Florida Network of Youth and Family Services Quality Improvement Program Report

Review of YFA-RAP House

on 03/01/2018

CINS/FINS Rating Profile

Standard 1: Management Accountability	
1.01 Background Screening of Employees/Volunteers	Satisfactory
1.02 Provision of an Abuse Free Environment	Limited
1.03 Incident Reporting	Limited
1.04 Training Requirements	Limited
1.05 Analyzing and Reporting Information	Limited
1.06 Client Transportation	Satisfactory
1.07 Outreach Services	Limited

Percent of indicators rated Satisfactory:28.57%
Percent of indicators rated Limited:71.43%
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	Limited
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:87.50%
Percent of indicators rated Limited:12.50%
Percent of indicators rated Failed:0.00%

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

Percent of indicators rated Satisfactory:60.00%
Percent of indicators rated Limited:40.00%
Percent of indicators rated Failed:0.00%

Percent of indicators rated Satisfactory:70.37%
Percent of indicators rated Limited:29.63%
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

Keith Carr, Lead Reviewer, FOREFRONT/FNYFS

Angel Colon, Senior Case Manager, Hillsborough County Children's Services

Shareet Pennino, Executive Director, Lutheran Services Florida (Southwest)

John Robertson, Program Services Director, Florida Network of Youth and Family Services

Nicole Leslie, LCSW; Senior Director of Residential Services; Family Resources

Persons Interviewed

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

0 Case Managers
1 Program Supervisors
0 Health Care Staff

0 Maintenance Personnel
0 Food Service Personnel

0 Clinical Staff
0 Other

Documents Reviewed

- [ ] Accreditation Reports
- [x] Affidavit of Good Moral Character
- [x] CCC Reports
- [x] Logbooks
- [x] Continuity of Operation Plan
- [x] Contract Monitoring Reports
- [x] Contract Scope of Services
- [x] Egress Plans
- [x] Fire Inspection Report
- [x] Exposure Control Plan
- [x] Fire Prevention Plan
- [x] Grievance Process/Records
- [x] 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
- [x] Vehicle Inspection Reports
- [x] Visitation Logs
- [x] Youth Handbook

9 # Health Records
0 # MH/SA Records
0 # Personnel Records
10 # Training Records
9 # Youth Records (Closed)
7 # Youth Records (Open)
0 # Other

Surveys

6 Youth 6 Direct Care Staff

Observations During Review

- [x] Intake
- [x] Program Activities
- [x] Recreation
- [x] Searches
- [x] Security Video Tapes
- [x] Social Skill Modeling by Staff
- [x] Medication Administration
- [x] Posting of Abuse Hotline
- [x] Tool Inventory and Storage
- [ ] Toxic Item Inventory and Storage
- [x] Discharge
- [ ] 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)
- [x] Group
- [x] Meals

Comments

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

Strengths and Innovative Approaches

Rating Narrative

RAP House had a few changes to management in late October. Keith Mukherjee has taken the position of Vice President of Central Programs, Cayse Houston has taken the position of Program Manager, and Tammy Holcombe has taken the position of Shelter Supervisor. RAP House also received the Basic Centers Grant from the Family and Youth Services Bureau. This grant funds two new positions; the Intensive Care Worker and the Outreach Worker.

The Intensive Care Worker is partnering with the Pasco County Sheriff's Office's Special Victims Unit to intensively work with the chronic habitual runaway youth and their families in Pasco County. The Intensive Care Worker will provide intensive level in-home case management, counseling, wrap-around services, and support services to these youth and their families. Services are directed towards a successful reunification back home, strengthening family stability and functioning to prevent future runaway episodes. These wrap-around services include, but not limited to: job readiness, school assistance, mental health referrals, positive role modeling, etc.

The Outreach Worker's efforts focus mainly on directly reaching youth that are in need of services (homeless, living in the woods, couch surfing, etc.), along with connecting to other sources who can refer these youth to our services. The Outreach Worker has started by networking with community partners to make connections between services. She is making gateway services by providing goody bags for homeless youth that include: a new outfit, hygiene products, food, and resource literature packets. She will be providing two drop-in times a week for a hot meal, of either breakfast or dinner, which will give these youth the opportunity to also meet with the Outreach Worker in hopes of getting them in to the services available to them.

Standard 1: Management Accountability

Overview

Narrative

At the time of this onsite program review, the YFA Residential program employs a Program Manager, a Shelter Supervisor, an Office Specialist, three Youth Development Specialist (YDS) Shift Leaders, two Residential Counselors, a Registered Nurse, and eleven Youth Development Specialists, both full-time and part-time. The agency operates continuous quality improvement teams that evaluate files of program participants to monitor the overall quality and appropriateness of the services provided. This team is includes various YFA staff members. Youth and Family Alternatives, Inc. is accredited by the Council on Accreditation (COA).

1.01 Background Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy that is called Background Screening of Employees/Volunteers. The agency policy requires that all employees, volunteers and interns with ongoing access to youth meet the established statutory requirements. The policy appears to have been last reviewed and approved on March 30, 2017 by the agency's Chief Operating Officer and Vice President of Prevention Services. The policy has basic language and content that address general requirements for this policy to be deemed acceptable.

The agency requires that all new hires be subject to a complete background check to include a Department of Juvenile Justice (DJJ) System check, Florida Department of Juvenile Justice (FDLE) check (National Crime Information Center-NCIC and Florida Crime Information Center-FCIC), local law enforcement check, FDLE Sexual Offender/Predator Database check and Department of Motor Vehicles (DMV) check through USIS.

All new hires must be live scanned fingerprint by the Human Resources. Once the agency receives the FDLE eligible rating, the employee can be considered for the FINAL for DJJ background screening. Additionally, prior to starting all employees must have a completed drug screen, local law enforcement check returned with no record found and a completed. The agency must also complete a notarized affidavit of Compliance good moral character that is required to be submitted to DJJ Background Screening Unit prior to January 31 each calendar year.

The agency provided a roster of all staff persons assigned to provide Children in Need of Services and Families in Need of Services (CINS/FINS). There was a total of twelve (12) staff personnel file reviewed to determine compliance with the requirements of this indicator. Of the 12 personnel files reviewed, eleven (11) files required general level 2 screening. All 11 personnel files contained evidence that the background screening process was completed with an official rating of eligibility found for each staff file reviewed. One (1) of the 12 staff persons required a 5 year re-screening that was found to be completed as required prior to the 5 year anniversary date. The agency provided evidence of a completed copy of an Affidavit of Compliance with Level 2 Screening Standards form. This form was submitted as required.

Indicator is in full compliance and there are no documented exceptions noted.

1.02 Provision of an Abuse Free Environment

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

The agency has a policy. The policy is called the youth and family alternatives: provision of an abuse free environment. The policy states that the agency provide an environment that is free of physical, psychological and emotional abuse. The policy requires the agency staff adhere to a code of conduct that forbids physical abuse, profanity, threats and intimidation. The policy states that the agency and all of its programs have a grievance process that permits youth to grieve, in writing, the actions of program staff, the youth peers or conditions or circumstances of care and treatment. The policy was the last reviewed on February 13, 2016. The policy was signed by the agency's chief operating officer and vice President of prevention services on February 13, 2016.

The agency policy includes procedures that require all employees and volunteers of the agency to be obligated under Florida law to immediately report all allegations of child abuse or suspected abuse, neglect, or Exploitation to the store abuse hotline. The procedures require youth that come into the program for shelter of the services be informed of the toll-free child abuse hotline number at the time of intake. Youth must have unimpeded access to self-report alleged abuse. Staff are required to contact the abuse registry immediately upon gaining knowledge of actual or suspected child abuse, neglect or exploitation. The DJJ CCC must also be made notice of any incidents. An incident report form must be completed and submitted in accordance with the agency procedures. Follow up to such incident(s) will be made in accordance with agency procedures.

The agency has an active Abuse Free environment reporting process. The reviewer conducted interviews with a total of four (4) direct care staff

members. Results of interviews include staff members that reported that children have open access to calling the Abuse Registry. In addition, some staff also reported that they directly assist residents in contacting the Abuse Registry Hotline. These staff members reported that they dial the Abuse Registry Hotline number and communicate the youth's allegation(s) and comment(s) to the Registry attendants on the resident's behalf.

A youth grievance policy is in place. The current grievance process provides the rights to formally grieve a problem in writing at any time. A total of two (2) grievances were documented as being reported to be addressed in the last 6 months. At the time of this onsite program review, the agency does not have evidence of a grievance forms box that residents can access to complete and submit an incident form. Once a resident completes an incident, the resident must give the completed incident to a staff member prior to it being given to management for review. Onsite interviews were conducted with direct care staff members resulted in staff members reporting that the youth must directly provide the completed grievance to a staff member prior to it being reviewed by the Supervisor.

Exceptions:

Abuse Hotline procedures used by some staff members do not enable residents to access the Abuse Hotline without asking assistance from a staff person to call in the hotline on their behalf. Direct Care staff members interviewed onsite reported during on site interviews that they directly assist in the process of contacting the Abuse Registry Hotline on the youth's behalf; though the youth may not necessarily need the assistance.

The current grievance/complaint procedure does not support a process that allows youth to grieve actions of staff and conditions or circumstances related to the violation or denial of basic right. The current status of the agency's grievance process is not consistent with the operation of an open Grievance process. Residents should have the option to get a form, complete it and submit without staff assistance.

1.03 Incident Reporting

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

The agency has a policy called Incident Reporting. The policy falls under the agency's risk management protocols. The policy requires all staff to document properly any incident that is not consistent with normal or usual operations of agency programs or its facilities. The policy lists what is a reportable incident in the event that it occurs. The policy was the last reviewed by the agency's president and CEO and board chair on October 20, 2015.

Agencies are required to follow specific procedure that applies to the incident reporting process. Incidents are required to be sent to a certain email address. Incidents are required to be password-protected and not include a subject in the subject line and should not have employees' or clients' names to ensure information remains confidential. The agency's procedures list the following types of incidents that are required to be reportable. There are a total of four (4) major categories of reportable incidents that fall under 4 major headings. These categories include property damage, staff incident in accidents, client incidents and accidents and adverse media coverage or threats. The procedures also include incidents that require an immediate notification and incidents that require general notification. Procedures also include protocols for reporting incidents related to the Department of Juvenile Justice. The procedures also include other mandatory reporting requirements. The procedures also include the notification process for all incidents and accidents. The procedures also include trend analysis.

The agency has an active incident reporting process. A review of all incidents reported to the DJJ Central Communication Center (CCC) in the last six (6) months was conducted on site. A total of thirty-eight (38) incident reporting forms were documented as having occurred during the aforementioned period. Of these incidents twenty-seven (27) total incidents reported and in compliance with the requirements and procedures outlined in the DJJ policy.

Exceptions:

The agency had a total of eleven (11) incidents that were reported or documented in a manner not consistent with the incident reporting procedure. Of these incidents, two (2) incidents were not reported to the DJJ CCC within the 2 hour reporting requirement to the DJJ CCC.

Further, there were three (3) incidents reported to the DJJ CCC that were not accurate or complete as required. Of these, one report was documented as accepted involving a dependency child and 2 incidents that did not have accurately documented evidence of times when the actual incidents took place.

In addition, there were six (6) incidents that were reported to the DJJ CCC and did not have a corresponding internal agency DJJ CCC incident report.

1.04 Training Requirements

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

The facility has an operating procedure for training requirements. The policy states that all staff will have an additional 40 hours annually and also states the mandatory first year training and hours needed. In addition, the facility includes refresher training. The Florida Network of Youth and Family Services requirement is for 24 hours annually after the first year of employment. The policy was last reviewed on March 31, 2017. The policy contained evidence that is was last reviewed and signed by authorized personnel at YFA.

The agency has a protocol that all staff including full-time, part-time, and on-call must Receive required training per the agency policy and related Florida Department of Juvenile Justice, Florida Network of Youth and Family Services policy manuals. The agency policy requires that all staff receive 80 hours of training prior to the closing of their first year of employment. The agency policy also states that all staff to help completed their first year training must receive a total of 40 hours of training every subsequent year that they are employed. The agency has a training process that begins once the offer employment has been made. Training is a combination of orientation, routine job tasks, safety and security training, youth supervision, abuse reporting, incident reporting, youth supervision, behavior management and other industry-related topics. The agency requires that all new hires complete specific training as mandated by the Florida Network with in 120 days of employment.

According to the last review all supervisors and directors kept training files for each of their staff. At the time of this review it does not appear that an individual training record is kept for each staff member. Trainings and details of trainings are kept in different electronic systems, which make it extremely difficult to get a true and accurate accounting of all the staff member trainings.

The facility Training policy states that required skill pro trainings are highlighted in bold. Human Trafficking is listed in the P/P as required within 120 days it is not bolded as indicated that it would be required to be taken in Skillpro. In addition while Suicide Prevention is bolded, it does not state in the facility policy that there are two parts required.

Sexual Harassment which is required as a Florida Network of Youth and Family standard is not listed in the facility policy.

Universal Precautions Florida Network requirements and standards, the title Universal Precautions is not listed in the YFA policy nor seen in the Relias training records. After many attempts to locate Universal precautions training for all staff, this writer was provided with the American Red Cross training binder/book. First aid universal precautions are covered on the book on pages 11-15.

Another example: While Suicide prevention is bolded. The requirement in the standard is Skill-pro Suicide Part 1 and 2. They are different course numbers.

Human trafficking in the facility policy is not bolded as stated it would be in the policy as a skill pro training.

Ensure that the requirements training worksheets reflect the correct template that is describes in the directions.

The print outs from Relias have a signature line for the staff and the staff supervisor to sign off that the trainings were in fact taken. None of the specified trainings was signed by any staff on the Relias printouts verifying they took the training as well as the supervisors. Certificates provided had the name of the staff, date and the number of hours.

Documentation provided reading of training for each staff included, Relias printouts, Skill Pro print outs and certificates. There were no agendas; sign-in sheets for trainings attended.

Ten (10) records were reviewed: 6 shelter staff cases and 4 non-residential staff.

Three of the 4 non-residential staff were in compliance with the FN standard number of hours, however not in compliance with the YFA policy and procedure that dictate that ALL staff is required to have 40 hours annually.

One residential staff had Managing Aggressive Behavior (MAB) in 2015 and has not been refreshed since. The standard is to take every 2 years.

Of the 6 residential staff reviewed, Trauma informed care and Cultural diversity have not been documented.

This writer reviewed several documents from several different systems: Relias, SkillPro, YFA data base. After several requests regarding 10 specific employees, all documentation was reviewed and findings for completed and compliant training and training hours vary among staff. This was a tedious process. There was no one program or file that had all the information available.

Exceptions:

There were several exceptions related to not finding evidence of the completion of training hours for several full and part time staff members. Among the 6 shelter staff reviewed none were found to have Trauma Informed Care and Cultural Diversity/Humility training.

Of the 6 shelter staff, 1 did not have a refresher on PREA (last one 5/15).

Of the 6 shelter staff, 1 did not have Understanding Youth development.

Of the 4 non res staff training files reviewed, 3 did not meet the 40 hour YFA requirement for annual training.

Of the 6 shelter staff, 1 has MAB training in 2015 and no refresher/new training documented.

1.05 Analyzing and Reporting Information

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

The agency has a series of policies related to addressing analyzing and reporting information. The agency has a total of five (5) policies that are comprised of various reviews of the operational practice and methods used to determine the accuracy and completeness of analyzing and reporting agency data. The policies include the quality improvement review of agency files, peer review teams, continuous quality improvement worksheet, continuous quality improvement process, continuous quality improvement teams. Continuous quality improvement teams last reviewed and signed the policy on September 1, 2016. Continuous quality improvement process policy was last updated on January 13, 2015. The CQI team quality improvement worksheet policy was last updated on January 13, 2015. Peer review teams policy was last updated on January 2, 2015. Quality improvement review of agency files policy was last reviewed on January 13, 2015.

The agency has a process that requires the organization to evaluate files of program participants to monitor the overall quality and appropriateness of the service provided. The agency has a process that also requires them to maintain a total of 2 peer review teams that are assigned the responsibility to review case records in its programs. The agency uses the CQI process to remediate negative trend identified through either the peer review process with regular review of data by the management staff of the agency. The agency also maintains an annual CQI plan. The plan's purpose and scope is to identify the CQI committees, subcommittees from another agency group, to get that contribution to the CQI process. The CQI processes in general is to be supported by management at all levels.

The senior leadership of the agency is required to oversee the efforts. A CQI counsel is required to approve the CQI teams that operate and execute the CQI structure. The CQI teams are required to meet quarterly with the CQI counsel. The CQI efforts shall include the process of gathering data, analyzing data, identifying trends, and spotting patterns and making recommendations to approve agency processes and systems based on the data. The CQ our team focuses on the overall agency performance rather than performance of the abilities of individual staff members.

There are multiple examples of the agency conducting review of practice on both the residential and non-residential program on a monthly and quarterly basis. These on-going performance reviews provide examples that the agency has management involved in finding weaknesses and strengths. There are limited examples of evidence of documented improvements/changes made from detail onsite program reviews and program service evaluation exercises performed by the agency's internal quality assurance department.

Exception:

There's a clear ability to detect and identify, but no clear examples of actual interventions for necessary improvements that should be implemented in areas of accuracy and completion of documentation in multiple areas of client file service delivery, incidents reporting, etc.

1.06 Client Transportation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a transportation policy called client transportation. The policy went into effect January 13, 2016. The policy was last reviewed on February 14, 2017. The policy was last reviewed and approved by the agency’s chief operating officer and vice president of prevention services. Current policy was designed to ensure that the safety and security of all residents and staff members when providing transportation during the resident's stay. This policy is applied across all shelter programs.

The agency’s transportation procedures require that all staff be capable of transferring youth and approved as drivers through the human services verification process. The agency requires all staff to utilize a trip and mileage log each time they use a vehicle whether they are transporting clients or not. Staff are required to take a shelter mobile phone with them when they are providing transportation. Staff are required to check in with the shelter once they arrived at their schedule destination.

Staff must take approved third-parties as additional staff in all situations that involve the transportation of the youth whenever possible. Third parties are approved agency staff, volunteers, or interns. Staff are required to make every attempt to avoid single part of transport situation. In the event this cannot be avoided, staff are required to ensure that their supervisor is aware and this will be documented in the agency logbook. Staff are required to also take in consideration the client's history and recent behaviors prior to transport. Staff are also required to show that the youth is sitting in the back row of the vehicle during a single party transport. Staff that have concerns regarding any safety issues during a single party transport will maintain an open line of a communication through the use of the agency mobile phone throughout the transport.

The agency uses an approved list of drivers that are permitted to transport residence during the shelter stay. The agency also uses a single

party transportation form. The form includes date, client name, reason for trip and destination, supervisor approval, supervisor initials, departure from and time of departure, destination and time of arrival, mileage to and from, and staff person name.

The agency has a practice and an approval process in place that requires that the transport of a single client single driver be approved prior to the transportation event. The agency does have a policy that prohibits transported client without maintaining at least one other passenger in the vehicle. The reviewed practice found that the agency is requiring staff members get approval prior to transporting a single client by a single staff member. The agency has a process with a third-party as an approved volunteer, in turn, agency staff, or other youth. The agency does have a transportation policy that includes exceptions in the event the third-party person is not present in the vehicle. There is documentation used that notes the name and/or initials of the driver, date and time, mileage, number of passengers, and purpose of travel and location. The agency records all of the before-mentioned data on a transportation log.

No deficiencies were noted for this indicator.

1.07 Outreach Services

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

There is a written policy that states staff will seek opportunities to conduct ongoing community outreach and education to communicate the agency's mission and roles to communicate the youth and community needs. The policy was last reviewed on March 27, 2017 and signed by authorized officials.

The agency also has a Community Outreach policy/procedure that has additional details regarding their outreach and education services, opportunities and forums. The review of this policy indicates that it meets the general requirements of this indicator.

Minutes and agendas from partner and community meetings are not available. This writer spoke to Shelter manager. She supplied a comprehensive list of programs and events in the community, dates they last met, the purpose and number of people attending list of all community agencies/events that RAP house is a part of. However, agendas, information, or minutes are not at all available. The list indicates most events were to promote RAP house. The log provided confirmed by the shelter manager is a log of outreach events and meetings that RAP house have attended.

It appears that it is clear to staff that their outreach activities are critical, and have lists of important groups and activities that must be attended.

Residential manager also provided a detailed list of meetings, dates and the descriptions of the meetings on a spreadsheet developed by YFA staff.

An agenda from DOH Pasco Community Mental Health Collaborative meeting Board of county commissioners West Pasco County. YFA states they were in attendance, but did not present at the meeting.

There are were interagency memos or agreements provided.

The list suggests that the Circuit 6 DJJ Advisory Council last met on August 7, 2017.

The Outreach log was provided. This is a list of the event and a description of the event. In addition, a log was given of community partners and meetings that staff are part of and the critical nature of being involved in the community.

Exception:

The agency was not able to provide minutes to meetings and verification of attendance at DJJ council/board meeting. Additionally, no proof of attendance in the agenda was provided.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

The agency provides non-residential services at the agency's office, local schools and other community based organizations. The agency utilize diligent efforts to engage the families in the solution of the youth's challenges which lead to the referral for Residential and Non Residential services. Evidence of innovative practices that are evident in the program. All documentation contain a concise summary of progress notes of communication with the youth/families and referrals. The progress notes are easy to ready and consistent.

A review of the case staffing procedure reflects excellent practice with required case staffing committee providers to meet the standard. A binder of documents was reviewed where memos to the case staffing committee members was provided and consistent. All legal documentation is consistent with the progress notes and with all signatures required.

2.01 Screening and Intake

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy that addresses the key elements of the QI indicator for Screening and Intake. The policy was last approved on 02/14/17 and was signed by the Chief Operating Officer and Vice President of Prevention Services.

The provider's procedure requires that a Program Supervisor/Director will ensure a counselor contacts the family to conduct an initial screening and document on the centralized intake screening form. The screening may be completed by phone of face to face and is to begin no later than seven (7) working days from the date of the youth is being referred. The screening is available to families twenty four hours a day which includes the presenting problems, immediate needs and determining if a youth is eligible for CINS/FINS services which is documented on the intake screening form. If a crisis or substance abuse service is determined there is support staff available and an on call supervisor to assist. There is also procedures in the policy in the event that youth/parent answers that the youth is currently suicidal or homicidal. There is a procedure that outlines service eligibility for non-residential programs during after-hours calls as well as if a family requires assistance with translation of languages.

A total of two (2) residential files and five (5) non-residential files were reviewed. At the time of the parent and youth are provided with available services options written on a brochures in English and Spanish for both residential and non-residential services. For all files, all Rights and Responsibilities forms were signed by parent and the child. The grievance procedures and outline of services are also provided to the child and the parent. All files had their screenings completed within seven (7) calendar days.

There were no exceptions for this indicator.

2.02 Needs Assessment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy that addresses the key elements of the QI indicator the Needs Assessment. The policy was last approved on 04/01/17 and was signed by the Chief Operating Officer and Vice President of Prevention Services.

The agency policy and procedure address the Needs Assessments and provides a baseline measurement for the effectiveness of services and the family's ability to implement skills learned through interventions. The Needs Assessments play an integral role in service development which develops an objective understanding of the family's strengths, needs, functioning, resources and understanding of their challenges. The agency policy and procedure also assist the counselors and case managers to make the most timely and appropriate service referrals possible for any challenge that the family is facing. Need Assessment are to be initiated within 72 hours of admission and if a more intensive Assessment is needed the family is to be referred in a timely manner. If the youth is admitted to the shelter then the residential counselor and the outpatient counselor will work closely to provide continuity of care. The Needs Assessment will be conducted every six (6) month when otherwise indicated. Completion of the Needs Assessment shall be within two to three face to face contacts following the initial intake if the

youth is receiving nonresidential services. Needs Assessment are completed by a Bachelors or Master's level staff and signed by supervisor. If a suicide risk is required as a result of the suicide risk, a license clinical supervisor signs and date the assessment.

A total of seven (7) files were reviewed, five (5) open and two (2) closed for both non-residential and residential programs. All files reviewed contained documentation of the Needs Assessment being initiated within the 72 hours of admission. All files reviewed were completed within the two to three face to face contacts following the initial intake. The Needs Assessments were completed by a Master's or Bachelor's level staff and signed by the supervisor. Out of the seven (7) files reviewed there was no suicide risk indication.

There were no exceptions for this indicator.

2.03 Case/Service Plan

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy that addresses the key elements of the QI indicator Case Service Plan and Monitoring. The policy was last approved on 02/14/17 and was signed by the Chief Operating Officer and Vice President of Prevention Services.

The agency policy and procedure meets the requirements for the Standard 2.03. Case plans are individualized utilizing strengths and limitations identified by the youth and family. The Case plans used by the agency includes the identified needs, type, frequency and location of services. Person responsible, target dates for completion, actual completion dates, signatures of youth, parent/guardian, counselor and supervisor. The case plans is to be developed no later than seven (7) working days following the Needs Assessment. If the Case plan cannot be signed due to the parent or youth unavailability, the counselor will document the reason the Case plan was not signed and efforts to obtain a signature are to be made. Case plans goals are monitored and formally reviewed at a minimum by the counselor/therapist and parent/guardian if available every thirty (30) days for the first three (3) months and every six (6) months thereafter for progress in achieving goals and objectives. Reviews are documented and highlighted in yellow in the youth's file. The counselor will documents all efforts to engage the youth and family in review process. A new plan is developed at the end of the ninety (90) days or at any time there are significant changes.

A total of seven (7) files were reviewed, five (5) open and two (2) closed for non-residential and two (2) of the files were residential. All files reviewed demonstrated a case plan was developed within the seven (7) working days following the completion of the assessment. One (1) of the non-residential files case plan was signed by the youth, parent/guardian and counselor within the time frame but the supervisor signed the case plan twenty seven (27) days later. All files documented reviews were completed within thirty (30) days.

There were no exceptions for this indicator.

2.04 Case Management and Service Delivery

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy that addresses the key elements of the QI indicator Case Management and Service Delivery. The policy was last approved on 02/14/17 and was signed by the Chief Operating Officer and Vice President of Prevention Services.

The agency policy and procedure address the process of Case Management and Service Delivery. Each youth is assigned a counselor who follows the youth's case and ensure delivery of services through direct provision or referral. Services are strength base and are in partnership with the family. The counselor utilize diligent efforts to engage the family in solution of the youth's issues which lead to the referral of Residential or Non-Residential services. Efforts may require school or home visits and collateral contacts. If counselor is unsuccessful in engaging the family in services, the counselor will document the efforts and will review the case with the Program Director. The SASSI instrument might be used by the counselor to determine if further assessment is needed by a Certified Addictions Professional or local substance abuse assessment center.

A total of seven (7) files were reviewed. All files are making referrals when necessary and are providing support for families and monitor

progress with services. Out of the seven (7) files reviewed, one (1) file doesn't have services initiated due to new admission.

There were no exceptions for this indicator.

2.05 Counseling Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy that addresses the key elements of the QI indicator for Counseling Services. The policy was last approved on 02/14/17 and was signed by the Chief Operating Officer and Vice President of Prevention Services.

Youth and families receive counseling services in accordance with the youth's case 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 (5) days per week. Non Residential programs provide therapeutic community based services designed to provide intervention necessary to stabilize the family in the event of a crisis, out of home placement, after care services for the youth returning to the home from any placement.

Seven (7) files were reviewed. All files reviewed demonstrated that the youth/family counseling is being provided and that presenting problems are addressed in the psychosocial assessment, case plan and progress notes. A binder with the Group counseling sign in sheets, length of time and topic was reviewed and is evident that group counseling is being provided.

There were no exceptions for this indicator.

2.06 Adjudication/Petitiion Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy that addresses the key elements of the QI indicator for Case Staffing and Adjudication/Petition Process. The policy was last approved on 02/15/17 and was signed by the Chief Operating Officer and Vice President of Prevention Services.

The Case Staffing may convened for individual cases or maintained as a standing committee but the composition of the case staffing committee are based on the needs of the youth and families. Families are contacted and reminded of the case staffing the day before the meeting. The case staffing meeting is scheduled to review the case of any youth or family that the program determines is in need of services if youth is not in agreement with services and no participation in the services selected. Should a parent request a case staffing in writing, the committee shall convene within seven (7) working days. The agency is responsible for contacting appropriate Case Staffing Committee members. All contacts with the child and family are to be documented on the chronological contact sheet. Copies of letters mailed to family are to be filed in the youth's record. The agencies Counselors are responsible to prepared all pre-dispositional reports and court orders. The Case Staffing committee meet at the locations which are central and convenient to the families and participants.

Two (2) files were reviewed. Both of the files CINS/FINS counselor initiated the case staffing. Families were notified by the standard 2.06 policy and procedure. Families were notified within the required time frame. In one (1) file, the family did not respond and the CINS/FINS counselor documented the efforts and monitored the case closely. One (1) file had court involvement. Copies of all letters mailed to the family were filed. CINS/FINS counselor prepared all legal documentation (PDR's, Notice of Hearing, Court Review, Petition and Affidavit). Case Staffing meetings appear to be convenient and centrally located to the families and participants.

There were no exceptions for this indicator.

2.07 Youth Records

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency maintains a Youth record policy and procedure, last reviewed and signed by authorized officials of YFA on 2/15/17. The policy matches the Florida Network standard.

The agency has a policy that addresses the Florida Network standard policy identically. The facility provided pictures of the file box and large opaque envelopes. In addition this reviewer also viewed the items.

All records are marked confidential and kept securely.

Seven files were reviewed, all are marked confidential. They are kept in a secure locked cabinet marked confidential in a locked room. The files are all transported in a locked box case and are secured by lock.

Non-residential records appeared to be in order, neat and properly filed. It is stated that they are all locked in a confidential file cabinet in another building. They were transported to the reviewer's site in a locked black box on wheels.

Exceptions:

Shelter records are "messy" out of order, some forms are in different areas of the file. Of the 4 shelter records reviewed papers were falling out, not filed properly. There were sticky notes on them that fell out as the file was opened.

Almost all files at the shelter have an intake list that is in the file but not filled out. There were forms that were not completely filled out; however there were some forms that were filled out and not done so in an informative approach. Additional documentation should be provided to determine what to do with the youth should a health issue arise. More direction and guidance needs to be documented in records, specifically on intake.

Standard 3: Shelter Care

Overview

Rating Narrative

The RAP House is an eighteen (18) bed crisis shelter facility located on Plathe Road approximately 2 miles West of Little Road in Port Richey. The program is operated by Youth and Family Alternatives which also operates two other CINS/FINS shelter facilities in Florida (Brooksville and Bartow). This residential shelter operates twenty-four hours a day, 365 days a year and is licensed by DCF to serve up to twenty residents for runaway and emergency shelter services. The youth shelter is contracted to serve both CINS/FINS youth and children placed by the Department of Children and Families (DCF). The youth shelter utilizes effective documentation practices in the agency's program logbook. At the time of this on-site Quality Improvement (QI) review, the RAP youth shelter had 11 youth in the shelter, 6 of which are CINS/FINS youth in the shelter.

3.01 Shelter Envonment

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

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

There is written procedure surrounding conducting weekly safety inspections and documenting them in the Weekly Inspection Log. Any corrective action will be communicated to the Program Director. Random checks are to be conducted by the Program Director, Residential Supervisor or Team Lead and the shift leader or designee is to conduct a formal daily inspection of each of the wings at the shelter three times a day.

A comprehensive tour of the facility was conducted to determine the environmental conditions of the facility and the living conditions for the youth. The facility is well designed, nicely decorated with client artwork, and has a beautiful backyard space complete with a screened in pavilion, basketball court, and space for volleyball once the net is replaced. All youth have individual beds and all needed bed coverings.

Exceptions:

There were minimal signs of graffiti, with one observed marking in room 10 and additional graffiti consisting of vulgar language in one of the vans (both on the back of the driver's head rest and the second row head rest). Additionally, there was trash/debris noted in a few spots around the facility as well as a broken faceplate on the lighting pole out back by the basketball court. Several vents and air returns had dust build up, with the vents in the kitchen and dining room being almost completely covered in dust.

The overhead lights in the kitchen were also observed to have what appeared to be dead bugs in them. Agency policy states that all furniture will be in good repair. There are 3 blue chairs in the living room that each have tears in them. These are noted occasionally on the weekly Facility Observation Checklists, but not consistently. Supervisor reports that the plan is to either reupholster or replace these chairs in the near future.

Lastly, the emergency tools, including the knife for life, are located behind three locked doors from the youth unit which would be difficult for staff to access if needed. It is important to have all emergency tools located in an easily, and quickly, accessible location.

3.02 Program Orientation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The policy states that during the first twenty-four hours of admission, the program must include a process that explains and outlines the rules of the program. It must also explain what steps are put in place for the consumer if they are not in agreement of how they are being treated. Policy SH 3.02 was last reviewed on 2/28/17.

The procedure details when the shelter orientation must occur (within 24 hours of Intake). It also describes what must be included in the client orientation, including but not limited to Identification of staff and their roles, a review of emergency building evacuation procedures, a tour of the program, review of daily schedule, how to contact the Florida Abuse Hotline, review of youth rights and grievance procedures, and review of policies on contraband. All youth are provided a comprehensive Youth Handbook and are asked to sign documentation confirming receipt.

In the review of five intake files, all files have a Facility Client Orientation Checklist where both staff and youth are to sign and date as evidence of the program orientation and grievance procedures being reviewed. Client orientation is also occurring within the 24 hour time frame and often occurs right at the time of Intake. Orientation and client handbook cover all areas required by policy and implement many of the topics into the Behavior Management System as well.

Exceptions:

There were noted inconsistencies in the completeness of the Facility Client Orientation Checklist form, as one had nothing checked off or signed off on by staff but the youth signed. Another one did not have 2 areas checked off on or staff signing off that those areas were addressed. Lastly, a third file had a staff initial the top line and date it and then draw a line down to cover the remaining areas (i.e. did not individually initial or date each area). In addition, the files have a Parent Acknowledgement form that provides documentation of the program rules and expectations being reviewed by staff with the parent/guardian. In the review of five intake files, three were not fully completed (i.e. missing information on them and had one where there was no staff/witness signature).

3.03 Youth Room Assignment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

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

The program has written procedures in place that address who is to complete intake packets and indicates that there should be no blanks on any agency form. Agency procedure also states who should review youth record(s) and intake packet to access any perceived risk or special needs and weigh the information before the youth is assigned to his/her room.

Five intake files were also reviewed and each file had accurate documentation of youth’s referral behaviors and what problems they presented.

The program’s goal is to implement procedures that maintain safety and security for each youth due to age, gender, disabilities and behaviors. During the interview with the program supervisor, she explained and outlined in detail the process of determining how a youth is classified and what determines what room they will be assigned to. The program has two single rooms that they can use for those youth needing this, one on the female side and one on the male side.

Examples:

The files inconsistently documented the youth’s assigned room and bed on the CINS Intake form (three of five files did not have this information). Four of the five files reviewed also did not have anything written under the 'summary observations/comments' section in the room assignment portion. Additionally, some of the Youth Room Assignment forms were not completely filled out (i.e. 2 were missing signatures of who completed the form and 1 was missing signature of it being reviewed).

3.04 Log Books

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

This agency has implemented policies and practices regarding its logbook to ensure staff are aware at all times of the hourly and daily routines of staff and youth. Policy SH 3.04 was last reviewed on 2/28/17. The policy states the direct care staff and supervisory staff are to review the book at the beginning of each shift.

The agency has written procedures detailing what must be included in logbook entries as well as how to record an error (single line strikethrough and “void” written by the error with the staff signature). Procedure also details that the program director or designee shall review the logbook every week and make a note as to any corrections, recommendations, and follow-up required. Additionally, oncoming staff should review the logbook for the previous two shifts to become aware of any unusual occurrences, problems, etc., and make an entry to document the review.

Five logbooks were reviewed and the supervisor and/or manager reviewed the logbook often, but not weekly as required by policy. It appeared this inconsistency occurred during a recent management transition. When the current supervisor was questioned regarding the logbooks she had adequate knowledge of what the logbook protocol entailed.

Throughout the logbooks, youth alerts were documented. The alerts in the logbook matched with the alerts on the intake files. It was also noted when youth came off of constant sight and sound watches. There were no signs of white out in any of the five log books reviewed. All visitations were documented in each logbook. As a whole, the logbooks are well written and contain a wealth of information about the shelter youth, daily activities, and any safety or security issues.

Examples:

There were some errors made throughout the log book, many of which did not have staff signature/initials as policy requires and instead just had a single line to strike through the error and in some cases had the word “Void” on top of the strike through, but not consistently. In addition, staff are not signing each log book entry but are just putting initials. While there is a legend at the beginning of the log book with all staff names, signatures and initials, both the agency policy and the Florida Network Standard state that staff signature will follow each entry. Staff did not consistently note that they are reviewing the last 2 shifts. It should be noted that the Supervisor review consistently addressed this issue throughout the last 6 months.

3.05 Behavior Management Strategies

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

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

The program has implemented policies and procedures needed to influence the youth to make better decisions and increase accountability and responsibility. After reviewing five intake files, it was confirmed that staff do explain the Behavior Management System (BMS) during the intake orientation process.

During the interview with the program supervisor, the BMS was explained in detail to the peer reviewer, including the process of implementing the Behavior Management System. There are positive reinforcements for seeking positive attention. The shelter uses a wide variety of rewards and incentives in order to motivate the youth. The program supervisor also explained their “Ninja Room” where the youth are allowed to purchase items for being positive during their stay. The organization also uses behavioral intervention practices to de-escalate youth verbally. They strive to use as little physical interventions as possible. This agency utilizes a process called Managing Aggressive Behavior as a behavioral intervention. There are two MAB trainers on site, the program director and the shelter counselor.

There were no exceptions to this indicator.

3.06 Staffing and Youth Supervision

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

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

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

The program maintains a schedule that includes the names of staff and shifts they are working and meets minimum staffing ratios. The overnight shift is staffed with two staff. The program attempts to maintain both genders on shift, however they have had periods where they were unable to employ male staff on a consistent basis. Recruitment efforts on the agency's website and on Indeed.com reflect efforts that target males. There is a staff schedule and holdover overtime roster that includes names and phone numbers which is maintained in a log book in the file room, accessible only to staff and is emailed to the staff when there are revisions. There is documentation in the house log that bed checks and the whereabouts of all youth are made, on average, every fifteen minutes. There were times documented outside of the fifteen minute window (i.e. 18-20 minutes) but there were also times documented sooner than the required fifteen minutes (i.e. 10-12 minutes). Overall, bed checks are consistently done and documented throughout the log books.

There are currently eleven youth (six of them CINS/FINS youth) residing in the shelter. Youth were observed during indoor time working on activities and having lunch. There were two staff supervising and interacting with the youth at all times.

There were no exceptions to this indicator.

3.07 Special Populations

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

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

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

Three Domestic Violence Respite files were reviewed from the last 6 months. These were the only Special Populations files available for the review period. All 3 files contained accurate referral source documentation from the JAC. 3 of the 3 files contained case management notes relevant to issues pertaining to anger management or violent behavior.

No exceptions noted for this indicator.

3.08 Video Surveillance System

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There is a written policy that states that video surveillance will be used as a means to provide a secure environment, protect its facilities, and enhance the safety of youth, staff, and visitors. The policy was last reviewed on 4/17/2017.

There are written procedures that outline the areas that will be recorded, designated staff who have access to footage, written staff acknowledgement of surveillance, requests for footage, timelines for review and maintenance of footage, and purpose of footage reviews. Notification of surveillance is posted on the front entrance door, the side door, and the door leading to the outdoor recreation area.

There are nineteen cameras that are visible and record footage of public areas, indoors and outdoors and has battery backup. There is a list of staff who have access to footage which includes the Residential Supervisor and the Program Manager. There are two Office Specialists that serve as backup staff. The system captures and maintains video for one month. Documentation of reviews conducted twice per month or more often if there is an occurrence of an incident, is maintained in a log book and includes random reviews of the overnight shift. Video images were observed and clearly recorded areas and images and were dated and time stamped. Bed checks were observed on video and verified via log book on 6 occasions throughout the last month and all checks were completed as required and documented.

Exception:

There was no proof of camera review for September 1, 2017- October 25, 2017. Program Director reported this was due to previous management leaving during that time. Per agency policy and practice, camera footage is to be reviewed at least every 14 days and and will be documented in a review log kept by the director.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

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

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

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

4.01 Healthcare Admission Screening

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

The program has a policy (SH 4.01) Healthcare Admission Screening that governs the process of screening all youth upon admission, to the fullest extent possible, for acute or chronic health concerns requiring immediate attention.

The healthcare admissions screening process is to begin with first contact with the referral source to aid in determining if the youth is a match for potential services according to criteria in the CINS/FINS CENTRAL INTAKE SCREENING FORM. If no prohibitive conditions are discovered in screening, the youth may be admitted to the shelter.

Upon admission into the shelter the CINS/FINS INTAKE ASSESSMENT protocol instructs the youth care staff conducting the intake to inquire about, observe, and document health-related issues or concerns. Should the youth require immediate first aid or medical attention the program follows the protocol to administer aid or arrange for transport to the adequate level of care required.

Should the youth be accepted into shelter, but require on-going supervision and monitoring for a concern, the medical alert process will identify by a letter-coded system the condition for which the youth is being monitored.

Seven files were reviewed for the required elements. The nurse was also present and available for the duration of the review process. She provided ample description of the priorities and process for the completion and review of physical health screening upon admission.

Exceptions:

Incomplete documentation for youth admitted on 2/24. There is no indication of screening for physical markings, no indication of parental notification, head injury question marked "N/A" rather than Y/N.

No evidence of health screening questions completed for Intake on 2/16.

Fields titled "Head Check" incomplete.

If youth is admitted and discharged before nurse can see them, the nurse does not review the file or specifically the physical health screening. "Has to focus on the youth who are here."

Nurse stated that she can be contacted when not on-site (off-duty) because she is full-time and salary. Nurse Palmer currently splits duty between RAP house and New Beginnings.

Youth 4/2/01- DV Respite Client- Pregnant, Asthma- no meds, Seizures-no meds. Checked "yes" for pregnancy. Does not indicate if currently pregnant or in the past.

Youth Intake 9/20/2017 Tuberculosis questions blank on initial screening, but full assessment elsewhere in file.

Consistent practice of leaving physical health screening questionnaire blank if client does not indicate for conditions.

4.02 Suicide Prevention

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

The program has a policy in accordance with CINS/FINS Indicator 4.02 governing the specific requirements for screening all youth for risk of suicide and to implement procedures to intervene in the event of an attempted suicide.

Each youth is screened for suicide risk in accordance with Florida Network's Policy and Procedure Manual for CINS/FINS. The initial screening occurs at first contact with the referral source prior to the youth's potential admission into services. If the youth indicates a high or imminent risk for suicide they may referred to emergency services immediately, or the youth may be admitted to services for further screening and evaluation. If youth indicate affirmative to one of six questions at intake they are immediately referred for evaluation by clinical personnel. The youth may be placed under constant sight and sound supervision until the evaluation is completed. The youth cannot be removed from Sight and Sound Supervision without the approval of a licensed clinical staff, or an unlicensed clinical staff under the supervision of a licensed clinical staff.

The program demonstrates consistent practice of evaluating suicide risk at the screening and intake stages and when necessary assigning the youth to heightened levels of supervision.

Exceptions:

The observations of sight and sound are missing key elements of documentation. In all instances the sight and sound log does not include 30 minute interval behavioral observations. The form contains location of the youth, initials of the staff, and time intervals handwritten at exact 5 minute intervals. The practice of staff signing the bottom of the form is inconsistent with instances of shift leader staff signing, but not monitoring staff who initialed the observations. In other instances the monitoring staff signed off, but not the shift leader. The internal form used by the program provides for a selection of level of supervision between "constant sight and sound" and "one to one supervision." The majority of files reviewed did not indicate either option. In one file reviewed it could not be determined when youth was taken off of heightened supervision by a licensed counselor.

4.03 Medications

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency ensures safe, uniform medication control and management.

The program adheres to the established practice as outlined in the Florida Network's 2017-18, CINS/FINS Policy and Procedure Manual. All staff participating in the medication management process are to be trained by the Nurse to assist youth in the self-administration of prescribed medications. The program does not allow for the storage of OTC medications for general or specific use by the youth in residence. All medication is kept in the Pyxis Med-station 4000 which is stationed in a locked room with a half-door to accommodate the medication management process without bringing youth into the direct area of the documentation and med storage area. The program maintains a paper Medication Distribution Log in addition to the digital tracking system. All prescription medications are verified by the Nurse if on-site or by contacting the pharmacy directly if non-licensed staff are conducting the verification.

The program practice is in accordance with the above stated policy. This reviewer witnessed the medication distribution process for one client. The Nurse discussed the importance of not missing antibiotic medications, as the youth refused the previous evening due to a conflict with the youth care worker assigned to medication for that shift. The youth was engaged and listening throughout the process. Once the medication was administered the youth received a small cup with 3 M&M candies as he has complained about the taste of the water and the medication. The Nurse demonstrated positive youth development principles by including the youth in the decision-making process to take the prescribed medicine and listening to his grievances about other staff without discounting his emotions.

Non-licensed staff demonstrated proficiency with the Pyxis machine and associated procedures when requested to facilitate a controlled medication count and verification by witness.

Discrepancies are cleared at close of the shift and the nurse reviews all transactions weekly by accessing the Knowledge Portal data collection and tracking system. When necessary, non-licensed staff requiring corrective action or remedial training receive this from the nurse directly.

No exceptions noted.

4.04 Medical/Mental Health Alert Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Program policy states that each shelter shall have an effective medical and mental health alert system in place to communicate the youths' medical condition, allergies, common side effects of prescribed medications, foods, and medications that are contra-indicated, or other pertinent information relevant to treatment that must be communicated to staff.

The program utilizes a letter-based code system to mark individual files and the shelter census board to indicate one or more of the following conditions:

A. Mental Health

B. Substance Abuse

C. Suicide Risk/History of Self-injurious behavior

D. Medication

E. Allergies

F. Flight Risk

G. History of Physical/ Sexual Aggression

H. Medical Issues

The program utilizes the described alert system uniformly for the census board in the shelter and in the youth files. All known allergies for staff and clients are posted in two locations in the kitchen, and reflect the current population and staff roster.

5 files were reviewed for medical/mental health alert systems compliance. All files were consistent with the coding system, and for those clients in shelter, the codes were also reflected accurately on the census board. Allergies were noted on the outside of all files, as well as on 2 marker boards in the kitchen, an the census board in the shelter as well.

No exceptions noted for this indicator.

4.05 Episodic/Emergency Care

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policy governing the response protocol for youth in need of emergency medical or dental care.

The policy stipulates the requirements for transport, referral, parental notification, and communication of needs related to follow-up care for youth who received emergency services. All incidents are recorded in the logbook and through internal incident reporting process. Upon return to the program from emergency services, all relevant documents related to aftercare and services rendered are copied for the Nurse and the originals are placed in the client files. The nurse reviews all documentation once on-site and assists the youth and/or family with understanding procedures and expectations for medical protocols.

The program is following their internal policies governing this indicator. The nurse and program staff were interviewed to affirm that stated protocol is consistent with practice. In files reviewed, medical documents related to follow-up and medication were placed in the youth files with side-effects highlighted and annotated according the alert process. All first aid kits were well-stocked and inventoried weekly by the nurse. This log is maintained in the nurse's office. The program also maintains a stocked hurricane supply kit which is zip-tied closed to ensure that the contents remain in the container in case of emergency. Training files were reviewed for staff compliance with First Aid and CPR training. The nurse also provided documentation for her own certification as an instructor for these courses. Knife-for-Life and wire cutters are well-maintained and available to staff.

No exceptions noted for this indicator.