book. Upon a youth's return to the shelter from an emergency medical facility, the shelter will keep in the file a verification of receipt of medical clearance, any discharge instructions and follow-up care that may be required.

Nine youth were transported to see a doctor/emergency room/clinic since July 2017. CCC was contacted and incident reports were documented for all 9 incidents. Parents were notified for all 9 incidents, and entries were made in the Communication Log Book for 9 of the 9 incidents.

All staff are trained on emergency medical procedures, and the administrative assistant monitors training with an excel spread sheet to ensure training is kept up to date. There is a knife for life in the Medication room and in the locked cabinet at the Youth Development Staff Control station. There are 4 first aid kits located in the building in the kitchen, Medication room, copy room, and at the YDS Control Station.

There are no exceptions to this indicator as of the date of the QI Review.