# Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Sarasota YMCA

on 02/12/2018

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

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

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

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

| **Standard 3: Shelter Care** | |
|---|---|
| 3.01 Shelter Environment | Satisfactory |
| 3.02 Program Orientation | Satisfactory |
| 3.03 Youth Room Assignment | Satisfactory |
| 3.04 Log Books | Satisfactory |
| 3.05 Behavior Management Strategies | Satisfactory |
| 3.06 Staffing and Youth Supervision | 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 4: Mental Health/Health Services** | |
|---|---|
| 4.01 Healthcare Admission Screening | Satisfactory |
| 4.02 Suicide Prevention | Satisfactory |
| 4.03 Medications | Satisfactory |
| 4.04 Medical/Mental Health Alert Process | Satisfactory |
| 4.05 Episodic/Emergency Care | Satisfactory |

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

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

## Rating Definitions

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

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

## Review Team

Members

Marcia Tavares, Lead Director, Consultant Forefront LLC

Alvin Bentley, Chief Financial Officer, Florida Keys Children's Shelter

Sheila Dixon, Clinical Director, Lutheran Services Florida Southwest

Joseph Mabry Jr., Residential Supervisor, St. Petersburg Shelter Family Resources

Tiffany Martin, Project Manager, Florida Network of Youth and Family Services

## Persons Interviewed

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

3 Case Managers
0 Program Supervisors
0 Health Care Staff

0 Maintenance Personnel
0 Food Service Personnel

2 Clinical Staff
0 Other

## Documents Reviewed

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

3 # Health Records
3 # MH/SA Records
8 # Personnel Records
4 # Training Records
3 # Youth Records (Closed)
3 # Youth Records (Open)
5 # Other

## Surveys

3 Youth 3 Direct Care Staff

## Observations During Review

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

## Comments

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

Other documents reviewed:

Community Meeting Log

Group Log

Group Notes Log

Episodic Emergency Care Log

## Strengths and Innovative Approaches

Rating Narrative

Sarasota YMCA, Inc. is headquartered in Sarasota, Florida and is contracted with the Florida Network of Youth and Family Services (Florida Network) to provide direct services to Children/Families in Need of Services (CINS/FINS). Sarasota YMCA, Inc. is located in the 12th Judicial Circuit that encompasses DeSoto, Manatee and Sarasota Counties. Sarasota YMCA is a private 501(c) (3) non-profit social services agency that provides a wide range of social and behavioral services to youth and families in Southwest Florida.

Sarasota Y is currently under the management of recently hired CEO Laura Gilbert. Ms. Gilbert was previously employed with the agency for over 20 years in various positions including Contract Manager for all programs and Vice President of Operations for Evelyn Sadler Jones Fitness Branch. She has also been involved in the community for many years and brings much experience to the position.

Some of the program and facility updates during the past year include:

Agency

? Interim CEO (Ms. Gilbert) transitioned to CEO position

? New Board members were added to the Board of Directors after the retirement of several Board members after many years of service

? The YMCA is actively involved in community projects such as the 3rd grade reading level program, Homeless Services serving unaccompanied youth ages 16-24, and "More to Life" program that works with trafficked youth

? The Y developed a new strategic plan including either building a new shelter or remodeling the present one

? Sarasota Y is a member of the National Safe Place. The ABC Coordinator is responsible for the Safe Place Program

? The agency received full reaccreditation from the COA

Staffing

? A new Residential Manager position was created on July 8, 2017

? A new Administrative Assistant began on August 29, 2017

? The program added two PRN Behavior Coaches

? One previous PRN Behavior Coach was transferred to a fulltime position

? A new Case Service Plan was implemented

? Three new counselor positions were added to replace staff who resigned

# Standard 1: Management Accountability

## Overview

Narrative

The Sarasota Family Young Men's Christian Association, Inc. (YMCA) is a charitable nonprofit organization, qualifying under Section 501(c)(3) of the U.S. Tax Code. Sarasota Y is under the leadership of a Board of Directors and President and Chief Executive Director. In July 2016 Kurt Stringfellow resigned as President and CEO. Laura Gilbert now serves as the first female President and CEO in Sarasota Y's history when she was promoted to the position on March 16, 2017.

Sarasota Y operates the CINS/FINS Residential and Non-residential programs under the leadership of Sonia Santiago, VP and Clinical Director for Youth and Family Services. According to the organization chart revised 1/29/18, the Family Management Services is comprised of 5 fulltime and 1 part time Direct Supervision Consultants; 3 Triad Clinical Consulting staff; and 1 youth shelter Clinical Consulting staff. The youth shelter is under the direction of Shad Renick, Program Director. The shelter is staffed by a Program Coordinator, Residential Manager, a Counselor, a Case Manager, six Behavior Coaches, and ten part time PRN Behavior Coaches. At the time of the quality improvement review, the program reported no staff vacancies.

The agency's human resources office handles all its personnel functions including the processing of state and local background screenings and human resource functions. Annual training is tracked according to the employee's date of hire. An individual training file is maintained for each employee, which includes supporting documentation such as sign-in sheets and certificates. The provider agency conducts orientation training to all shelter personnel through a combination of training sources that include the Florida Network, local community resources, and various local providers. Each employee has a separate training file that contains a training attendance form and corroborating documentation for training received.

## 1.01 Background Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The provider has a Background Screening Policy and Procedure # 1.01 and HR-2.01 that was reviewed and signed by the President in August 2017 and 10/20/16, respectively. Sarasota Y Youth and Family Services (Sarasota Y) requires each employee, volunteers, and interns to successfully pass appropriate governmental background screening prior to any offer of employment or volunteer service.

Sarasota Y requires all staff and volunteers to complete a DJJ Background Screening (DJJ BSU) in accordance with FS Chapter 435 with the request for final background screening submitted within five days of their date of hire or start date. Prior to completing a Live Scan, Human Resources will check the clearinghouse database to see if the applicant has a current background screening on file. If the prospective employee's record is not found, the agency will proceed with the submission of a Live Scan. Upon receipt of an eligible screening result, the agency will formally make an offer of employment. An Annual Affidavit of Compliance with Good Moral Character is submitted to DJJ each January for all staff. All employees are re-screened every 5 years from the initial date of hire.

A total of eight (8) applicable personnel files were reviewed for seven (7) new staff and one eligible for 5-year re-screening. The seven new staff were hired after the last onsite QI visit and all seven files maintained evidence of eligible screening results prior to hire. The one staff that was eligible for a 5-year re-screening (DOH 4/5/12) had the re-screening conducted; however, the clearing house re-screening was late and shows an eligibility date of 4/14/17, after the staff's five-year anniversary date. The program had no volunteers/interns providing service during the review period.

Electronic submissions of Department of Homeland Security E-verify for the seven new employees were verified, confirming the employees' work eligibility.

The agency submitted its Annual Affidavits of Compliance with Level 2 Screening Standards via email to DJJ BSU on 1/04/2018 prior to the January 31st deadline.

Exception:

One eligible 5-year re-screening was completed outside of the employee's 5-year anniversary date. The staff's DOH is 4/5/12 and the clearing house re-screening shows an eligibility date of 4/14/17.

## 1.02 Provision of an Abuse Free Environment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policy and procedure # 1.02-Provision of an Abuse Free Environment that that meets the requirement of the indicator. The

policy and procedure was last reviewed August 2017 and signed by the President and Shelter Director. In addition the agency has HR-4.04 – Code of Conduct and Behavior (revised December 18, 2008) and HR-4.07 Child Protection Policy (revised October 2016) that establish the agency's requirement regarding professional behavior. It is the policy of Sarasota Y that the program provides a safe and secure environment that is free from any form of abuse, harassment, and threats.

The agency requires staff to adhere to a code of conduct that prohibits the use of physical abuse, profanity, threats or intimidation. The Y's Code of Conduct is described in HR 4.04 (personnel policy and procedures) that establishes the standards and the agency's behavioral expectations of staff and prohibits use of any kind of abuse (verbal, sexual, or physical), threats, intimidation, and use of profanity. Employees sign an acknowledgement of receipt of the code of conduct and behavior policy during hire and the signed copy is maintained in the employee's file.

Policy and procedure 1.01 also requires staff to report all allegations of child abuse to the Florida Abuse Hotline as well as DJJ CCC hotline. The program requires that calls made to the Abuse Hotline be written in a full report and documented in the Communication Log and the youth's file. The hotline number is accessible to youth and is posted throughout the facility in the shelter living room, dining room, conference room, education room, front lobby, and above copier.

The program has a current grievance procedure that is utilized by youth to file a complaint. The procedure is reviewed with youth during intake. A copy of the grievance procedures is included in the resident handbook and the program has a grievance box for depositing grievances. Per the program's procedures, youth are instructed to put their grievance in the box and direct care workers do not handle the complaint/grievance process unless requested by the youth.

A sampling of 7 personnel files verified acknowledgement of receipt of the personnel policy and procedures which includes information about the required code of conduct.

During the tour of the facility abuse hotline numbers were observed to be posted in multiple places including but not limited to the shelter living room, each dorm room, dining room, conference room, education room, copier area, and front lobby. The program reported only 4 incidents of abuse allegation since the last onsite visit. Three of the 4 abuse calls were accepted by the hotline. Per the agency's procedures, all child abuse hotline calls must be documented in the program log book; staff documented 3 of the 4 abuse hotline calls in the program logbook. All 4 incidents of abuse allegation were documented on an incident report form.

Surveys were completed with three youth on-site during the QI visit. Two of the three youth surveyed were knowledgeable about the abuse hotline and knew the location of the number. Two of the three youth indicated they have attempted to call the hotline while in the shelter.

During the tour of the facility, the grievance box and forms were observed to be mounted in the shelter living room. The shelter director stated there was only one grievance reported by youth during the review period. The youth disagreed with staff about a change (drop) in his behavior level system. The youth indicated a resolution was reached when the grievance was discussed with the Program Director.

Per the Program Director, there have not been any disciplinary actions necessary as a result of physical and/or psychological abuse, verbal intimidation, use of profanity, or excessive use of force by staff during the review period.

Exception:

Per the agency's procedure, all child abuse hotline calls must be documented in the program log book; however, staff did not document 1 of the 4 abuse hotline calls made in the program logbook.

## 1.03 Incident Reporting

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The provider has an incident reporting policy # 1.03 which was revised and reviewed in August 2017 and signed by the President and Shelter Director. The policy meets the reporting, notification, and follow-up requirements of the Florida Network indicator 1.03.

The provider's procedures include requirements for reporting and completing all required documentation, a numbering system, staff arrest notification, "out of the ordinary" incident reporting, filing, and review of incidents within 24-hour period. The program director will sign the original report and maintain an incident report file. Serious incidents are immediately reported to the on-call management staff. All incident reports are reviewed to detect behavioral trends.

Six DJJ CCC reportable incidents occurred within the previous six months; all six incidents were reported within the two-hour time-frame. The provider completed all follow-up communication tasks/special instructions required by the CCC.

Exception:

There were two CCC reportable incidents that were not entered into the program log book (11/21/2017 #201705778 & 10/18/2017 #201705186). Also, two CCC reportable incidents did not have an incident report completed (10/18/2017 #201705195 & 9/13/2017 #201704548); however, the provider has record of the incidents being reported to CCC within the two-hour time frame and all correspondence

from these incidents saved.

## 1.04 Training Requirements

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The provider has a policy # 1.04 for training requirements that was revised and reviewed in August 2017, which specifies positions, number of hours to be completed, and timelines for completion of mandatory training. The policy and procedure was signed by the President and Shelter Director.

The provider's procedure specifies training topics and time-frames for completion. There is a description of the organizations that will provide the trainings along with which staff members will have access to JJIS/SVS. The procedure notes that each staff member will have a training file that includes documentation of completed trainings. The provider requires staff to attend a pre-service orientation, program orientation, and job shadowing with the program director or designated direct care staff within 30 days of hire. During the first year of employment, direct care staff will receive 80 hours of training. Following the first year of employment, direct care staff receives at least 40 hours of job related training annually.

A total of six training files were reviewed which included three employees within their first year but beyond 120 days of employment. The other three were in-service staff training files. All three first year training files met the required 80 hours of training within first year employment and the three in-service staff training files met the required minimum 40 hours of continued training. All training files included more than the required minimum training for staff.

Exceptions:

One training file DOH 7/08/2017 did not complete Managing Aggressive Behavior training within their first 120 days of employment; however, the employee has completed the Managing Aggressive Behavior training as of 12/19/2017. Another training file DOH 3/29/2017 never received training for Universal Precautions and did not complete the Confidentiality training within the first 120 days of employment; however, the employee has completed the training as of 1/19/2018.

Two of the three in-service staff training files did not have the fire safety equipment training completed within the last two years of employment; training file DOH 4/5/2012 last completed the training 1/27/2015 and training file DOH 2/10/2015 last completed the training 2/4/2016.

The provider has two contracted nurses that come to the facility to complete delivery of medication and provide medication training to staff but the provider does not have training files for either of the contracted nurses. Each nurse works less than 10 hours each week.

## 1.05 Analyzing and Reporting Information

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The provider has a policy #1.05 that briefly describes how several sources of information is collected and reviewed for patterns and trends. The policy was last reviewed in August 2017 and was signed by the President and Shelter Director.

The program has an Administrative Assistant who oversees the data collection. Per the policy, data collected is shared with staff and identifies strengths and weaknesses as well as improvements to be implemented or modified. The procedure reviewed outlines the specific data that is collected, staff positions responsible for collecting and reviewing the data, and the purpose for the data collection. Specifically, case files are reviewed during intake and discharge by the Program Director, Case Manager, and Director. A quarterly review is also done by members of management.

Incidents, accidents, and grievances are reviewed monthly. The Risk Manager reviews incident reports monthly and a summary report is sent to the Executive Director and shelter Program Director. Grievances are reviewed upon submission by the Program Director. Results of the reports and satisfaction surveys are shared monthly at staff meetings and documented in the minutes.

The Administrative Assistant reviews satisfaction surveys and areas of concern are shared with the Program Director, reviewed at monthly staff meetings for trends, and recommendations are put in place if necessary.

Monthly outcomes are reviewed by the Administrative Assistant and shared with management. Areas of concern or those not being met are discussed. An annual review is completed by the Administrative Assistant, Program Director, VP of Youth and family Services, and the Contract Manager.

A review of NetMIS reports is conducted monthly by the Administrative Assistant and management. Data is discussed at monthly staff meetings. Missing data and areas not being met are discussed with staff for a solution.

Peer record reviews are to be conducted quarterly by the PQI team consisting of program managers. The team uses the Case Record Checklist provided by COA for the review of files. Oral reports of the reviews are provided during PQI Committee meetings held quarterly. Peer review reports are maintained by the contract manager. During the QI review, the Program Director provided documentation of the last Peer Record review held in November 2016 and stated that one is scheduled for February 2018.

Residential case files are also reviewed systematically weekly for intakes and again at discharge by the Program Coordinator or Case Manager for 100% of youth records. A file review checklist is used at intake to verify receipt of pertinent information during the intake process. Prior to discharge, case supervision occurs to ensure oversight of services and the client records. Upon discharge, a residential file review is completed by the counselor/case manager, Program Director, Clinical Supervisor, and Administrative staff. The checklist includes all sections of file and the completed list is maintained in the closed file.  Besides peer reviews, nonresidential files undergo supervisory reviews periodically.

Incidents and accidents are reviewed and signed by a supervisor as they occur, or within 24 hours. They are reviewed by the Risk Manager who completes a spreadsheet that delineates the type of incidents/accidents for the month which is reviewed by management to determine if there are trends. Trends are discussed by the safety team at the Director's meetings.

The program reported only 1 grievance filed by the youth in the previous six months. Grievances are reviewed and resolved by the Program Manager in a timely manner.

All youth complete a satisfaction survey at discharge. A compilation of the data is completed by the Administrative Assistant and sent to management for review at monthly staff meetings. The agency also conducted its annual stakeholder survey and reviewed its results at the PQI Committee meeting held February 1, 2018.

Outcome data is reviewed by management and discussed at the monthly director's meeting. Progress and trends are reviewed and any necessary changes to the process or system are made. Documentation of Director's meetings was found monthly for the review period with the exception of September and October 2017 due to Hurricane Irma.

The VP of Program Services, Program Director, and Administrative Assistant review the NetMIS data reports monthly to determine missing data and maintain accuracy. Copies of the data reports are maintained and the data is shared at monthly staff meetings to determine areas not being met and solutions.

Exception:

Evidence of quarterly peer record reviews was not observed to be consistent with the provider's policy and procedure and requirement of the QI indicator. There was no documentation of peer reviews conducted during the review period. The Program Director stated the next peer review is scheduled for February 2018.

## 1.06 Client Transportation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There is a client transportation policy #1.06 that was revised and reviewed in August 2017. It is the provider's policy that all youth and trained drivers are safe during transportation. The policy is to avoid situations that put youth and staff in danger of real or perceived harm, or allegations of inappropriate conduct by either staff or youth. The policy and procedure was signed by the President and Shelter Director.

The provider's procedure includes an on-line training as well as a physical driving training administered by administrative personnel prior to being cleared to provide transportation. It's the provider's procedure to have a third party be present if feasible in the vehicle while transporting a client. If the third party cannot be obtained the client's history, evaluation, and recent behavior are considered. When a driver is transporting a single client in a vehicle, there is to be evidence that the program supervisor or director is aware prior to the transport and consent has been given and documented. Documentation of vehicle use will indicate the name or initials of the driver, the date and time of the transportation, the mileage on the vehicle, the initials or name of passengers in the vehicle for transport, and the purpose of travel and location. Staff will log the purpose of travel and clients being transported in the facility log book. A school transportation schedule is created every evening to indicate which school to transport the youth. The schedule is signed off by the residential manager, director or other management team member.

The past 6 months of vehicle logs were reviewed. All transports were properly documented on the vehicle logs and the provider's log book. The documentation included time of travel, destination, mileage, fuel level, and initials for drivers and passengers. The agency transports youth without a third party to school and, to guarantee that a supervisor has approved the transport, the provider completes a school transportation schedule that is signed off by a supervisor every day.

Exception:

During the review of the last 6 months of transportation logs, 3 of the school transportation schedules were missing signatures from one of the provider's supervisors. The dates of the schedules missing signatures are 1/29/2017, 1/19/2018, and 9/18/2017.

## 1.07 Outreach Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

It is the policy of the Sarasota Family Y to participate in the Local DJJ board and council meetings to ensure services are represented in a coordinated approach to increasing public safety by reducing juvenile delinquency through effective prevention, intervention and treatment services.

Program director or designated staff attends the local Juvenile Justice Council for the 12th Circuit as well as the Safe and Drug Free Schools Meeting held by the Sarasota county School Board. Program Director or designee participates in the local and circuit level meetings to contribute to the implementation of Departmental objectives. Outside agencies provide groups for the youth at the shelter. Written agreements with community partners are maintained by the Director.

Agency has a practice of attending a variety of meetings within the community that occur on a weekly, monthly and quarterly basis. Attending meetings is a shared responsibility between Vice President of YMCA Youth and Family Services and the Program Director. Meeting information reviewed were Truancy Meeting that occurs weekly, 12th Circuit Meetings that occur quarterly, Safe and Drug Free Schools Advisory Committee meetings that occur monthly, Coalition of Care meetings that occur quarterly. For all meetings that were reviewed, there were minutes provided and verification that shows a representative of the agency attended. The program also has written agreements with other community partners which include services provided and a comprehensive referral process.

No exceptions noted.

# Standard 2: Intervention and Case Management

## Overview

Rating Narrative

The Y provides centralized intake and screening twenty-four hours per day, seven days per week for youth who meet the criteria for CINS/FINS, Staff Secure, DV and Probation Respite, and DMST. Trained staff members are available to determine the needs of the family and youth during the screening and intake process. Residential services include individual and family counseling, and group services. Aftercare planning includes referring youth to community resources, on-going counseling, and educational assistance.

The clinical component of the program is under the supervision of a Clinical Director who is a licensed mental health counselor (LMHC). A total of ten Counselors are responsible for providing counseling and case management services and linking youth and families to various community services. Youth are referred to the Y by a family member, school, or a community partner. Upon referral, the youth goes through an intake screening process, followed by an intake, and a needs assessment. A service plan is developed within a week of the completion of the service plan. Case management and counseling services are provided to meet the needs and goals identified during the intake/service plan process. Counseling and supportive services are offered to parents/guardians/family members as well.

Community based counseling consultants are housed in a separate office building adjacent to the shelter. The residential counselor has an office in the administrative offices of the shelter which is accessible to youth allowing easy access to the counselor. Staffing of cases is done on a regular basis and peer record reviews are done quarterly.

The Y is responsible for coordinating 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. A review of cases staffed by the Case Staffing Committee is indicative that the provider has initiated case staffing for youth and files for CINS Adjudication as needed.

## 2.01 Screening and Intake

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of the CQI indicator. The policy manual was last reviewed August 2017 and was signed by the President, Program Director, and Clinical Director.

The provider's procedure requires that all youth be screened for eligibility and appropriateness prior to admission for services. Screenings will be completed in their entirety by identified personnel in both shelter and non-residential programs. After hours screenings will be conducted via phone or in person by shelter staff. Non-residential services may receive referrals from school personnel, law enforcement, family/friends of youth, and community providers. Referrals received regarding habitual truancy shall be governed by current Florida Statute and School Board. The purpose of the screening is detailed in agency's policies. When a referral is received in the non-residential program, contact will be made within seven (7) working days of receipt of referral and documented on the referral form. If shelter and non-residential services are not appropriate, referrals will be made to the appropriate community agency offering assistance for their particular problem and documented. Waitlists in both programs may be developed if needed. Intake procedure includes gathering of information with an intake assessment, Needs Assessment, Service Plan, NetMIS, consent for services, PAT, and JJIS.

A total of three (3) shelter files were reviewed (2 closed, 1 open) and three (3) non-residential files (2 closed, 1 open). All files reviewed showed an eligibility screening was completed within 7 calendar days. The agency has a form in the client case files that indicated the youth/parent receive in writing the available service options, rights and responsibilities, and the parent/guardian brochure. This form also documents that youth/parents are aware of possible actions occurring through involvement with CINS/FINS as well as the grievance procedures.

No exceptions noted.

## 2.02 Needs Assessment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of the CQI indicator. The policy manual was last reviewed August 2017 and was signed by the CEO and Clinical Director.

The agency's intake procedures include completion of the Needs Assessment and development of the service plan recommended by the standards of the Sarasota Y, the Florida Network of Youth and Family Services, and the Council of Accreditation. The agency's procedure requires that the Needs Assessment is completed within 72 hours of intake to the shelter and by the end of the third session in Non-Residential program. A Needs Assessment can be completed by a Bachelor's or Master's Level staff along with other identified staff that can complete a Needs Assessment and supervisor's signature indicates review of information. The procedure includes reviewing documents outlined in procedure to complete the Needs Assessment.

A total of three (3) shelter files were reviewed (2 closed, 1 open) and three (3) Non-Residential files (2 closed, 1 open). All files reviewed showed that a Needs Assessment was initiated within 72 hours of admission for shelter and completed by the third visit for the non-residential program. All Needs Assessments reviewed were completed by a Bachelor's or Master's level staff member and supervisor signature for review. Of the files reviewed there were none that were in need of a suicide risk assessment as a result of the needs assessment.

No exceptions noted.

## 2.03 Case/Service Plan

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of the CQI indicator. The policy manual was last reviewed August 2017 and was signed by CEO, Program Director, and Clinical Director.

The agency's procedure requires the case plan to be developed using information gathered during the initial screening, intake, and Needs Assessment. In addition the case plan used by the program includes specific needs of the youth identified through the assessment process. The goals include: time frames, target dates, measurable components, location of services, and identify the person responsible. The agency's procedures include services that may be included in the case plan as well as the requirement for case plans to be developed within the first 72 hours of admission. Once the Needs Assessment is completed, additional goals will be included if appropriate. The procedures indicated that all youth cases are reviewed and additional goals may be added during weekly case review for shelter program. Non-residential program service plans are developed with youth and their parent/guardian within 7 working days following face to face contact. Non-residential program case/service plan reviews occur at a frequency that adheres to CQI standards. Case/Service plans are reviewed and signed off by a supervisor.

A total of three (3) shelter files were reviewed (2 closed, 1 open) and three (3) Non-Residential files (2 closed, 1 open). All files adhered to the agency's policy and procedure for 2.03 Case/Service Plan. All files reviewed included documentation of case/service plan completed within the required time frames and included individualized/prioritized needs and goals as identified by the Needs Assessment. Case/Service plan includes service type; frequency and location; persons responsible; target dates for completion/actual achievement dates; and appropriate signatures required. All case/service plans reviewed included 30,60, 90 day treatment plan reviews for Non-Residential files and there were no shelter files due for a review during time of shelter stay.

No exceptions noted.

## 2.04 Case Management and Service Delivery

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of the CQI indicator. The policy manual was last reviewed August 2017 and was signed by CEO and Clinical Director.

The agency's procedure in Case Management and Service Delivery includes assigning a Consultant who will follow the youth and family and be responsible for the delivery of services directly or through follow up on referrals made. Consultants are assigned to assist the family, make appropriate referrals to assist the family, monitor and confer with shelter staff or other placement personnel, follow up on referrals, referrals to Case Staffing, and assisting families through CINS petition process.

A total of three (3) shelter files were reviewed (3 closed, 1 open) and three (3) Non-Residential files (1 closed, 2 open). All case files reviewed had a case manager/counselor assigned. Two (2) Non-Residential and shelter files showed referral needs and coordination of referrals to services. All files reviewed showed coordination of service plan implementation and monitoring youth's/family's progress in services. All files reviewed showed the agency staff provided support to families. Three (3) closed files that were reviewed showed case termination notes as well as the 30/60 day follow ups were completed.

No exceptions noted.

## 2.05 Counseling Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of the CQI indicator. The policy manual was last reviewed August 2017 and was signed by CEO and Clinical Director.

The agency's procedure states that individual case files will be maintained and contain signed forms. The Service Plan will be developed to address presenting problems identified through the intake process and the "six questions" on the Intake Form are used as a screening tool for suicidal behavior used for youth admitted to the shelter and Non-Residential services. The procedures require each youth and family to receive appropriate services to improve or stabilize the family unit, adhere to confidentiality, and contain chronological documentation; case files and services will be reviewed weekly during case review for youth in shelter placement. Non-residential cases are reviewed with Clinical Director during supervision time and a log is kept in case files. Referrals to services are made accordingly depending on youth/family needs as part of discharge plan.

Three (3) Non-Residential case files were reviewed (1 open, 2 closed) and three (3) Shelter case files (2 closed, 1 open) Shelter case files show. Non-Residential and shelter case files show that presenting problems are addressed in the psychosocial assessment, initial case/service plan, and case/service plan reviews. Case notes for all counseling services provided documented youth's progress. The program provides individual/family counseling and youth/families received counseling services according to service/case plan. There is an ongoing internal process that ensures clinical reviews of case records and staff performance which is documented on a form in the case files at a minimum of twice per month which is signed by both supervisor and case manager/consultant. For shelter there is a form that documents weekly case/service plan reviews and documents youth's progress towards case/service plan goals which is signed by staff participating in case plan review.

The Shelter Group Notes binder was reviewed and it shows that group is being provided at least 5 days/per week but often group is provided more than once in a day. Groups are at least 30 minutes, document a clear leader or facilitator, include a clear and relevant topic, and opportunity for youth engagement is documented in individual client notes that are in the client's case file. There are a variety of informational, developmental, and educational topics that are provided during group counseling sessions and the agency has presenters from the community. Three (3) shelter case files reviewed showed group was provided 5 days/week.

Exception:

One (1) Non-Residential closed case file did not address family relationships on the case/service plan as per the Needs Assessment impressions.

## 2.06 Adjudication/Petitiion Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of the CQI indicator. The policy manual was last reviewed August 2017 and was signed by CEO and Clinical Director.

The agency's procedure indicates a Case Staffing Committee is comprised of representatives required per CQI indicator and regularly scheduled bi-weekly. The procedure includes documenting reasons for referrals to the Case Staffing Committee and indicates that families are notified two weeks before the scheduled staffing meeting via certified mail. The agency's procedure requires family to be provided with a copy of the recommendations made and a parent is mailed a letter listing the recommendations. The procedure also includes service plan revisions and filing petitions within the 45 day time frame.

Three (3) Adjudicated CINS/FINS case files were reviewed. All case files reviewed showed the person initiating the case staffing, notification to family and committee occurred at time frame indicated in the agency's policy, and appropriate case staffing members including local school district and DJJ rep or CINS/FINS provider. The agency has an established Case Staffing Committee that has regular communication with committees' members; members include a mental health/substance abuse representative, local law enforcement, school personnel, and agency's staff. The agency also has an internal procedure for the case staffing process including a schedule for committee meetings. In all files reviewed a written report was sent to the family outlining the recommendations and reasons behind recommendations. In two (2) files reviewed a case manager/counselor completed a review summary prior to the court hearing and the one (1) file did not result in a petition being filed. One (1) file reviewed showed that a parent requested a case staffing meeting with the appropriate documentation provided and a meeting was scheduled in two days. Two (2) applicable files reviewed showed that the case staffing recommendations were included in a new or revised treatment plan.

No exceptions noted.

## 2.07 Youth Records

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of the CQI indicator. The policy manual was last reviewed August 2017 and was signed by CEO and Clinical Director.

The agency's procedure requires Counselors, Consultants, and Case Managers to be responsible for maintaining this information in a confidential file. The procedures include signed and dated forms that are provided in both the shelter and non-residential program. The procedure also includes color coding of files and order of files. It is also indicated that files are transported from one office to another in a locked case.

Upon review of agency case files, all records are marked "confidential" and kept in a secure room. Agency's files are placed in a locked, secure room in a file cabinet marked "confidential". When in transport, files are locked in a black locked box which was demonstrated by agency staff during review. All records are maintained in a neat and orderly manner. One (1) shelter file that was reviewed had a case/service plan in the client's binder and not "soft" file.

No exceptions noted.

# Standard 3: Shelter Care

## Overview

Rating Narrative

Sarasota Y shelter primarily serves youth from Sarasota and DeSoto Counties and is licensed by the Department of Children and Families (DCF) effective through May 31, 2018 for twenty (20) beds. In addition to CINS/FINS, the shelter also provides services to youth referred by the Department of Children and Families. The Sarasota YMCA shelter facility is located in central Sarasota near the intersection of Bahia Vista Street and Tuttle Avenue. The shelter is adjacent to the YMCA's gymnasium which provides access to recreational opportunities for youth during their shelter stay. The shelter building includes: a day room, girls and boys dorm style bedrooms, an industrial kitchen, dining room, and laundry room. The shelter Director and staff offices are also located in the building as well as a multipurpose activity/computer room. On the exterior, youth have access to a large deck and open courtyard area with basketball hoops.

The Sarasota Y residential team is comprised of sixteen (16) Behavioral Coaches, including six full-time and ten part-time/ PRN positions. In addition, there is also a full-time Program Director, Program Coordinator, Residential Manager, Case Manager, and Administrative Assistant. The Behavioral Coaches are responsible for processing new admissions and providing orientation of youth to the shelter, the supervision of youth, and for maintaining inventories on all sharps and medications. The dormitory is divided into two separate areas, one for the boys and one for the girls. There are 2 large bathrooms, one for each gender.

## 3.01 Shelter Envonment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of the CQI indicator. The policy manual was last updated August 2017 and was signed and approved by the President of the Sarasota YMCA and the Shelter Director.

The program has procedures in place to ensure a safe and clean environment as follows:

1. The Y Shelter's Health and Fire Safety Inspections are conducted on an annual basis by the local health department and fire inspector, respectively.

2. Furnishings at the shelter are maintained in good condition and repairs are addressed promptly.

3. The Y Shelter is treated for insects monthly.

4. The Y Shelter has a contract with a local landscaping company who maintains the grounds.

5. Bathrooms and showers are cleaned daily as part of youth chores

6. Walls, doors, and windows are checked for graffiti or damages on a daily shift perimeter checks.

7. Upon arrival to the program each youth is assigned their own bed and provided with clean sheets, blanket, and a pillow.

8. Proper lighting is provided throughout the Y Shelter.

9. Youth lockers are located in the dorms in and kept locked. Each youth also has a box in the staff office which is only accessible through the staff.

10. Youth participate in life skills groups five nights a week. Three afternoons a week youth have an opportunity to participate in adventure based counseling groups.

11. Youth are provided physical activity at least one hour a day.

12. Homework time and tutoring is offered. The shelter daily programming schedule is posted in the kitchen and the living room.

A tour of the facility was conducted by the Reviewer to observe overall condition/cleanliness of the facility, safety, and completion of required inspections. The Department of Health Inspection, Fire Inspection, DCF Certification and Equipment Inspections were reviewed. All of the inspections were successfully completed by the appropriate entities with no outstanding issues. A copy of the health inspection is posted in the kitchen and the DCF license is posted in the lobby of the shelter.

Reviewer inspected furnishings indoor and outdoor. All but those items mentioned as exceptions were in good repair. Walls, doors and windows were free of graffiti and damages. Reviewer observed youth's bedrooms being provided with their own clean sheets, blankets, and pillows. Reviewer observed proper lighting throughout the shelter. Reviewer observed personal lockers in youth's bedrooms and area behind the staff desk to secure other youth personal items.

Reviewer observed 3 open files and 3 closed files in which it was documented youth participated in life skills groups 5 nights a week and adventure based groups 3 afternoons a week.

Reviewer observed documentation in the logbook and activity schedule stating youth participate in 1 hour of physical activity daily. Reviewer observed documentation in the logbook and activity schedule that stated homework time and tutoring is offered.

Reviewer received vendor sign in log sheet that showed signature of a Pest Control person from Good News Pest Control Company for providing pest control services at the facility.

Exceptions:

1) Floor/carpet was stained (covered a large area) at the back door entrance.

2) One staff person's vehicle was unlocked. There was another vehicle on the property, owner unknown that was unlocked as well.

3) One dryer had an enormous amount of lint in the lint collection receptacle.

## 3.02 Program Orientation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of the CQI indicator. The policy manual was last updated August 2017 and approved by the President of the Sarasota YMCA and the Shelter Director.

All youth are interviewed upon admission to determine the most appropriate sleeping arrangement to protect their safety and well-being. Screening forms and Risk Assessment forms are contained in the intake packet. The Behavior Modification System is part of the intake checklist and is initialed by client and staff as well.

All services and program schedules are explained to the youth and their parent/guardian at this time. Youth and parents sign informed consents regarding the shelter program. Youth's legal guardian will document on a contact list who the youth can receive phone calls from and have visitation with while at the shelter. The screening and intake will serve as admission to capture key demographic and emergency information on each youth. A digital photo will be taken of each youth and maintained in the youth's file for identification purposes.

Youth are advised of the grievance procedure at intake, in the resident handbook. A grievance box containing blank forms is available in the living room. The content is checked daily by the Program Director.  Grievances are kept in file maintained by the Program Director.

Confiscated contraband will be treated as follows: Tobacco items will be destroyed, other personal items will be returned to the youth upon discharge. Other items will be turned over to Law Enforcement for prosecution.

Reviewer looked at 3 open files and 3 closed files. All 6 youth's files included Orientation Checklists with items referred to in Sarasota Family YMCA Shelter's procedures were signed by the youth, their legal guardian and a staff member. All personal items are inspected upon admission to make sure youth do not have possession of contraband. During orientation, all of the youth received a Youth Handbook Youth and are informed random searches will be done to ensure contraband is not brought into the shelter. The handbook also includes disciplinary actions, grievance procedures, emergency procedures, abuse hotline telephone number, daily activity, and physical layout of the facility. Youth were also assigned a room and any alerts including suicide prevention were noted.

No exceptions noted.

## 3.03 Youth Room Assignment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of the CQI indicator. The policy manual was last updated August 2017 and was approved by the President of the Sarasota YMCA and the Shelter Director.

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All youth are interviewed upon admission to determine the most appropriate sleeping arrangement to protect their safety and well-being. Information gathered from parent and child includes: physical characteristics, gang affiliation, current alleged offences, prior delinquency history, exposure to trauma, reported risk, observation of level of aggression, attitude upon admission, past involvement in assaultive or aggressive

behavior, sexual aggression, predatory behavior, demonstration of emotional disturbance, existence of medical or mental health issues, and physical disabilities and suicide risks. These characteristics are evaluated by the intake staff to determine the most suitable room assignment.

Reviewer looked at 3 open files and 3 closed files. All of the items referred to in the Sarasota Family YMCA procedures were addressed on the youth's screening and CINS/FINS Intake form. The only item that was found to be inconsistent had to do with whether youth were asked what gender they identified with. One of the open files did not have the updated form in it and all 3 closed files did not have the updated form asking the youth this question.

Exception:

One of the open files and all 3 of the closed files did not have a document that asked the youth what gender they identified with.

### 3.04 Log Books

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of the CQI indicator. The policy manual was last updated August 2017 and approved by the President of the Sarasota YMCA and the Shelter Director.

Staff will sign in the logbook when they come on shift with date, time noted, and document that they have read entries of at least the last two shifts. Staff will record acceptance of keys and accepted headcount. Staff members will sign out at the end of their shift. The logbook will indicate the security of the facility and the current program status using an alert code. Entries will be made to the log on each shift to document group activities, incidents, changes in headcount, perimeter checks, and general information necessary to provide appropriate care of the residents. All entries will be brief and written in black ink including a full signature. All recording errors are struck through with a single line and initialed by the staff making the correction. The use of white out is prohibited. Log entries which could affect the safety and security of the program will be highlighted. Each communication log will include an exemplar signature and initial of all current staff. After a logbook is completed it will immediately be removed from the staff office and placed in the Director's Office. Logbooks will be bound and pages numbered consecutively. The Director will review the content of the logbook each shift worked and, if needed, will note corrections, and /or follow-up required to comply with documentation best practices. Entry must be signed, dated, and highlighted in pink.

Reviewer observed logbooks dating back to August 2017. All items required by the indicator were being carried out. The provider is currently using a paper log book that is bound. The log book documents group activities, incidents, changes in headcount, perimeter checks, and general information about the daily activities of the program and residents. Entries are made in ink and included a signature of the recording staff. Recording errors are struck through with a single line and initialed by the staff making the correction. Staff sign in the logbook when they report for duty with date, time noted, and document that they have read entries of at least the last two shifts. Supervisory reviews of the logbook are conducted weekly and were dated and signed.

Exception:

All of the logbooks reviewed were not marked “confidential” on the outside cover of the logbook.

### 3.05 Behavior Management Strategies

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There is a behavior management strategies policy # 3.05 that was revised and reviewed in August 2017. The policy is to implement a behavior management level system to define rewards, privileges, and consequences.

The provider’s procedure is to have the level system explained to each resident at intake and written in the youth handbook along with each level’s privileges and restrictions. The level system uses daily point sheets for each youth, the amount of points a youth earns will determine their eligibility for moving up a level. The points are tallied daily by the third-shift. Consequences are delivered on an individual basis and will not include group punishment.

The provider’s staff will not employ physical intervention techniques unless the safety of the resident, other residents, or staff is involved. Staff are trained in verbal de-escalation techniques which include the “five second rule” which has youth exit the room where a youth generated disturbance occurs.

It’s the provider’s procedure to contact police in almost every situation where a child is being violent to the point where he or she presents an

immediate danger to himself/herself, other youth, or staff members occurs. Disciplinary measures do not deny youth regular meals and snacks, clothing, sleep, physical health services or mental health services, educational services, exercise, correspondence privileges, or contact with parents/guardians, attorney of record, juvenile probation officer or clergy.

During the review, two behavioral coaches, the program coordinator, and the program director were interviewed about the provider's implementation of a behavioral management strategy. All individuals interviewed provided information consistent with the Y's policy and procedures. The goal of the behavioral management system is to promote positive reinforcement and provide fair consequences with explanations to the youth. The provider focuses on each individual youth's situation and does not give consequences on a group basis.

The behavioral management system implemented by the provider uses a point system and each youth starts with a limited quantity of points that are earned for positive behavior or removed because of negative behavior. The quantity of points earned indicates which level a youth will be place on. If a youth wants to reach "master level" they are given individual goals to complete.

Staff explains the daily point system to youth during the intake and reminds the youth of the point system daily. The staff uses the point system as a tool to redirect youth to make a positive choice. All staff have a strong understanding of the behavioral management system and review the system during staff meetings. If there are questions regarding the behavioral managements system staff are encouraged to seek guidance from their peers and supervisor.

No exceptions indicated.

## 3.06 Staffing and Youth Supervision

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of the CQI indicator. The policy manual was last updated August 2017 and was approved by the President of the Sarasota YMCA and the Shelter Director.

The staff schedule is posted in the staff office. Staff members are expected to cover their shift; if they cannot make it to work a PRN phone list is available to contact alternative staff. If it is an emergency, staff members are expected to call the on-call manager who will attempt to find coverage for the shift. If nobody can be found to cover the shift, staff members may be required to stay over or someone from the management team will cover the shift. During sleeping hours, youth will be observed by staff at least once each 10 minutes. Observations, notated in real time will be documented in the appropriate log. Youth who are at risk of harm to self or others will receive supervision as directed by the Policy and Procedure 4.02. Documentation regarding these youth will be maintained as directed by that policy and procedure. Youth on bed rest due to illness or physician's order are observed at least once every 10 minutes and documented on the bed rest sheet in real time. After completion of bed checks, the sheet will be put in the resident's file.

Reviewer observed the staff schedule in the staff office and was presented with the PRN phone list provided to each employee in the event they need to take off. Reviewer also observed on video when a management team member worked an overnight shift due staff shortage. Reviewer observed video footage of three overnight shifts on different days in which bed checks were completed and documented every 10 minutes in real time. Reviewer also observed a youth sleeping on sight and sound being checked and documented on a separate sheet in the appropriate times. Staff schedules indicate Sarasota Family YMCA has 6 full time staff members. Staffing ratios of 1 staff to 6 youth is maintained by the program during awake hours and 1 staff to 12 youth during sleep hours.

Exception:

In most instances the program utilizes a male and female staff on each shift. However, there are instances where there is not a name in the box to indicate if the staff member is male or female or they may have scheduled two staff persons of the same gender.

## 3.07 Special Populations

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of the CQI indicator. The policy manual was last updated August 2017 and was approved by the President of the Sarasota YMCA and the Shelter Director.

The program has specific procedures that meets the requirement for the intake, orientation, assessment, case planning, and aftercare – as well as established criteria for documentation, supervision, data entry, services, and communications related to the special populations it serves. The procedures include all the elements required by the indicator.

The only special population served by the provider during this review period was Domestic Violence Respite. Reviewer conducted a review of the 3 DV Respite files for youth that were admitted to the shelter during this review period. All of the requirements were met in each file reviewed except when the youth was transitioned to CIN/FINS after they had been in the shelter beyond 14 days. Each of the youth reviewed had been in the shelter longer than 14 days. Director was able to present a data entry printout that stated these youth had been transitioned to CINS/FINS.

Exception:

Documentation does not exist in youth's files of transition to CINS/FINS or Probation Respite. However, Director was able to provide information from a data entry print out.

### 3.08 Video Surveillance System

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There is a video surveillance system policy # 3.08 that was revised and reviewed in August 2018. It's the provider's policy that there is a video surveillance system that is in operation 24 hours a day, 7 days a week. The policy addresses the requirements of the indicator regarding video surveillance.

The provider's procedure address their video surveillance system that has the capacity to capture and retain footage for a minimum of 30 days, ability to record date, time, location, and includes a resolution that enables facial recognition. There is a back-up capability for the cameras that allows operation during a power outage.

The provider has 16 operational cameras, 8 are on the interior and 8 are on the exterior of the facility. The cameras are placed in general locations where youth congregate and visitors enter and exit. There are no cameras in the bathrooms or sleeping quarters; all cameras are visible to youth and staff and there are no hidden or covert cameras. Parents and youth are notified of the presence of the cameras at intake. In addition, there is written notice posted on the premise. A supervisory review of the video is conducted at least once every 14 days. The results of the reviews are documented in the log book. The reviews assess shelter activities and include a random sample of overnight shifts.

The provider identifies staff with accessibility to the video surveillance system namely, the program director, residential manger, residential counselor, and case manager. The program director has off-site capabilities to view cameras. All video recording will be made available for third party review after a request from program quality improvement visits and or when an investigation is pursued after an allegation of an incident.

During the review of indicator # 3.08, the provider's surveillance system was viewed and confirmed to have the capability of recording time, date, location, and facial recognition. The facility has cameras that are visible to youth and staff. The provider does not have cameras in any bathroom or sleeping quarter. All cameras worked properly during the review and the program director can view the surveillance system remotely.

The program director has computer access to the surveillance system in his office and reviews the recorded video within 14 days of the last review. The review conducted by the supervisor consists of at least three separate shifts on three separate days.

If a third party requests any recorded video the shelter director makes the determination of eligibility and if found eligible the program director will give the opportunity to view the surveillance. If required the recorded video can be downloaded to a zip drive and provided on an as needed basis.

No exceptions indicated.

# Standard 4: Mental Health/Health Services

## Overview

Rating Narrative

Sarasota Y has specific procedures related to the admission, interviewing and room assignment of youth to ensure the safety and appropriate supervision of youth admitted in the program. Upon admission, program staff will interview youth. An initial assessment occurs to determine the most appropriate room assignment.

Staff conducting the initial interview and assessment considers the youth's physical characteristics, maturity level, history including gang or criminal involvement, potential for aggression, and apparent emotional or mental health issues. Based on this information, the youth is assigned a bed which can change after further assessment. Room assignment is documented on the CINS/FINS Intake Assessment page 2.

Staff on duty at the time of admission immediately identifies youth who are admitted with special needs and risks, such as risk of suicide, mental health, substance abuse, physical health, or security risk factors, etc. The Clinical Director and Residential Program Director are notified immediately if risks and/alerts are present and recommendations regarding placement and supervision are provided to the direct care staff. This information is documented on the alert board, youth alert forms, and in the youth files using a color coding system.

Youth admitted to the shelter with prescribed or over the counter medication will surrender those medication to staff during admission. The agency stores prescribed medications in the Med-Station 4000 cabinet. Several staff members are trained as regular users and there are 2 Super Users of the Pyxis Med-Station 4000. The provider contracts with a RN whose main responsibility is the provision of medical care and/or medication management in the facility. Topical and injectable medications are stored separately from oral medication. Refrigeration is available for medication requiring cool storage. The program has a list of staff who are authorized to distribute medication ensures that an approved staff is scheduled on each shift. Medication records are maintained for each youth and stored in a MDR Binder.

## 4.01 Healthcare Admission Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Sarasota YMCA has a policy and procedure # 4.01 for Healthcare Admission Screening. The policy and procedure was last reviewed August 2017 and signed by the President and Shelter Director.

Sarasota YMCA screens all youth regarding their physical and dental health upon admission and provides access to medical and dental care to enable residents to obtain access to health care without impediment. If present on premises the Nurse will conduct the health screening. If not, a non-health care staff will perform the screening. In the event the Nurse doesn't conduct the screening they will review all intakes within 5 business days.

During the screening and admission process youth and parent/guardian will be questioned by staff about any medical needs or problems. Staff will collect information by asking screening questions and by observation of resident. During the initial screening youth are screened for serious conditions such as diabetes, seizure disorder, cardiac disorders, asthma, tuberculosis, hemophilia, pregnancy or head injuries. For any of these, parent/guardians will identify guidelines for daily medical care and routines. Consents for distribution of medicine and emergency medical needs are to be signed. Allergies are to be highlighted on Medical and Mental Health alert sheet. Food related allergies are to be posted in the kitchen. Parent/Guardians will transport youth to any appointments. When emergency medical attention is needed arrangements will made for the youth to go to the emergency room.

Three files were reviewed for this indicator (1 open, 2 closed). All files reviewed have a health care admission screening that show current medications, existing medical conditions, recent injuries or illnesses. Files also have places for information regarding observation for illness, injury, pain, presence of scars, tattoos or other skin markings. Other chronic medical conditions checked at intake are diabetes, pregnancy, seizure disorder, cardiac disorder, asthma, tuberculosis, hemophilia and head injuries. In all files reviewed there were no needed coordination for medical related follow-up. Additionally, there were no medical referrals documented in any files.

No exceptions noted.

## 4.02 Suicide Prevention

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Sarasota YMCA has a policy and procedure # 4.02 for Suicide Prevention. The policy and procedure was last reviewed August 2017 and signed by the President and Shelter Director.

Each youth seeking or entering services at the Y Youth Shelter will be screened to determine eligibility for services and the existence of mental health and substance abuse issues which would indicate an immediate need for crisis stabilization, the need for a heightened level of shelter supervision, and/or referral to an appropriate service provider for further assessment and treatment, if necessary. From the time the youth is admitted and throughout their stay observation of mental health, substance abuse and suicidal statements/behaviors is monitored for the safety of the youth.

Mental health and substance abuse screening begins prior to admission, in person, or via telephone, through completion of the Sarasota Y Youth and Family Services Screening/ Intake form that determines whether the youth meets criteria for shelter admission. If over the phone or in person the parent/ guardian reports youth is exhibiting current thoughts or gestures of harm to self or others, a staff member will ask the parent guardian to immediately phone 911 to contact emergency services. If parent communicates over the phone that a youth is under the influence of alcohol or other drugs the parent will be instructed to transport child to a physician or ER for evaluation and clearance before being admitted to the shelter. If youth exhibits they may be under the influence while at the shelter a staff will arrange for transport to a medical facility or will request that parents transport youth.

At time of admission, mental health, substance abuse and suicide screening continue via completion of the CINS/FINS intake form. Staff also document observations that indicate orientation to time, place and person, depression and agitation.

On the intake form if the youth provides an affirmative (yes) to any of the 6 questions the youth will be placed on one to one supervision with documentation made in the logbook or the client file. While on one to one supervision youth will be constantly monitored and behavior will be documented on the observation log during waking hours every 30 minutes and while asleep every 10 minutes. If staff observes youth and believes the youth or others to be at imminent risk, staff will contact 911 immediately. An Assessment of Suicide Risk will be conducted by a licensed professional. This assessment will determine supervision status for youth.

3 youth files were reviewed. 1 open and 2 closed. In 2 files suicide risk screening occurred at intake, the screening results were reviewed and signed by the supervisor, youth was placed on sight and sound as a result of responses to suicide risk questions. For these files a staff person was assigned to monitor youth's behavior, youth was placed on the appropriate level of supervision based on the results of the suicide risk assessment. Additionally, in these 2 instances the supervision level was not changed/ reduced until a licensed professional completed a further assessment.

In one file there was one youth that wasn't placed on sight and sound due to the time of his intake. Youth indicated yes on at least one of the 6 risk questions. According to the logbook review, chronological note review, and Assessment of Suicide Risk Form the youth was assessed by a licensed professional during the intake process and there was no need to initiate a sight and sound log.

No exceptions noted.

## 4.03 Medications

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Sarasota YMCA has a policy and procedure # 4.03 for Medications. The policy and procedure was last reviewed August 2017 and signed by the President and Shelter Director. It is the policy of the Y Youth Shelter to follow a procedure that addresses the safe and secure storage, access, inventory, disposal, and administration/ distribution of medications in accordance with the DJJ Health Services Manual.

At the time of admission to a program if a youth is prescribed medications the parent guardian must provide medications in the original prescription container. Any over the counter medication must be in the original container and accompanied by a doctor's order. A Medication Distribution Log will be completed for each youth prescription. All medications with the exception of refrigerated medications will be stored in the Pyxis. Only staff members that are trained in medication distribution by a Registered Nurse are able to assist in the administration of medication. Medications will be inventoried on a regular basis and documented in Pyxis as well as in youth files and Over the Counter Sheet in Medication Log. Oral Medications will be stored separately from topical medications. Medications requiring refrigeration are stored in a small refrigerator located in the locked staff office. In an instance where Pyxis med station is mal-functioning all medications will be stored behind a locked drawer in the staff office. Sharps are counted on every shift daily. All discrepancies will be cleared each shift.

All medications are stored in the Pyxis and the agency has a minimum of 2 Super Users for the Med Station. There is a refrigerator onsite in the locked staff office that has a temperature of 36-48 degrees F for the storage of medications. There were no refrigerated medications at the time

of the review. Shift to shift counts are conducted and documented for controlled substances. There is a sheet located in the staff office that lists all staff that have been trained in assisting in the administration of medication. OTC medication counts are conducted weekly by the Nurse or another assigned individual. There is indication of monthly review of Knowledge Portal or Pyxis Med Station reports as evidenced by a review of staff meeting minutes that reflect communication/ training with staff regarding discrepancies or other medication practices that need improvement. Medications are reviewed by staff contacting the pharmacy and documenting information on the Medication Transfer Log.

No exceptions noted.

### 4.04 Medical/Mental Health Alert Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Sarasota YMCA has a policy and procedure # 4.04 for Medical/Mental Health Alert Process. The policy and procedure was last reviewed August 2017 and signed by the President and Shelter Director. It is the policy of the Y Youth Shelter that a medical alert system is in place that ensures information concerning a youths medical/mental health condition, allergies, common side effects of prescribed medications, food, medication contradiction, and other pertinent treatment information is communicated to staff.

A medical alert system is in place such that when a youth comes in the shelter with allergies or a medical/mental health condition of which staff needs to be aware, staff will be notified by seven means including: red dot in file; medical/mental health form placed in front of each client's open file; any resident placed on sight and sound will have a yellow dot on census board until cleared for normal supervision by the Clinical Director; medications/ and or medical issues on each residents screening form in the client file; and if a resident has a food allergy, the information will be posted in the kitchen.

Staff is responsible for checking at the start of each shift for any medical alerts they need to be aware of. Staff will note any medication changes or medical restrictions in the communication log on the youth's daily log note. All staff are trained so they are fully aware of the system and able to recognize and respond to medical and mental health conditions/allergies.

3 youth files were reviewed for this indicator (2 closed and 1 open). Staff has an alert system for food and medical mental health allergy. Alerts are placed on the spine of youth files, on the census board and allergy information is posted in the kitchen for youth that have allergies. For the open file that was reviewed there was a Mental Health Alert form placed in the clients file that outline pertinent information regarding mental health and medications. Through a staff interview, information was provided to explain what practice is used for training to respond to allergic reactions or medical and mental health problems. Staff is trained to utilize an Epi Pen in the event a youth is prescribed one. Staff is also trained to call 911 if there is not prescription available. Staff is trained to observe youth behaviors regarding any mental health issues. Staff has learned to communicate with youth counselors in the event a youth is exhibiting the need for additional clinical support, staff has learned to recognize times/events when youth are likely to experience negative emotions and have been trained to communicate with youth directly regarding what is occurring with them to offer support.

There are no discrepancies noted for this indicator.

### 4.05 Episodic/Emergency Care

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Sarasota YMCA has a policy and procedure # 4.05 for Episodic Emergency Care. The policy and procedure was last reviewed August 2017 and signed by the President and Shelter Director. It is the policy of the Y Youth Shelter to ensure client safety by providing rapid and appropriate emergency medical and dental care.

All staff who have Direct care responsibilities will maintain training in CPR/CCR, first aid and Knife for life. Parents/ guardians will transport youth to any medical appointments. Mock emergency drills will be conducted on a quarterly basis. Instances of First Aid will be documented in the First Aid Log. All deaths or serious medical events necessitating medical care will be reported to the Central Communications Center as appropriate. Parent guardians are notified immediately of any medical/ dental emergencies. Upon return to the Shelter, verification of receipt of medical clearance, discharge instructions and follow up care are documented. An incident report will be completed on any youth leaving for off-site emergency services. The CCC and Florida Network will be contacted as required.

Staff is responsible for checking at the start of each shift for any medical alerts they need to be aware of. Staff will note any medication changes or medical restrictions in the communication log on the youth's daily log note. All staff are trained so they are fully aware of the system and able to recognize and respond to medical and mental health conditions/allergies.

Three youth files (3 closed) were reviewed for this indicator. In all files reviewed there was emergency medical or dental care required. In all files

there was verification of receipt of medical clearance via discharge instructions. There is evidence in all youth files that there was parent guardian notification of youth medical state. In one file there was no incident report regarding youth being transported out by parent to receive medical attention.

Exception:

In one file there was no incident report regarding youth being transported out by parent to receive medical attention.