Florida Network of Youth and Family Services Quality Improvement Program Report

Review of YFA-New Beginnings

on 11/14/2018

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

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	Failed
2.07 Youth Records	Satisfactory
2.08 Sexual Orientation, Gender Identity/Expression	Failed

Percent of indicators rated Satisfactory:75.00%
Percent of indicators rated Limited:0.00%
Percent of indicators rated Failed:25.00%

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	Failed
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:0.00%
Percent of indicators rated Failed:12.50%

Standard 4: Mental Health/Health Services

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

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

Percent of indicators rated Satisfactory:46.43%
Percent of indicators rated Limited:0.00%
Percent of indicators rated Failed:53.57%

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

Ashley Davies - Lead Reviewer

Gwen Nelson - DJJ Peer Reviewer

Persons Interviewed

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

0 Case Managers
0 Program Supervisors
0 Health Care Staff

0 Maintenance Personnel
0 Food Service Personnel

0 Clinical Staff
0 Other

Documents Reviewed

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

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

Surveys

1 Youth 0 Direct Care Staff

Observations During Review

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

Comments

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

Strengths and Innovative Approaches

Rating Narrative

Standard 1: Management Accountability

Overview

Narrative

1.01 Background Screening

☐ Satisfactory ☐ Limited ☒ Failed

Rating Narrative

The program has a policy and procedures for Background Screening of employees, volunteers, and interns. The policy and procedures effective date was September 13, 2013 and the policy and procedures last review date was March 30, 2017.

The program's policy requires all applicants for employment must submit to a background screening and be compliant with current Florida Department of Juvenile Justice policies and procedures which requires a complete background screening before the applicants receive an eligible rating. The program's policy also requires background information from all local law enforcement agencies. The program's policy also requires a sexual offender/predator search be completed, and a record check of the Department of Motor Vehicles driving history on all applicants.

The program's policy requires federal criminal checks for all employees, interns, or volunteers thirty days prior to the employees, interns, or volunteers' five-year anniversary with the program.

The program's policy states on or about the beginning of January each calendar year, the program will submit to the Department of Juvenile Justice the Annual Affidavit of Compliance with Level 2 Screening Standards.

The program hired twelve staff since the last on-site Quality Improvement Review. The twelve staff were background screened and determined to be eligible for employment. The program had one staff requiring a five-year re-screening during this review period. The staff was rescreened thirty days prior to the staff's anniversary date. The Annual Affidavit of Compliance with Level 2 Screening Standards was submitted on January 29, 2018.

1.02 Provision of an Abuse Free Environment

☐ Satisfactory ☐ Limited ☒ Failed

Rating Narrative

The program has a written policy and procedures for the Provision of an Abuse Free Environment. The policy and procedures have all the key elements of the QI Indicator. The policy was last approved on 2/13/2016 and signed off by the Chief Operating Officer and Vice President of Prevention Services.

The program shall provide an environment free of physical, psychological and emotional abuse. The program has a code of conduct that prohibits the use of physical abuse, profanity, threats, or intimidation. The written procedure includes a section for code of conduct, grievances, abuse and neglect reporting, client access to reporting, and allegations against staff. Staff is directed to follow the American Counseling Association (ACA) Code of Ethics and Standards and Practice. Any deviation from the policy shall be reported to appropriate management staff or other appropriate program. All employees and volunteers are obligated to report any abuse and/or neglect to the Florida Abuse Hotline. During intake youth are informed by staff they have the right to have unimpeded access to the telephone to report if they have been mistreated.

The program has a code of conduct for staff members that prohibits the use of physical abuse, profanity, threats or intimidation by staff of the youth. The Florida Abuse Hotline and the CCC numbers are posted in the living room. The program has conducted in-service and pre-service training on child abuse reporting for all staff. The program's management took immediate action to address two substantiated incidents (improper supervision and improper search). The program provided documentation showing one staff received coaching and one received an oral reprimand. The program provide has a policy and procedures for youth to file a grievance. At intake and in the youth's handbook the grievance process is explained. Grievance forms are in the living room and on the wall next to the program director's office. Both grievance boxes were locked. The program grievance form allows for the youth to provide feedback.

There were a total of twenty-six grievances and nineteen did not have dates of completion by staff.

1.03 Incident Reporting

☐ Satisfactory ☐ Limited ☒ Failed

Rating Narrative

The program has a written policy and procedures incident reporting. The policy was last revised on 10/20/2015. The policy was signed by the President/CEO and Board Chair.

The program's policy and procedures states all incidents not consistent with normal or usual operation of program programs or its facility will be document promptly. The written procedure states the program will comply with Incident Reporting requirements, including report all incidents to Central Communication Center (CCC) within two hours of incident occurring or becoming aware of the incident.

There were thirty-one CCC reports in the last six months. All were reported within the two-hour time frame. Twenty-two CCC calls were medical related incidents, four youth on youth batteries, four contraband searches and one abscond. All incidents were documented in the program's log book.

1.04 Training Requirements

☐ Satisfactory ☐ Limited ☒ Failed

Rating Narrative

Two staff reviewed for 120 days only and both staff were missing one training each.

Two staff reviewed for first year training and one staff had 44 hours with two months left and other staff had 28 hours with 1 month left. One staff did not receive 4 required trainings in first 120 days and the other staff did not receive 8 required trainings in first 120 days.

Three staff reviewed for annual training. One staff had 7 hours with 1 month left. One staff had 6 hours with 3 months left. One staff had 22 hours with 2 months left.

Employees do not have an annual training hours tracking form documenting all trainings received and total number of hours. Each employee also needs to make sure all supporting documentation in maintained in an individual file.

1.05 Analyzing and Reporting Information

☐ Satisfactory ☐ Limited ☒ Failed

Rating Narrative

The program has multiple policies and procedures that outline its Continuous Quality Improvement (CQI) process (QI 275, dated 1/13/15), CQI Teams (QI 280, 9/1/16), and Data Collection and Evaluation (QI 350,12/1/15).

The program comprehensive CQI Plan for FY 2017-2018 describes the CQI structure, committees, stake holders, CQI cycles, data collection and analysis, reporting, and corrective actions. Staff are assigned to teams such as Peer Review, Outcomes Measurement, Risk Prevention and Management, Training, Safety Committee, Employee Retention, and Stakeholder Involvement. Each team has an appointed team leader who is responsible for coordinating team meetings and attending the CQI Council meetings. The CQI council and CQI teams meets quarterly. The Director of QI and Risk Prevention maintains a calendar and a log of all team meetings. Agendas for all team meetings and minutes are maintained in a binder for one year. The CQI teams are responsible for providing updates and recommendation to the CQI Council on a quarterly basis regarding areas outlined in the purpose and goals for each team. Quarterly reports are completed for each team. Annual reports are required from each CQI Team by July 31 for the FY activities.

The program does monthly reviews of case records through peer review groups. The reviewer completes a Review Tool for each case. Upon completion of case record reviews, the results are aggregated and a report is submitted to the VP of QI to be presented at the Executive Leadership Team meetings. The case reviews were last completed in October 2018. Incidents, accidents, and grievances are reviewed

quarterly by the Risk Prevention Committee and Safety Committee. The committees are responsible for reviewing incidents, accidents, and grievances for each program and report to the Executive Leadership Team. The Risk Prevention Committee and Safety Committee last meeting was September 19, 2018. Agendas and minutes of the meetings were reviewed. The Incident Report Rollup was reviewed for the current FY to date containing the aggregated monthly report of incidents, accidents, and grievances (if applicable) for the program's programs. Evidence of shelter staff meeting agendas showing discussion of Florida Network/QA, incidents, grievances, and safety during the staff meeting. Customer Satisfaction Data is reviewed by the Stakeholder Involvement Team. The Stakeholder team last met on June 19, 2018 and October 9, 2018. Copies of the agendas and minutes for these dates were reviewed. The survey results for the YFA New Beginnings CINS/FINS program indicate 100% satisfaction for the shelter for the period July 2018 through September 2018. Outcome data is reviewed quarterly by the Outcome Measurement Committee. The Outcome Measurement Committee last meeting was September 19, 2018. A copy of the agenda and minutes were reviewed. The team collects outcomes data for the CINS/FINS program separately and aggregates the data in a spreadsheet monthly. CQI Council discontinued April 2018. The Executive Leadership Team replace the CQI Council. The Executive Leadership Team meets monthly. The meeting minutes and agendas were reviewed and include attendees and reports from all committees+. Monthly review of NetMIS data is emailed out to the management team to review.

1.06 Client Transportation

☐ Satisfactory ☐ Limited ☒ Failed

Rating Narrative

The program has a policy and procedures for Client Transportation. The policy and procedures were last reviewed on February 14, 2017.

All staff transporting youth must be approved by the Human Resources Department. Drivers must complete the "Monthly Trip and Mileage Log" each time they use the program vehicles. Drivers must answer each of the questions on the log including the name of the driver, date, and time, the availability of safety equipment, client initials traveling in the vehicle, the origin and destination of the trip, any tolls incurred, and the odometer readings. The driver must ensure the shelter phone on the vehicle to communicate with the program. Staff should take an approved third party on transports, whenever possible. Third parties are approved program staff, volunteers, or interns. Staff will make every attempt to avoid single party transport situations; however, when this cannot be avoided staff will ensure that their supervisor or designee is aware and this will be documented in the logbook. Staff must consider the client's history and recent behaviors before transporting. Staff must ensure youth are seated in the back row of the vehicle during a single party transport. Staff who are concerned about any safety issues during a single party transport will maintain an open line of communication with the shelter throughout the transport. The program has a list of approved drivers that is sent out monthly from the program's Human Resources (HR) Office. The Human Resources Department uses a system called Checkr to randomly runs driver's license checks on employs and flags the employ if the license comes up invalid. All drivers are covered under the company's insurance policy.

The shelter maintains a Single Youth Transport Log. This log documents the date, the client name, reason for transport/destination, supervisor approval, supervisor initials, departure from/time of departure, destination and time of arrival, mileage to and from, and staff name. The Single Youth Transport log is completed for all single youth transport. The program documents in the shelter logbook all the single youth transport begins and ends. The Shift Lead or Program Manager is notified prior to a single youth transport and approves the transport and initials the log. Prior to transport, the staff takes into consideration the youth being transported, including the youth's history and recent behavior, and if there is need for additional support. The staff on the transport keeps an open line of communication on a cell phone, with a staff member at the shelter, during single youth transport. There were seventy single client transports documented in the log in the last six months. A Monthly Trip and Mileage Log is maintained for non-single youth transports. This log documents the date, driver, safety equipment, number of youth, purpose, stops, and odometer start and end. These logs are maintained for the two vans the shelter uses for transports.

1.07 Outreach Services

☐ Satisfactory ☐ Limited ☒ Failed

Rating Narrative

The program has a written policy and procedures for Outreach Services. The policy was last reviewed on 3/27/2017 and signed by the President/CEO and Board Chair.

Staff shall seek opportunities to conduct ongoing community and education to communicate the Program mission, role, functions, capabilities, and the strengths, needs and challenges confronting children and families.

The program's community outreach policy and procedures provide for staff to participate in educating the community about program services.

Staff members encouraged to join state, county, and district boards. Participate in community forums on issues of youth and families. The staff members are encouraged to attend DJJ circuit meetings.

The program maintains binder with documentation of inter-program agreements. The staff attended events in the community from NetMIS. The staff attended twelve events between May and October 2018. The staff attended the Department of Juvenile Justice Circuit meetings. Copies of agendas and minutes from the last two meetings were provided. The program has outreach agreements with Baycare, Bene's Career Academy, Pasco Kids First, United Way of Hernando County, Lighthouse for the Visually Impaired and Blind, Pasco Sheriff's Office Special Victims Unit, Sumter County School Board, and Saint Leo University. All outreach agreements are up-to-date.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

2.01 Screening and Intake

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure that was revised 2/14/17 and signed by chief officer and vice president of preventative services. The policy addresses all of the elements of the indicator.

Procedure; screening began at first contact and no later than seven days from the youth being referred to the program. During intake they are given service options, Youth and the parent/ guardian will receive rights and responsibilities, possible actions occurring through involvement with CINS/FINS services and the grievance procedure.

There were six cases reviewed and all six were referred for truancy. Three of the six cases were opened within the seven calendar days. One case the open date was eight days from the referral date. Next case the opened date was 2 weeks from the referral date, there was case notes stating that the case manager tried to contact the parent for an intake session. The next case the intake date was about two and half weeks. The case manager made case notes stating that there were attempts to reach the family for an intake session.

The files had the appropriate documents signed by the parent, youth and staff members. The family was given the appropriate documents needed to be signed in order to authorize services.

There were three Domestic Violence files reviewed. Of the three files one file didn't have a treatment plan. There was a case note stating that the client was discharged.

no exception

2.02 Needs Assessment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Policy: The agency has a policy in places for the Needs Assessment, last reviewed 2/14/17 and signed by the Chief Operating Officer and Vice President of Prevention Services.

Procedure: The needs assessment is conducted to get a general background of the client and their family. The assessment is completed by a staff member who has a Bachelors Degree or a Masters Degree. The Needs Assessments are to be completed within 72 hours of admission. If a more intensive assessment is determined to be needed, a referral will be completed and documented in the case file. An updated needs assessment shall be conducted every 6 months or when otherwise indicated.

· The Needs Assessment will be completed within two face-to-face contacts following the initial intake if the youth is receiving nonresidential services.

· If the suicide risk component of the assessment is required (as a result of the suicide risk screening then it must be reviewed (signed and dated) by a licensed clinical Supervisor.

There were six files reviewed, all of the files had assessment completed within 72 hours of admission or done within 2 to 3 face to face contacts. The assessments were conducted by a staff member that had a BA or MA, there was a supervisor signature upon completion and there was risk of suicide.

One of the files reviewed the signatures on the treatment plan sheet for the parent didn't match the dates signed by the youth and the Staff member. Also on the treatment plan sheet the target date is 7/2018, case was opened 7/24/18.

There were three Domestic Violence files reviewed. One file the after care plan didn't have the parent signature. There was a case note that stated that the Dad refused to pick up the client from the shelter.

Another file the client was places on sight and sound, client was referred for further assessment and was later taken off of sight and sound.

no exceptions

2.03 Case/Service Plan

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has written policy and procedures that address the elements of the indicator. The policy was last updated 2/14/17 and signed by the Chief Operating Officer and VP of Prevention Services.

All clients file shall contain a service plan. The service plan are goals that the client shall achieve

If the CINS/FINS program is unable to provide needed services, a written referral will be made by the counselor.

· For mental health or substance abuse referrals, the counselor will refer to either licensed or certified substance abuse mental health provider or to the local community mental health center.

· The service plan and the After-Care plan will be developed with the youth and, if possible, the parent/guardian at the time of the Needs Assessment and no later than seven working days following completion of the Needs Assessment.

· If service plan cannot be signed by the youth or the parent the counselor will document the reason for unavailability and will make efforts to review and obtain a signature as soon as possible.

· Service plan will be reviewed every thirty days at a minimum for the first three months by counselor/parent or guardian and every three months thereafter. These reviews shall be documented, and highlighted in yellow in the youth's file on the Chronological Contact Sheet and Progress Notes.

· At the end of 90 days or at any time there are significant changes in the youth's progress and goals, a new Service Plan must be developed with the youth and family.

· The Service Plan and aftercare plan are reviewed and signed by the program director.

There were a total of six Non- Residential files reviewed, three closed and three opened. All six files had service plans developed within seven days of the needs assessment. Five of the files had the individual goal, person responsible, completion date if the file was closed or it had the target date, youth signature, parent/ guardian signature, counselor signature, supervisor signature, date the plan was initiated and the files were reviewed for progress.

One file target date was 1/3/18, I believe the date was supposed to be 1/3/19.

One file didn't have a completion date on the treatment plan but the file was closed.

One file the target date was 7/2018, the target date should be set for a later date. On the treatment service plan there wasn't a location for treatment stated.

There were three Domestic Violence files reviewed, 1 client was discharged before the 30 day review. 2nd file there was no completion date on the treatment plan, doesn't have parent signature on the plan. 3rd file there was no service plan completed nor was there an aftercare plan completed.

2.04 Case Management and Service Delivery

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has written policy and procedure that addresses the key elements of the QI Indicator for Case Management and Service Delivery as well as Family Involvement. The Case Management and Service Delivery policy was last reviewed on 2/14/17 by the Chief Operating Office and VP of Prevention Services.

All clients shall be assigned a counselor to assist in the provision of needed or assigned services. Youth and Family Alternatives, Inc. believes

families should be engaged in assessment, planning, implementation, monitoring and follow-up care. Both residential and non-residential counselors and staff will encourage family input and involvement in decision making for the youth and family.

Each youth is assigned a counselor who will ensure the delivery of services through provision or referral.

Case management process includes: establishing referral needs and coordinating referrals to additional services if needed, continue case monitoring and case termination with follow up.

There were six Non- Residential files reviewed there was a counselor assigned to the case, there were no referrals made based upon the clients on-going assessments. Service plans were implemented, monitors youth progress and provide support for the family, there was no need for out-of-home placement. There were no referrals for case staffing, no court hearings, there were no referrals for additional services. The 30 or 60 day follow ups were kept in a binder.

There were three Domestic Violence cases reviewed the 30 or 60 day follow up was located in a separate binder.

2.05 Counseling Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure that addresses the key elements of the QI indicator for CINS/FINS Counseling Services and Family Involvement. The policy was last reviewed on 2/14/17 by the Chief Operating Officer and VP of Prevention Services.

Youth and families receive counseling services, the services address the needs that are identified during the assessment process. the counseling services reflect all case files for:

· coordination between presenting problem(s)

needs assessment

· case/service plan

· case/service plan reviews

· case management and follow-up

· maintain individual case files on all youth and adhere to all laws requiring confidentiality

· maintain chronological case notes on the youth's progress

YFA also maintains an ongoing internal process that ensures:

· clinical review of case records

· youth management

· staff performance regarding CINS/FINS services.

This site don't do group counseling.

There were six files reviewed, three closed and three opened. The needs assessment was done, the initial case/ service plan and case service plan review was done. The files contained case notes for all counseling services provided and it documented the youths progress in the program. The files contained on-going internal process that ensures clinical reviews of case records and staff performance. The youth and the family received counseling services in accordance with the service plan. The program provides individual/ family counseling, there is no group counseling sessions at this site so this section doesn't pertain to the six Non- Residential files.

There were three Domestic Violence files reviewed 1st file the client didn't have any family counseling sessions. The family refused to pick up the child. The child was picked up by a CPI. 2nd file client attended counseling group for at least an hour. 3rd file client attended counseling groups.

no exceptions

2.06 Adjudication/Petitiion Process

☐ Satisfactory ☐ Limited ☒ Failed

Rating Narrative

Reviewed a total of 3 non-residential files that had been referred for Case Staffing.

Although none of the case files reviewed indicated that a parent or guardian initiated the case staffing, the program's procedural policy on this indicator requires that it be held within 7 days of such a request. In each of the files reviewed, documentation confirmed that each youth's family was notified of the case staffing well in advance and no less than five working days prior to the staffing. The documentation further indicates that every staffing included a school district representative, a program representative and at least one parent of the subject child, as well as the youth. Each file contains a revision to each youth's treatment plan as a result of the

case staffing and a written Summary of the case staffing, which outlines the recommendations and basis for them, is documented as being provided to the parent/guardian of each youth within 7 days of the case staffing.

None of the files reviewed contained a judicial intervention or summary review in preparation for a court hearing; however, the program's procedural policy for this indicator requires the counselor/case manager to prepare a review before a court hearing and to work with the circuit court for judicial intervention for the youth and family.

The program provided a CINS/FINS Case Staffing Notebook indicating that it has regular communication with committee members which, in addition to the program's staff, include: DJJ representatives, DCF representatives, Mental Health providers, State Attorney, School District and Law Enforcement officials. This notebook further established that the program has an internal procedure for the case staffing process and at least a monthly schedule for case staffing.

2.07 Youth Records

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has written policy and procedures that addresses the key elements of the QI Indicator for Youth Records. The policy was reviewed 2/15/17 by the Chief Operating Officer and Vice President of Prevention Services.

The program maintains confidential records for each youth that contains information involving the youth and his/her treatment at the program. All records are marked "confidential" and kept in a secure room or locked in a file cabinet that is marked confidential, which is accessible to program staff. All records that are transported are locked in an opaque container that is marked confidential. Youth records are maintained in a neat and orderly manner so that staff can quickly and easily access information

There were six files reviewed three opened and three closed. The six files were marked "confidential", the files were brought from another location, during transport they were kept in a locked black bag. All files were maintained in a neat and orderly manner.

There were three Domestic Violence files reviewed, the files were marked "confidential" and they were kept in a neat and orderly manner.

no exceptions

2.08 Sexual Orientation, Gender Identity/Expression

☐ Satisfactory ☐ Limited ☒ Failed

Rating Narrative

The agency has a draft policy in place that was developed in July 2018. The policy is awaiting approval by the CEO and COO.

Youth will be addressed by their preferred name and gender pronouns. All staff, service providers, and volunteers are prohibited from engaging in any form of discrimination or harassment of the youth based upon their actual or perceived sexual orientation, gender identity, or gender expression. All staff, service providers, and volunteers who have intentional contact with youth will have knowledge of this policy. Areas in which youth reside or are served will have signage indicating the program is a safe space of all youth regardless of actual or perceived sexual orientation, gender identity, and gender expression. Youth will be identified in the logbook and all public-facing documents by their preferred name and gender pronouns. Youth are to be assigned a room aligning with their gender identity, or the program will provide specific

documentation as to why other room assignment was determined to be suitable. Youth will be provided with hygiene products, undergarments, and clothing that affirms their gender identity or gender expression.

All volunteers who enter the shelter are required to read the Zine, located in the lobby, prior to entering the shelter. The volunteers then sign a statement stating they have read and understand the pamphlet and that they will be respectful of any LGBTQ issues while in the shelter. All staff were also required to read the Zine and sign the same statement. This documentation is maintained in the staffs personal file.

The shelter has signage located throughout the shelter including in the: lobby, dayroom, hallways, intake office, and classroom, indicating the program is a safe space for all youth regardless of actual or perceived sexual orientation, gender identity, and gender expression. Signage includes signs of rainbows and statements in rainbow colors. Many of the signs throughout the shelter are signs youth in the shelter have painted and made themselves. The agency recently hung a new sign outside, at the entrance of the building, with the name of the shelter in rainbow colors and handprints in rainbow colors. Previous youth in the shelter designed the sign and the agency had the sign made.

The agency has had one transgender youth in the last six months. This youth was a female who identified as a male. The youth’s preferred name and gender pronoun were used in the logbook and on all outward facing documents. The youth was able to sleep on the male side dorm. The youth was able to wear the clothes the youth brought in and was provided male hygiene products. The youth was only in the shelter one day.

Standard 3: Shelter Care

Overview

Rating Narrative

3.01 Shelter Envonment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The Shelter environment shall be clean, neat and well maintained at all times. Shelter facilities shall be safe and to the extent possible, reflect a home-like environment.

The residential supervisor or designee conducts weekly inspections of the physical plant utilizing the physical plant checklist and daily room check list and attends to areas needing attention. The residential supervisor or designee maintains a log to note areas needing attention and facilitates needed repairs and maintenance as needed.

Random facility checks will be conducted by the Program Director, Residential Supervisor or Team Lead to ensure that all buildings are in presentable condition at all times. The Shift Lead or designee will conduct a formal daily inspection of the wings at least three times a day. Room checks include ensuring: beds are made and free of clothing; clothing is properly stored; furniture is in good repair; program is free of infestation; bathroom and showers are clean and functional; there is no graffiti on walls, doors or windows.

Fire drills were conducted monthly on at least two of the three shifts for the last six months. Emergency care drills were conducted monthly on at least one shift. The form documenting emergency care drills are in a binder includes date, time, type of emergency.

The shelter's environment is safe clean and extremely well maintained. Youth bedrooms were clean and well maintained. Each youth had their own individual bed with clean covered mattress, pillow, sufficient linens and a blanket. Youth wishing to lock up personal items can place them in the Matrix System. Youth are also given the opportunity to personalize and decorate their rooms within a set of guidelines. The rooms have client rights, shelter rules evacuation and disaster plans posted. There is adequate lighting in each room and space for youth to store their personal belongings. The bathroom and shower areas were clean and functional. The laundry room has functional machines and it is well kept and organized. There is a daily program schedule posted and it affords youth an opportunity for a variety educational groups presented formally and informally. The groups and activities are facilitated by counselors, direct care staff as well as outside providers.

Additionally there is SOGI signage throughout the building indicating the program's inclusion of everyone. The grounds on the exterior of the building were well maintained and free from debris. The exterior offers ample space and opportunity for youth to engage in pro-social and recreation activities.

The agency's health and safety inspections are current and in compliance. The agency's Group care Inspection was conducted by the Department of Health on 9/28/18 and was rated satisfactory. The fire safety inspections were conducted: extinguishers 1/2018; Sprinkler System 5/2018; Fire Alarm 2/2018 and Hood System 2/2018. There were no violations were noted.

No exceptions.

3.02 Program Orientation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place to ensure all youth are appropriately oriented to services upon intake into the facility or program.

At the shelter, client orientation is to be completed within twenty-four (24) hours. Orientation to the shelter is begun at the time of admission. At the discretion of the Youth Development Staff during the third shift (12 a.m.-8 a.m.) a brief orientation can be provided at the time of admission, while the comprehensive orientation is postponed until the following morning. It is the duty of the day shift leader to assign responsibility for completing the client orientation previously initiated during the third shift (12 a.m. – 8 a.m.).

Newly admitted youth and youth development staff participating in the orientation process are to sign and date the client orientation checklist confirming all provisions of the orientation. If a youth does not speak English, staffs are to utilize the language line should there be no in-house interpreter available. Youth are encouraged to ask questions during orientation.

The Client Orientation Process includes the following:

* Identification of key staff and their roles ·

* A review of emergency building evacuation procedures and a tour of the program ·

* A review of the suicide prevention process and alerting staff to any suicidal thoughts ·

* Room assignment ·

* A review of the daily program schedule ·

* A review of “Youth Rights”, “Grievance Procedures”, and how to contact the Florida Abuse Hotline ·

* A review of program goals and the services available ·

* A review of the behavior contracting process and its impact on eligibility ·

* A review of the visitation schedule, telephone procedures and mail procedures

* A review of the religious activities ·

* A review of program rules governing conduct and consequences if rules are violated ·

* A review of medical treatment procedures and how to access medical care services ·

* A review of how to access mental health services ·

* Review of policies on contraband, dress code, and expectations related to hygiene ·

* Review of linen exchange

At the time of the review, six files were reviewed. The review consisted of three open files and three closed files. It was noted that in one of the files there was no orientation checklist indicated all aspects of the orientation process was conducted. All other files contained evidence of youth being provided a comprehensive Youth Handbook. During the orientation process the handbook is reviewed with youth and program expectations and client’s rights are explained and discussed. Information on disciplinary action, the grievance procedure, activities, contraband and the level is part of the discussion. It was noted that the agency identifies the “buddy system” as an additional orientation step in their procedure. However, documentation of utilizing the buddy system was missing from three of the six files reviewed. It is recommended that the agency document an explanation in cases when the “buddy System” is not or cannot be utilized.

No exceptions.

3.03 Youth Room Assignment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

It is the policy of Youth Family Alternatives, Inc. to ensure all youth are protected in the shelter/residential program. All youth shall be interviewed upon admission to determine the most appropriate unit/sleeping room assignment.

During the initial screening and intake process staff will complete all forms appropriately indicating that all pertinent information has been obtained. Agency policy indicates “there are to be no blanks on any agency form”. Staff is to complete the admission sleeping assignment form to be reviewed with the Shift Leader or designee when assigning a youth to a room. Consideration of special needs, behavioral history, age, maturity level including identification of youth susceptible to victimization, individual needs, general physical stature gang affiliation, current alleged offenses, level of aggression, attitude, sexual misconduct, demonstration of emotional disturbance mental health, and exposure to trauma, is given when assessing a youth for a bed assignment.

There were six residential files reviewed for Room Assignments. All files contained information obtained during the intake process to support the appropriateness of room assignments. Information was collected on recent and past behaviors that could impact youth’s adjustment to the program. In addition, there was information documented pertaining to staff observations of youth during the intake process. The room assignments in the active files matched the census/ alert board. Alerts documented on each file were also documented on the alert board. Each youth room can be identified by the number on the door. It was noted that in one of the files that there was no documentation of date room was as the room assignment form was not dated by client or staff.

No exceptions.

3.04 Log Books

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

It is the policy of Youth Family Alternatives, Inc. to maintain log books in its shelter facilities to document daily activities, events and incidents in the program. Additionally, the logbooks are to be reviewed by direct care and supervisory staff at the beginning of each shift.

The agency has procedure in which logs shall be signed by all staff upon arriving or leaving assigned shifts. Direct care staff should read at least the previous two shifts in order to be aware of any unusual occurrences. Logbook entries which could impact the security and safety of the program may be highlighted. House census and room assignments will be noted at the beginning of each shift or when the house count changes.

The agency has a logbook policy in which safety and security issues are documented. The agency uses a highlight system which is consistent and easy to follow. The highlight system helps to distinguish and track significant activity. The occurrence of one to one transport, fire drills, youth movement and critical incidents was documented throughout logbook. Each activity is documented in a different color. Supervisory review is documented weekly in purple and used to provide evidence of the review.

No exceptions.

3.05 Behavior Management Strategies

☐ Satisfactory ☐ Limited ☒ Failed

Rating Narrative

Youth crisis shelters shall use proactive behavior management techniques that emphasize positive and preventive measures in the management of youth behavior. Restrictive behavior management in the form of physical restraint may be used only in an emergency and only as a means to protect a youth from imminent harm to self or others. Seclusion, mechanical and chemical restraint is strictly prohibited.

The program has a written description of the BMS, and it is explained during program orientation.

During intake, youth is explained the program rules, expectations, and the BMS system, also called the YDS system. Youth receives the youth handbook and signs off on it at admission. The YDS system consists of four different phases (Orientation, Education, Graduation and Collegiate). Youth are placed on orientation level for three days after entering the program. While on the orientation level, emphasis is on getting oriented to the program's core values (6 pillars of character) and youth development strategies (12 developmental outcomes).

Upon completion of orientation level, which requires setting a weekly goal, youth advances to the Education level. While on the Education level, emphasis is placed on youth's ability to demonstrate skills learned on the orientation level as well as to actively engage in educational activities, outings and groups. Upon completion of the Education level, youth advance to the Graduate level of the program. Once a youth is placed on Graduation level, the expectation is to enhance demonstration of the skills learned on the previous levels of the program. and start exemplifying the characteristics of a role model. The final level of the program is Collegiate. While on the collegiate level, youth are expected to exemplify the characteristics of a role model and serve as peer leaders. Additionally, youth putting the six pillars (Responsibility, Respect, Caring, Citizenship, Fairness, and Trustworthiness) into practice affords them the opportunity to start earning money (monopoly money) to buy the desired items from the "New Beginning Box."

Staff members observe and coach youth through the level system. Youth are introduced to the system during the orientation process and are supported until discharge. The "Reflection Form" is utilized to assist youth in correcting negative behaviors. If youth disrupts the program, not following program rules, disrespectful to staff members or other youth, then the youth is reverted to a lower level or is placed on reflection level. At this level, youth complete the "Reflection Form" which is designed for youth to be accountable and reflect on behaviors that help them to make the necessary corrections.

3.06 Staffing and Youth Supervision

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Policy: It is the policy of Youth and Family Alternatives, Inc. that shelter Programs are appropriately staffed to ensure adequate supervision of youth, and safety and security of youth and staff.

The agency strives to maintain one male and one female staff member on duty at all times. A staff to youth ratio of 1:6 is maintained, and additional staff is activated for coverage, whether there are two staff members and the population of the shelter, exceeds twelve youth. The full and part-time employees are contacted for shift coverage by the Program Director or designee. In the case the full and part-time employees cannot fulfill the coverage, the Program Director and Residential Supervisor are on-call on a twenty-four-hour basis for shift coverage. Staff will observe youth at least fifteen minutes while they are in the bedroom/sleeping area regardless of the time of day/circumstance. An entry will be made in the communication log book every fifteen minutes. For youth placed on Constant Sight and Sound, their whereabouts will be noted

every five minutes.

The agency has a policy in place for Staffing and Youth Supervision. The staff schedule is maintained at the staff station and is emailed to all staff. There is also a Shift Coverage protocol in which the expectation is for staff to attempt to secure coverage from another staff member for their shift. In the event they are unable to secure coverage, the Program Manager will be responsible for getting coverage and maintaining compliance. A staff list with phone numbers is located at the staff work desk in case additional coverage is needed. Staff schedules reviewed for the last six months reconciled with the program's logbook revealed that on numerous occasions the agency was unable to staff the program with male staff. The program provided documentation to support efforts to hire male staff over the last review period (six months). Six individuals were reportedly offered employment, accepted and failed to complete the process. The dates of the offfers:5/10/18; 7/18/18; 7/31/18; 8/10/18; 8/24/18 and 10/8/18.

The site has a surveillance system that is located at the staff desk and also in the Residential Supervisor's office. Both stations monitor the daily activity in and around the facility. Random samples of the overnight shift revealed bed checks were being conducted while youth were in their rooms during the hours of sleep in 15 minute increments.

Staff schedules reviewed for the last six months reconciled with the program's logbook revealed that on numerous occasions the agency was unable to staff the program with male staff. The program provided documentation to support efforts to hire male staff over the last review period (six months). Six individuals were reportedly offered employment, accepted and failed to complete the process. The dates of the offfers:5/10/18; 7/18/18; 7/31/18; 8/10/18; 8/24/18 and 10/8/18.

3.07 Special Populations

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The provider has a written policy and procedures in place that state shelters provide services to special populations such as Domestic Violence Respite (DV), Domestic Minor Sex Trafficking Youth (DMST), Probation Respite, and Staff Secure. Effective 4/1/16 signed by Chief Operating Officer and Vice President of Prevention.

Shelter provides services to both male and female youth ages 10 to 17 who meet the criteria and a certain exception can be made on a case by-case basis. There are a description of services, The services that are offered may be altered to the clients needs. Shelter staff are appropriately trained and complete training for the Florida Network. If YFA determines a referred youth is not appropriate for DV respite service, the shelter may decline the referral and contact the youth's JPO and JPO supervisor to review the referral if they are available. The services can be rejected due to youth's history of fire setting behavior, sexual offenses, need for acute inpatient care, or safety risk to other youth or staff.

A Domestic Violence youth may fill a bed for up to fourteen days, per admission. If additional bed days are needed, additional seven days shall be approved but will not exceed twenty-one days. Services to youth funded under Domestic Minor Sex Trafficking (DMST) will include enhanced supervision include positive activities designed to encourage the youth to remain in shelter. Referrals for Probation Respite must be received from the Department's Juvenile Probation Officer and may be approved for up to thirty bed days per admission. Youth eligible for staff secure placement must be adjudicated CINS/FINS youth. The youth meets the legal criteria outlined in Chapter 984 F.S. for being formally court ordered into staff secure services

The population that was serviced at this center was Domestic Violence. Three files were reviewed. There were no Probation Respite or Domestic Minor Sex trafficking files to review.

Three files reviewed for DV respite youth. Youth admitted to DV respite placement have a pending DV charge and have evidence of being screened by JAC/Detention or JPO. DV youth were discharged within twenty-one days and not transitioned to CIN/FINS or Probation Respite. The provider initiates youth's service/treatment plan addressing goals focusing on aggression management, family coping skills, or other interventions design to reduce re-occurrence of violence in the home, after seven days of admission. One of the files didn't have a case plan, the client was discharged seven days after coming to the center.

no exceptions

3.08 Video Surveillance System

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

YFA will utilize video surveillance technology at each of the three youth crisis shelters as a means to provide a secure environment, protect its facilities and enhance the safety of youth, staff and visitors. Such technologies, however, will be used only to meet YFA's critical goals for security and in a manner that is sensitive to interest of privacy, free assembly and expression. Video surveillance of public areas will be limited to uses that do not violate the reasonable expectation of privacy as defined by law.

The agency has a written policy and procedure to ensure that the agency is meeting the requirements set by the Florida Network to ensure the safety of all youth, staff, and visitors.

The agency shall have cameras in interior and exterior to cover general locations of the shelter. Cameras are not to be placed in private areas such as bathrooms or sleeping quarters. The recorded video is stored for a minimum of 30 days and stored in a separate storage for the length of time needed to complete investigation. Only designated staff trained to handle the equipment and monitor footage in an ethical manner. Supervisory review of the video is conducted bi-weekly and documented to assess the activities of the facility. The cameras have the ability to record date, time and location, and backup capabilities that enable cameras to operate during the power outage.

A review of the cameras on six dates from October 18, 2018 through November 12, 2018 revealed the room checks were being conducted in 15 minute increments. The time of the checks differed from the time documented in the logbook by 5-6 minutes consistently. However, they were conducted consistently every 15 minutes. Supervisory review of the cameras in maintained in a separate binder and maintains compliance by being conducted at a minimum every 14 days.

No exceptions.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

4.01 Healthcare Admission Screening

☐ Satisfactory ☐ Limited ☒ Failed

Rating Narrative

The agency has a policy titled Healthcare Admission Screening. The policy was last reviewed on January 24, 2018 by the Chief Operating Officer.

In determining the appropriateness of admission, staff shall inquire about any issues related to medications, symptoms of tuberculosis, physical health problems, allergies, recent injuries or illness, or any other potential presence of pain or other physical distress, substance abuse and or intoxication.

Upon admission staff shall utilize the CINS/FINS Intake Assessment and Health Screening form to inquire about, observe and document the following client related issues: mental health, dental or chronic medical conditions at time of intake, if client is currently under medical treatment or on medication, physical deformities or handicap, evidence of abuse or neglect, issues related to medications, symptoms of tuberculosis, allergies, recent injuries or illness, hemophilia, asthma, cardiac disorders, pregnancy, diabetes, substance abuse, and evidence of scars, tattoos or markings.

If the program has a nurse the nurse will review the youths medical history within five business days. Any mental health and or substance abuse issues/needs assessed in the CINS/FINS Intake, Health Screening, or Needs Assessment are to be addressed in the Individualized Service Treatment Plan. Whenever possible the parent should be involved in coordination and scheduling of medical appointments or care.

There were seven youth files reviewed. In five of the seven files a health care admission screening was completed on the day of intake using the CINS/FINS Intake Assessment. One of the remaining two files documented a health care admission screening was completed at admission using the Health Screening form. This form included all required information. The last file documented the CINS/FINS Intake Assessment was completed five days after admission and the Health Screening form was not dated so it could not be determined when it was completed. However, the Registered Nurse (RN) did review the Health Screening form the day after admission. Out of the remaining six files the RN reviewed all health care admission screening documents, within five working days, in five of the files. There was still time remaining in the last file for the RN's review. In addition, the RN also completes a very thorough health screening and a body chart on every youth within five days of admission. This was documented in six of the seven files reviewed. The remaining file was recently admitted and had not yet been seen by the RN at the time of the review.

In four of the seven files, the CINS/FINS Intake Assessment was not completed in its entirety. Two out of the four forms were not signed by a supervisor. One form did not include a date when the supervisor signed it. On three of the four forms the Physical Health section was left blank. It was inconsistent across the files reviewed as to how this section was being completed. In some of the files items would be circled or "none" or "NA" would be documented to indicate the section had been reviewed with the youth and there were no applicable conditions. In other files this section would be left blank if there were no applicable conditions. This made it difficult to determine if the section had been reviewed in these files.

There were no youth with any chronic conditions requiring any type of follow-up medical care. However, the agency does have a policy in place for the parent/guardian to transport the youth to any follow-up medical appointments. If the parent/guardian cannot transport the youth or refuses to then the agency will transport the youth for any needed medical appointments or follow-up care.

Faith - CINS/FINS Intake form not dated by supervisor and physical health section blank

Samantha - Physical health section blank

Mckenzie - CINS/FINS Intake form 5 days after intake, health screening form no date but reviewed by RN 10/26. So no health screening done at admission.

Gabrielle - CINS/FINS Intake form not signed by supervisor, physical health section blank

Alex - CINS/FINS Intake form not signed by supervisor

4.02 Suicide Prevention

☐ Satisfactory ☐ Limited ☒ Failed

Rating Narrative

The agency has a policy in place titled Suicide Prevention. The policy was last reviewed March 31, 2017 by the Chief Operating Officer.

Mental health and substance abuse screening begins prior to admission, in person, or via telephone, by utilizing the Centralized Screening Form. If over the phone or in person the parent/guardian reports youth is exhibiting current thoughts or gestures of harm to self or others the screener is to call 911 and document on the form the time and service that was called. Screener is to call on call supervisor and document the name and time of the call. The screener is to document what was said and done by the family and supervisor. Screener is to document if the abuse registry was called; if the report was accepted, who it was taken by, and the referral number. The supervisor will ensure that the family receives a follow up call from a clinical staff person within one business day for follow up and document. Screener will complete a YFA incident report.

At time of admission if the youth responds positively to any of the first six questions on the CINS/FINS Intake form Youth Development Staff (YDS) will complete the Evaluation of Suicide Risk among Adolescents (EIDS), as an additional screening tool. YDS will then score the EIDS and mark it on the EIDS Summary form. YDS will will review the EIDS with on call if a counselor is not on site.

An assessment must then be completed by a licensed professional or an unlicensed professional under the supervision of a licensed professional. The assessment will occur no later than twenty-four hours after the screening. The youth will be placed on Constant Sight and Sound supervision while awaiting assessment.

If at any time during the screening or at any time during the youth's stay at the shelter any staff observes or believes a youth presents as an immediate threat to themselves or others, the youth will be placed on One-to-One Supervision and staff will immediately call 911 and/or follow Baker Act procedures.

The agency uses two different levels of supervision. The first level used is One-to-One Supervision. This is the most intense level of supervision and will be used while waiting for the removal of the youth form the program by law enforcement or parent/legal guardian for the purpose of Baker Act assessment. The second level of supervision used is Constant Sight and Sound Supervision. This level of supervision is for youth who are identified as being at risk of suicide but are not expressing current suicidal thoughts or threats.

Documentation of One-to-One and Constant Sight and Sound Supervision will be completed in five minute or less intervals using the sight and sound form. Documentation should include time of day, behavioral observations, any warning signs observed, and the observer's initials. Documentation must be reviewed by supervisory staff each shift and must be placed in the youths file.

There were five youth files reviewed. In all five files the suicide risk screening occurred at intake using the six questions on the CINS/FINS Intake form. Two of the screening forms were not signed by a supervisor. All five files also documented the Evaluation of Imminent Danger of Suicide (EIDS) was completed on each youth. All five youth were placed on sight and sound supervision until an Assessment of Suicide Risk could be completed. All five files documented the Assessment of Suicide Risk was completed by the counselor within twenty-four hours or seventy-two hours if over the weekend. All the assessments documented a telephone consultation with a Licensed Mental Health Counselor (LMHC) from a sister shelter. Supervision of the youth was not changed until after this telephone consultation took place. The LMHC signed all the assessments the next time on site. The counselor maintained clear and consistent documentation regarding who the Licensed professional was and the exact time youth was removed from sight and sound. The staff maintain five-minute observations of the youth while on suicide precautions. These observations were documented for all five youth with the exception of a three-hour gap for one youth and an eight hour gap missing for another youth. There was also one observation sheet from another youth that was not reviewed by the supervisor nor dated. All other observation sheets documented a shift supervisor review.

4.03 Medications

☐ Satisfactory ☐ Limited ☒ Failed

Rating Narrative

The agency has a policy titled Medication Control and Management. The policy was last reviewed on March 29, 2017 by the President/CEO and Board Chair.

At the time of admission to a program youth and parent guardian will be interviewed about youths current medications. If a youth is prescribed medications the parent guardian must provide medications in the original prescription container with a patient specific label intact on the original medication container. If previous steps are covered staff is able to proceed to verification process.

Verification may occur by Staff, agency Nurse or youth counselor by contacting the pharmacy. Once contacted the script, contents on container should be verified. Verification must be documented in file and on youth verification form. Once completed medication can be loaded into the Pyxis.

All medications with the exception of refrigerated medications will be stored in the Pyxis. Only staff members that are trained in the assistance of self-administration of medication by a Registered Nurse are able to assist in the administration of medication. Staff should wash hands prior to commencing the process of medications and between each youth medication. Staff will verify 5 rights (right dose, right youth, right route, right patient, right time) before assisting with self-administration of medication.

Once youth is at ten days of medication shift leader or designated staff on duty is to complete a Low Med Alert Form and forward it to the youths assigned counselor.

Shift leader on duty shall complete Medication Release Form for all authorized discharges of any youth taking medication. YFA Shelters do not keep a supply of any Over the counter medications.

Staff members have access to the Nursing Drug Guide to research most current information regarding medication side effects and interactions. Inventories of controlled medications are completed shift to shift. A perpetual inventory is maintained on all medications in the youths individual Medication Log sheet.

The shelter provided a list of twenty-one staff who are trained to supervise the self-administration of medications. There were four staff on that list who were listed as “Super Users” for the Pyxis Med-Station.

The shelter has a Registered Nurse (RN) who is on-site every Tuesday, Thursday, and every other Friday. The RN also works at another shelter operated by the agency. During the hours the RN is at the sister shelter staff are able to call the RN with any problems or questions. During the hours the RN is not on duty at the shelter or the sister shelter staff call the nurse hotline with any questions or concerns.

The RN conducts training with all new hires on using the Pyxis Med-Station and distributing medications. This is a one hour training the RN completes one-on-one with the staff. The RN and staff initial each item on the training form when completed and the form is signed and dated by the staff and RN when all items are completed.

The RN runs a monthly KPI report, discrepancy report at least twice weekly, and an inventory verification report two to three times per month. These reports are discussed during the monthly staff meetings. In the last six months there have been four discrepancies and all four were closed out by the end of the staff members shift.

All youth medication is stored in the Pyxis Med-Station. Each medication is stored in its own separate bin within the Med-Station so topical medications are always stored separately. Only the youth’s prescription medication is stored in the Pyxis Med-Station. Medication storage will start in drawer two and once that drawer is full will continue into drawer three and so on. Drawer one is used for agency keys and credit cards that staff are required to sign out. Drawer five is used for over-sized medications. The shelter has a system in place for refrigeration of medication if needed; however, there was no medication that required refrigeration during the time of review. There was documentation the RN checks the temperature of the refrigerator at least once per week and documents the actual temperature on the weekly medication inventory sheet. The temperature consistently stayed between 36-46 degrees Fahrenheit.

Agency did not have any sharps other than metal lice combs. These are counted at least once weekly. Controlled medications are counted each shift and a list of all current controlled medications is maintained in a purple binder for inventory documentation. At the time of the review the shelter had one controlled medication. There was documentation this medication was inventoried each shift and each inventory was initialed by two staff members. A red binder is kept in the medication room which has all current Prescription Medication Log sheets for all youth on medication. There were seven youth taking prescribed medications at the time of the review. All Prescription Medication Log sheets were reviewed for all seven youth. According to the Logs all youth received medications as prescribed. A running, perpetual inventory was maintained for all these medications when given. The RN also completes an inventory of all medications in the shelter at least one time each week. All Prescription Medication Log sheets documented the youth’s name, allergies, doctor name, pharmacy, prescription number, reason for the medication, the medication name, instructions, dosage, possible side effects, beginning count, and documentation each time the youth received the medication. There is a picture of the youth located in front of the Log sheets. The RN reviews these Log sheets each time on-site and keeps a log of any corrections made to the sheets or any missing information added to the sheets. The shelter does not have any over-the-counter medications. All medications in the shelter require a prescription.

There was documentation the RN completes all remedial training and verbal coaching for all staff when needed. Documentation of this training and coaching was found all incidents that were reported to the CCC as medication errors during the last six months.

The RN maintains a Medication Destruction Record for any medications the agency is required to dispose of. There has been one medication in the last six months that was required to be disposed. This medication was documented on the log, along with the method of disposal and two initials of witnesses to the disposal.

4.04 Medical/Mental Health Alert Process

☐ Satisfactory ☐ Limited ☒ Failed

Rating Narrative

The agency has a policy in place titled Medical and Mental Health Alert System. The policy was last reviewed April 6, 2017 by the Chief Operating Officer.

At intake assessment a “medical alert” and an “allergy” label will be placed in respective order on the top left-hand corner on each case record identifying each youths medical condition or allergy. Youth Development Staff completing the intake documentation are to post the name of any youth with a medical alert or allergy on the Allergy, Medical and Risk Alert Board in the Medication Room, in the front of the file, and note the

codes on the census boards. Youth Development Staff are to document any special dietary needs and/or food allergies. Due to confidentiality rules/laws specific documentation of alleged HIV status as reported by a youth to staff is prohibited. In the event a youth requires emergency medical care, upon return to the facility the shelter will keep in the file a verification of receipt of medical clearance, discharge instructions and any follow up care that may be required. Staff will also ensure the “Medical Alert” and/or “Allergy” labels are updated to reflect any changes as appropriate.

Medical, mental health/substance abuse, allergies, flight risk, history of aggression, and suicide risk alerts are documented using codes A through H, with each letter representing a different alert.

There were seven youth files reviewed. All seven files had medical and allergy alert stickers placed on the top left-hand corner of the file. Alerts documented on the sticker on the front of the file corresponded with the alerts documented on the alert form in the front of each youths file. Any allergies documented in the youths file were documented on the “allergy” sticker on the front of the file. All alerts documented on the alert form in each file corresponded with alerts identified on screening and assessment forms completed during the admission process.

All alerts were appropriately documented on the youth census board. The medication room also has a board with all youth listed that are assigned to take medication and how frequently. The kitchen also has a board that has youth allergy/dietary needs listed.

There were no exceptions to this indicator.

4.05 Episodic/Emergency Care

☐ Satisfactory ☐ Limited ☒ Failed

Rating Narrative

The agency has a policy in place titled Episodic/Emergency Care. The policy was last reviewed on March 20, 2017 by the COO.

All staff are to have current training in CPR/ First Aid and the use of Knife for Life. The location of the Knife for Life, Wire cutters and First Aid Kits are indicated on the egress charts. Healthcare simulations are conducted on at least a quarterly basis. These are to be conducted on each shift and on various emergency situations. All instances of first aid and emergency care are documented as required. All deaths or serious adverse medical events shall undergo root cause analysis within the risk management process of the Critical Incident Review Team. The emergency preparedness/Disaster Plan ensures all staff are informed of potential emergency situations. The assigned counselor/Therapist is to contact the parent/legal guardian to make arrangements for and transportation to appointments for general medical care. In the event a Parent or guardian is unwilling or unable to transport a youth the Youth Development Staff will provide transportation. In an emergency event, the shelter will follow chain of command. However, any staff aware of a medical or mental health emergency situation is required to call 911 immediately.

The shelter keeps a Monthly Incident and Accident Review log that lists all emergencies/incidents that occurred which required medical attention or follow-up care, including but not limited to those incidents reported to the CCC. The log documents a brief description of the incident, the episodic care required, and if any follow-up care was needed.

In the last six months the agency has had twelve incidents in which a youth has needed transport from the facility for medical care. There was an internal incident report for eleven of the twelve incidents. The incident reports and documentation in the CCC detailed report documented all notifications to the youth’s parents and other required parties were made. The CCC report also documented a detailed description of the incident, care received, and any follow-up care needed.

Knife-for-life and wire cutters are maintained in the medication room. Also, first aid supplies are located in the medication room, pantry, and in each vehicle. The RN checks the first aid kits weekly and documents this on the First Aid Kit Inspection Log. Any items that are replaced or expired are documented on the Log.

The program has completed an Episodic/Emergency drill quarterly for the last quarters. The drill was completed on September 25, 2018 and involved a youth running into a tree resulting in blurred vision and confusion.