Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Sarasota YMCA

on 02/06/2019

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Standard 2: Intervention and Case Management

2.01 Screening and Intake	Satisfactory
2.02 Needs Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management and Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petitiion Process	Satisfactory
2.07 Youth Records	Satisfactory
2.08 Sexual Orientation, Gender Identity/Expression	Satisfactory

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

Standard 3: Shelter Care

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

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

Standard 4: Mental Health/Health Services

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

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

Percent of indicators rated Satisfactory:96.43%
Percent of indicators rated Limited:3.57%
Percent of indicators rated Failed:0.00%

Rating Definitions

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

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

Review Team

Members

Marcia Tavares, Lead, Consultant-Forefront LLC

Duane Gross, Program Manager, Children's Society West Palm Beach

Stephanie Lobzun, QI Monitor, Department of Juvenile Justice

Melissa Quinn, Clinical Support Director, Boys Town

Cindy Starling, Regional Coordinator, CDS Family & Behavioral Health Services, Inc.

Persons Interviewed

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

1 Case Managers
2 Program Supervisors
0 Health Care Staff

0 Maintenance Personnel
0 Food Service Personnel

1 Clinical Staff
1 Other

Documents Reviewed

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

0 # Health Records
0 # MH/SA Records
9 # Personnel Records
6 # Training Records
11 # Youth Records (Closed)
8 # Youth Records (Open)
0 # Other

Surveys

3 Youth
3 Direct Care Staff

Observations During Review

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

Comments

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

Strengths and Innovative Approaches

Rating Narrative

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

Sarasota Y is currently under the management of interim CEO Steve Bourne. Mr. Bourne has been with the agency for over ten years and most recently served as the Chief Financial Officer. The VP of Programs provided the following update of programmatic achievement and significant activities that occurred since the last onsite QI review February 12-13, 2018.

Sarasota YMCA former CEO Laura Gilbert resigned in November 2018. CFO Steve Bourne was named Interim CEO upon her leaving and remains the Interim CEO.

The program hired a new shelter counselor Dale Lewis as of 6/5/18. Mr. Lewis is a licensed mental health counselor.

A new alert system was implemented in December 2018. The new alert system includes use of colored dots/check mark which indicates if a youth has medical concerns, behavioral concerns, mental health concerns, substance abuse concerns, or no concerns at all. The program also maintains a shelter alert system log for each youth to document the type of alert each youth has, the reason for the alert, a referral column and a spot for resolution of the alert. A client board in the staff office indicates all youth currently residing at the facility including corresponding color dots/check marks next to their names indicating each youth's specific alerts/concern.

The agency is in the process of securing funds for renovations of the shelter. Minor renovations will begin in February 2019.

Turnover in the residential program resulted in the hiring of 5 new Behavior Coaches in the last 6 months. Non-residential services has also experienced turnover in counseling positions this year; however, the program has been successful in filling the vacated positions as recently as 1/21/19.

The TRIAD Alternative School Program closed in July 2018. Two counselors from the TRIAD Alternative School that closed in July 2018, transferred to the Family Services Program.

Staff participates in Crisis Intervention training with law enforcement 3-4 times per year and simultaneously conducts outreach.

Standard 1: Management Accountability

Overview

Narrative

The Sarasota Family Young Men's Christian Association, Inc. (YMCA) is a charitable nonprofit organization, qualifying under Section 501(c)(3) of the U.S. Tax Code. Sarasota Y is under the leadership of a Board of Directors and President and Chief Executive Director. The agency is currently under the leadership of the former CFO, Steve Bourne who is the interim President and CEO.

Sarasota Y operates the CINS/FINS Residential and Non-residential programs under the leadership of Sonia Santiago, VP and Clinical Director for Youth and Family Services. According to the organization chart revised December 2018, the Family Management Services is comprised of 7 fulltime and 1 part time Direct Supervision Consultants, and 1 youth shelter Clinical Consulting staff. The youth shelter is under the direction of Shad Rennick, Program Director. The shelter is staffed by a Program Coordinator, Residential Manager, a Counselor, a Case Manager, seven Behavior Coaches, and twelve part time PRN Behavior Coaches. At the time of the quality improvement review, the program reported vacancies for 2 fulltime behavior coach and an Administrative Assistant.

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

1.01 Background Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The provider has a Background Screening policy and procedure # 1.01 that was reviewed and signed by the President and Shelter Director in July 2018. Sarasota Y Youth and Family Services (Sarasota Y) requires each employee, volunteers, and interns to successfully pass appropriate governmental background screening prior to any offer of employment or volunteer service.

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

A total of nine (9) applicable personnel files were reviewed for eight (8) new staff and one staff eligible for 5-year re-screening. The eight new staff were hired after the last onsite QI visit and all eight files maintained evidence of eligible screening results prior to hire. One staff was eligible for a 5-year re-screening (DOH 7/17/13) and had the re-screening conducted prior to the staffs' five-year anniversary date. The program had no volunteers/interns providing service during the review period.

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

The agency submitted its Annual Affidavits of Compliance with Level 2 Screening Standards via email to DJJ BSU on 12/17/2018 prior to the January 31st deadline.

The program has developed a pre-employment assessment tool that uses behavioral interview questions, a method that has been determined through research to identify an applicant's skills and suitability through past behavior which is a good predictor of future behavior. The tool includes an interpretive guide that assesses the applicant's levels of essential skills such as: trainability, policy adherence, patience, supportiveness, judgment, and boundaries. In addition, the interpretive guide also helps to determine the applicant's risk to abuse youth. As of the date of the QI visit, the provider has not utilized the tool with any new hires since it is pending final approval and implementation and the current policy and procedure has not been updated to include the use of the pre-assessment tool with regards to suitability criteria and agency protocol.

No exceptions were noted for this indicator.

1.02 Provision of an Abuse Free Environment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The provider has a policy number 1.02 for Provision of an Abuse Free Environment which meets the requirement of the indicator. It is the policy of the Sarasota Y that the program provides an environment in which youth, staff, and others feel safe, secure, and not threatened by any form of abuse or harassment. All allegations of suspected child abuse in the home are immediately reported to the Florida Abuse Hotline. All allegations of suspected child abuse within the program are immediately reported first to the Florida Abuse Hotline and then to DJJ's Central Communications Center Hotline. The policy/procedure was last revised in August 2017 and reviewed in July 2018 and signed by the President and Shelter Director.

The provider's procedure indicates that all staff are expected to sign and comply with the program's Code of Conduct that prohibits the use of physical or emotional abuse, profanity, threats or intimidation.

Sarasota Y has a grievance process that is accessible to youth to file a complaint related to conditions and circumstances of a violation or denial of basic rights. The procedure is reviewed with youth by staff upon intake, and is included in the Resident Handbook. Direct Care Workers do not handle the grievance process unless requested by youth. All grievances filed will be handled directly by the Program Director or designee with the assistance of a witness.

Staff are required to report all allegations of suspected child abuse, whether in-home allegations by youth upon intake, or that occur while youth are at the Shelter. For In-Home abuse allegations, a call is made to the Florida Abuse Hotline and a full report is made and the call is noted in the Communications Log and Youth's file. An Incident Report is also completed and processed. For In-Shelter abuse allegations, a call is made to the Florida Abuse Hotline and DJJ Central Communications Hotline by the Director or designee within two hours of the incident or knowledge of the incident.

The Florida Abuse Hotline number is posted in the Shelter Living Room, dining room, conference room, education room and front lobby.

The Program Director provided a Code of Conduct form utilized by the agency; upon hire, staff signs the acknowledgement of receipt of the form and it is then placed in said staff's personnel file.

During the initial tour of the facility, it was observed that the grievance box and forms were mounted in accessible locations for youth to both obtain and file as needed. There were seven grievances reported by youth during the review period. Three grievances were between the Clinical Staff and youth. The youth and staff indicated a resolution was reached with the grievance was discussed with the Program Director. Two grievances were in regards to the uncleanliness of the female bathrooms. Meeting was held by Program Director with clients and the issues were resolved. Two grievances were in regards to client-to-client threats; each were resolved when the Program Director met with staff and clients alike. Staff are to continue to watch for signs of threats. Keep youth separated if an incident should arise. Notify PD immediately if and when this type of incident occurs.

During the initial tour of the facility, it was observed that the Hotline Number is accessible to youth and is posted throughout the facility in the Shelter Living Room, both male & female dorms, Dining Room, Conference Room, Education Room, Front Lobby, and above copier in Staff Office Area.

The program reported four incidents of abuse allegations since the last onsite visit. Two of the four calls were accepted by the Abuse Hotline. Per Sarasota Y's procedures, all child abuse hotline calls must be documented in the program logbook; however, staff did not document 1 of the 4 abuse hotline calls in the program log book. All four incidents of abuse allegations were documented on an Incident Report form.

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

No exceptions were noted for this indicator.

1.03 Incident Reporting

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The provider has a policy number 1.03 for Incident Reporting, which was last revised in August 2017 and reviewed in July 2018. The agency's policy meets the requirement of the indicator. The President and Shelter Director signed the Policy & Procedure.

The provider's procedure lists the requirements for documenting and reporting incidents which includes an "internal numbering system" for all incident reports, reported arrests by any staff, "out of the ordinary" incidents, and review and filing of incidents in the 24-hour report log. The Program Director will sign the original report and maintain an incident report file. Serious incidents (involving outside agencies, institutional

abuse, law violations, or injury) will be immediately reported to the on-call management staff. All incident reports will be reviewed by the Y Risk Manager to detect behavioral trends.

Five DJJ CCC reportable incidents occurred within the review period; all five incidents were reported within 2 hours of the incidents. All five incidents were entered accordingly in the logbook, as well as having incident reports completed and entered in the incident report file. The agency completed the necessary follow-up communications regarding incidents, including tasks and special instructions required by the CCC.

No exceptions were noted for this indicator.

1.04 Training Requirements

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The provider has a policy number 1.04 for training requirements which was last revised in August 2017 and reviewed in July 2018. The President and Shelter Director signed the policy & procedure.

The provider's procedure specifies training topics and timeframes for completion. There is a description of the organizations that will provide trainings along with which staff members will have access to JJIS/SVS. The procedure notes that each staff member will have a training file that includes documentation of completed trainings. The provider requires staff to attend a Pre-Service Orientation, Program Orientation & Job Shadowing with the Program Director or designated direct care staff within the first 30 days of hire. During the first year of employment, direct care staff will receive 80 hours of training. Additionally, specific trainings are to be completed within the first 120 days. Following the first year of employment, direct care staff receives at least 40 hours of training annually.

A total of six training files were reviewed, which comprised of two employees within 120 days of hire, and one employee within their first year but beyond their 120 days of employment. The other three were In-Service Staff training files.

One of the two staff (date of hire October 2018) is still within the initial 120 days of hire. The staff had completed 6 of the 12 mandatory trainings required within the first 120 days and had 19 days to complete the remaining required training. The third staff (DOH August 2018) is beyond the first 120 days of employment but did not have evidence of orientation training in the file and had not completed the required Skill Pro Suicide Prevention training during the first 120 days as required. All three staff are on target for completing the required annual 80 hours of training.

Two of the 3 in-service staff were on target or had completed the 40 hours of annual training. The third in-service staff (DOH 03/08/16) has accumulated only 16.5 of the 40 training hours needed annually and was only missing timely renewal of the Fire Safety training at the time of the review.

The provider hired a Clinical Shelter Staff during the review period; however, the staff is a licensed mental health counselor and therefore, there were no applicable non-licensed mental health clinical shelter staff applicable for this indicator.

Staff DOH: 8/10/18 (Over 120 Days) did not have the Program Orientation Training Checklist (required for first 120 Days) in the file. Suicide Prevention in Skill Pro was completed outside of the 120 day requirement on 2/6/18 during onsite visit.

In-service Staff - DOH 3/8/16 did not complete the refresher Fire Safety Equipment Training required every 2 years on time. The training was initially taken on 1/31/17 and expired on 1/31/19. It is noted that the staff completed the training on 2/6/19 during onsite visit.

1.05 Analyzing and Reporting Information

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The provider has a policy #1.05 that briefly describes how several sources of information is collected and reviewed for patterns and trends. The policy was last reviewed in July 2018 and was signed by the President and Shelter Director. Per the policy, data collected is shared with staff and identifies strengths and weaknesses as well as improvements to be implemented or modified.

The procedures indicate that the program has an Administrative Assistant who oversees the data collection. However, this position has been vacant since October 2018 and the responsibility was shifted to the Program Director in the interim.

The procedure reviewed outlines the specific data that is collected, staff positions responsible for collecting and reviewing the data, and the purpose for the data collection. Specifically, case files are reviewed during intake and discharge by the Program Director, Case Manager, and Director. Residential case files are also reviewed systematically weekly for intakes and again at discharge by the Program Coordinator or Case Manager for 100% of youth records. A file review checklist is used at intake to verify receipt of pertinent information during the intake process. Prior to discharge, case supervision occurs to ensure oversight of services and the client records. Upon discharge, a residential file review is

completed by the counselor/case manager, Program Director, Clinical Supervisor, and Administrative staff. The checklist includes all sections of file and the completed list is maintained in the closed file. Besides peer reviews, nonresidential files undergo supervisory reviews periodically. A quarterly review is also done by members of the PQI committee.

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

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

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

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

Peer record reviews are to be conducted quarterly by the PQI team using the Case Record Checklist provided by COA for the review of files. Peer review reports should be maintained by the contract manager. During the QI review, the Program Director provided documentation of the Case Record Checklist as well as the last peer record reviews held in August 2018 and stated that one is scheduled later in February 2019. Evidence of review of 6 shelter case files during the August 2018 peer record review was provided. Non-residential peer record reviews were not evident for the current fiscal year to date.

Incidents and accidents are reviewed and signed by a supervisor as they occur, or within 24 hours. They are supposed to be reviewed by the Risk Manager who completes a spreadsheet that delineates the type of incidents/accidents for the month which is reviewed by management to determine if there are trends. Trends are discussed at the Executive Director’s meetings. However, there was a turnover in the Risk Management position twice during the review period resulting in inconsistent reporting of incidents via the spreadsheet. Documentation showed the provider compiled incident report data for the months of July and August 2018 only. The agenda for the last Director’s Staff Meeting held in October 2018 included reporting of accidents and incidents.

The program reported 7 grievances filed by the youth in the previous six months. Grievances are reviewed and resolved by the Program Manager in a timely manner.

All youth complete a satisfaction survey at discharge. A compilation of the data is reported quarterly by the Shelter Program Director and also sent to Sarasota County Contracted Human Services. The non-residential program staff inputs the satisfaction data into Netmis and keeps the hard copy in the youth’s file. The program provided aggregated client satisfaction reports for each program that was generated from Netmis for the current FY to date. Shelter staff meetings agendas for the past six months were reviewed. There were no reviews of satisfaction survey results at staff meetings as required by the provider’s policy and procedure.

Outcome data is reviewed by management and discussed at the monthly director's meeting. Progress and trends are reviewed and any necessary changes to the process or system are made. Documentation of monthly Y Youth Shelter Reports demonstrate a review of these outcomes. Outcomes are also discussed at the Executive Director’s meetings: July and October 2018 and January 2019.

The VP of Program Services, Program Director, and Administrative Assistant review the NetMIS data reports monthly to determine missing data and maintain accuracy. Copies of the data reports are maintained and the data is incorporated into the Outcomes Reports.

Evidence of quarterly peer record reviews was not observed to be consistent with the provider’s policy and procedure and requirement of the QI indicator. There was no documentation of peer reviews conducted after August 2018 for the current FY. The Program Director stated the next peer review is scheduled for February 2019.

There was a turnover in the Risk Management position twice during the review period resulting in inconsistent analyzing and reporting of incidents and accidents, via the spreadsheet, and enforcing a review of trends by program staff to address areas of concern.

Satisfaction surveys are conducted by the program and entered into NetMIS. In addition, the shelter survey results are submitted quarterly to Sarasota County Contracted Human Services. However, there were no reviews/discussion of satisfaction survey results at monthly staff meetings as required by the provider’s policy and procedure.

1.06 Client Transportation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a current policy and procedures in place for client transportation. The program’s policy number is 1.06 and was revised in August 2017 and reviewed by the shelter director and the program President in July 2018. The policy and procedures follow the Florida Network of Youth and Family Services quality improvement standards.

The agency staff are required to pass a driver’s license background check prior to beginning employment. Upon hire the staff are required to pass an on-line training, as well as a physical driving training administrated by administrative personnel prior to being cleared to provide client

transportation. All staff who have completed the above listed requirements are covered under the agencies insurance policy.

The policy and procedures also require all vehicles to have a camera and the cameras are monitored by the program director, as necessary. The policy also requires if feasible a third party will be present in the vehicle while transporting a client. If a third party is not available for transport the client's history, evaluation, and recent behavior is considered along with the drivers work history and performance.

The program is required to document all vehicle usages and are required to indicate the driver of the vehicle, the date and time of transport, the mileage of the vehicle, and the purpose of travel and location. The staff providing the client transportation are required to document the purpose of travel and clients transported in the facility log book.

Each evening the program shall complete a school transportation schedule indicating the youth being transported to school along with the school they will be transported to. The transportation log is to be signed off on by the residential manager, shelter director or management team member.

The agency maintains an approved drivers list in the staff office. The program currently has five full-time behavior coaches, nine part-time behavior coaches, one case manager, one residential manager, one counselor, one program director and one program coordinator approved to transport clients. All approved drives have a valid Florida driver's license, passed the agency on-line training and physical driving training, and are covered under the agencies insurance policy. The program does not prohibit transporting a client without maintain at least one other passenger in the vehicle during the trip.

The program maintains a transportation binder which is where they maintain the daily school transportation schedule. A review of the binder indicated there were over six months of school transportation schedules, which were developed every evening prior to the next school day and were signed by the shelter director or designee. All school transportation logs also have a statement indicated they were approved by the Director and after review of the staff and client history any single client transports documented on the schedule are approved by the director.

The program has three Kia mini-vans, which they use to transport their clients in. There was documentation to support each min-van received weekly inspections conducted by the program coordinator. There was also documentation to support each vehicle had received maintenance services from the local Kia dealership.

An inspection of the three agency vehicles indicated each vehicle is equipped with a video camera and the shelter director indicated themselves, the program coordinator, residential manager, residential counselor, and case manager are the staff with permission to review the cameras.

A review of the three agency vehicles indicated each vehicle had a transportation tracker located within the vehicle. The transportation tracker indicates the date of the transport, time the vehicle was taken out, mileage out, fuel level, purpose of the transport, time in, mileage in, driver and the youth transported. A review of six months of transportation trackers were reviewed for all three vehicles and there was documentation each vehicle was used to transport the youth in the six-month period. All transportation trackers were filled out completed with all the required information.

There were no exceptions noted in any of the reviewed records.

1.07 Outreach Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The provider has a policy number 1.07 for Outreach Services. It is the policy of the Sarasota Y to participate in local DJJ board and council meetings to ensure services are represented in a coordinated approach to increasing public safety by reducing juvenile delinquency through effective prevention, intervention and treatment services. The policy/procedure was last revised in August 2017 and reviewed in July 2018 and signed by the President and Shelter Director.

The Program Director or designated staff attends the local Juvenile Justice Council for the 12th Circuit as well as the Safe and Drug Free Schools Meeting held by the Sarasota County School Board. The Program Director also attend the Human Trafficking Coalition Meeting for both Manatee and Sarasota Counties. In addition, a program designee participates in the Behavioral Health County meeting. Outside agencies provide groups for the youth at the shelter. The Program Director maintains written agreements with community partners.

The Provider regularly attends a variety of community meetings that occur on a monthly, quarterly and annual basis. Either the Program Director or the VP of Youth & Family Services (Clinical Director) attends meetings. Review of the Program Outreach Organizer depicted meetings with Safe and Drug Free Schools (SDFS) Advisory Committee, Youth Action Board and Behavioral Health Stakeholder' Consortium are attended monthly, 12th Circuit Juvenile Justice Advisory Board and Community Health Improvement Plan (CHIP) are attended quarterly, and the Community Alliance of Sarasota County Legislative Meeting is attended annually. Meeting agendas and minutes were provided, as well as verification, which indicates a representative from the Sarasota Y attended. The agency also has Interagency Agreements through a number

of community partners, which include services provided and a comprehensive referral process.

No exceptions were noted for this indicator.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

The Y provides centralized intake and screening twenty-four hours per day, seven days per week for youth who meet the criteria for CINS/FINS, Staff Secure, Domestic Violence and Probation Respite, and Domestic Minor Sex Trafficking. Sarasota Y does not provide intensive case management services and does not participate in the Family/Youth Respite Aftercare Services. Trained staff members are available to determine the needs of the family and youth during the screening and intake process. Residential services include individual and family counseling, and group services. Aftercare planning includes referring youth to community resources, on-going counseling, and educational assistance.

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

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

The Y is responsible for coordinating the Case Staffing Committee, a statutorily-mandated committee that develops a treatment plan for habitual truancy, lockout, ungovernable, and runaway youth when all other services have been exhausted or upon request from the parents/guardians. The Case Staffing Committee can also recommend the filing of a CINS Petition with the court. A review of cases staffed by the Case Staffing Committee is indicative that the provider has initiated case staffing for youth and files for CINS Adjudication as needed.

2.01 Screening and Intake

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Agency policy number 2.01 was last reviewed 8/18/19 and revised 8/16/18 b the President and Vice President. Policy does meet requirement by providing shelter services to youth and families twenty-four hours, seven days a week.

Families are contacted within seven working days of the original inquiry. Information provided at the intake includes; service options, rights and responsibilities of youth, parents and program; consent for services; confidentiality agreement, grievance procedures and HIPPA information and parent brochure. The non-residential program also provides information on case staffing procedures and the petition/adjudication process. All youth are screened for eligibility and appropriateness prior to intake. Screenings are completed by phone or in person. Non-residential counselors will contact the families within seven working days of the receipt of the referral. If admission is not appropriate for the youth/family referrals will be made to the appropriate community agency. The intake procedure includes the gathering of information with an intake assessment, needs assessment, service plan, NETMIS, consent for services, PAT and JJIS.

A total of 6 files were reviewed,3 open and 3 closed. All files had the eligibility screening completed within 7 days of the referral. All files documented that youth and parent/guardians received all available service options, rights and responsibilities, parent/guardian brochure, grievance procedure and possible actions occurring through involvement with CINS/FINS services in writing. Approximately 20 minutes of one intake was also observed. The Behavioral coach did a great job trying to build rapport and get the buy in from the youth while also getting paperwork completed. Empathy was observed and the behavioral coach also reviewed the grievance process during the intake.

No exceptions were noted for this indicator.

2.02 Needs Assessment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Agency policy number 2.02 was last revised on 8/14/18 and reviewed on 8/18/18. The policy was approved by the President and Clinical Director. Policy does meet the requirements of the indicator.

A Needs Assessment will be completed on all youth within 72 hours of admission for those in shelter care and within 2-3 face to face interviews with non-residential services. Shelter staff also completes a suicide risk assessment (ASR) when necessary. The ASR will be reviewed and signed by the Program Director and Clinical Director.

Needs Assessment for shelter and non-residential youth contains the following information; demographics, date of assessment and who was present, presenting problems, family/home constellation, education history, social history, delinquency, aggression, sexual misconduct, strengths, emotional/mental status, medical/physical disabilities, substance use, suicide history and staff impressions. Service plan is then developed based on information gathered from the Needs Assessment unless youth has been admitted to the Sarasota YMCA shelter within the last 6 months.

A total of 6 files were reviewed, 3 open and 3 closed. Six of 6 files reviewed had a needs assessment completed the same day as the intake. All six needs assessments were completed by bachelor's or master's level staff and all 6 files reviewed included a supervisor signature. Three of 6 files reviewed identified a risk of suicide and all 3 files then had an Assessment of Suicide Risk completed under the supervision of a licensed mental health professional.

No exceptions were noted for this indicator.

2.03 Case/Service Plan

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Agency policy number 2.03 was reviewed on 8/18/18 by the CEO and Clinical Director. Policy does meet requirements for developing service plans for each youth and family within seven working days, after the completion of the Needs Assessment.

The service plan will address the specific needs of the youth/family identified in the needs assessment. The goals on the service plan will include; time frames, target dates, measurable components, location of services and person responsible. New goals may be developed during treatment as new concerns arise and appropriate referrals are made to outside providers as needed.

Youth admitted to the shelter have service plans created within the first 72 hours of admission. Following the completion of the Needs Assessment, additional goals will be created as needed. Service plans are reviewed weekly and parents are invited to attend. Non-residential youth have a service plan completed within 7 working days following face to face contact upon the completion of the needs assessment. Service plans will include; specific goals, target dates, completion dates, measurable components, person responsible, referrals to other agencies when needed, and location of services. Service plans will include specific actions to help youth/family achieve the goal. Signatures by youth, parent/guardian, counselor and supervisor will be included to show/encourage participation. Service plans are reviewed every 30, 60, 90 days to assess progress. Service plans are reviewed by clinical supervisor and counselor using a supervision log every 2-3 weeks and no less than 1 time/month.

A total of 6 files were reviewed, 3 open and 3 closed. All 6 files reviewed had a service plan completed on the day of intake. Six of 6 files had service plans that included; individualized goals identified by the needs assessment, service type, frequency and location, person responsible, target dates for completion, actual completion dates, signature of youth, parent/guardian, counselor and supervisor and date the plan was initiated. Four of 4 applicable files reviewed had service plan reviews conducted every 30 days.

No exceptions were noted for this indicator.

2.04 Case Management and Service Delivery

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency policy number 2.04 was reviewed on 8/18/18. This policy was approved by the CEO and Clinical Director. The agency has a policy and procedure that address all of the key elements of the QI indicator. The policy states once the screening has been completed a counselor will be assigned to provide services to the youth/family. The counselor will be responsible for delivery of services through direct contact or referrals made. These needs will be identified through information obtained during intake, needs assessment, Netmis, risk factors, prevention assessment tool and other assessment tools.

The Clinical Director will ensure each youth is assigned a counselor who will follow the youth/family and be responsible for delivery of services. A service plan will be developed to address identified objectives for each youth/family. The counselor assigned will follow the case and ensure delivery of services and make changes/referrals as needed throughout the duration of services. Referrals to case staffing will be made depending on the progress youth is making. Case staffing referral will result in scheduled appointment with case staffing committee.

Four non-residential files were reviewed. All files had a counselor assigned and established referrals based on youth/family needs. All files monitored youth/family progress, provided support for families, made referrals when needed, provides case monitoring and 2 of 2 closed files had case termination notes. The 30/60 day follow up binder was reviewed. Ten, 30 day follow up reviews were reviewed and all ten 30 day

follow ups were completed on time. Five, 60 day follow up reviews were reviewed and all five were completed on time.

No exceptions were noted for this indicator.

2.05 Counseling Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency's policy number 2.05 was revised 8/14/18, reviewed on 8/18/18, and approved by the CEO and Clinical Director. The written policy and procedures contain all the key elements of the QI indicator.

The policy states the Sarasota Y will provide community based services to youth/family to further prevent involvement in delinquency and dependency systems and stabilize the family unit. Shelter services will be made available for those needed. Shelter youth may be transferred to non-residential services as well. Non-residential counselors will provide services to youth in the community, accept referrals from school administrators, school resource officers, local law enforcement, DJJ, other community providers, youth and parents/guardians. Services received may include; crisis intervention, individual/family counseling, group counseling, case management and referrals to other community resources. Services will be provided for an average of 12 sessions, but may be extended depending on the case.

Individual case files will be maintained and contain signed form for consent of services, confidentiality and release of information. Service plans will address identified needs and assessment tools will be used to identify any further self-harm concerns. Each youth/family receiving services will be provided with strategies, individualized interventions and skills to help stabilize and improve the family unit. Each case will adhere to confidentiality and contain chronological documentation to capture progress made on services provided. Case files and services are reviewed weekly during case review for youth in placement. Shelter counselor receives individual weekly supervision from clinical director. A referral process is in place if shelter youth want to participate in non-residential services.

A total of 6 files were reviewed, 3 open and 3 closed. All files addressed the youth's presenting problems in the needs assessment and the service plan. Four of 4 applicable files reviewed had service plan reviews completed. All files contained case notes for services provided, had on-going internal reviews of case records, counseling services were received in accordance with the service plan, all shelter files had individual/family counseling provided and group counseling was provided to all 3 shelter files reviewed. The group counseling binder was reviewed. Group sessions were provided at least 5 days/week. Groups were one hour in length and had a designated facilitator, clear relevant topic and opportunity for youth engagement. A group counseling session was observed and the facilitator, who was the adventure base counselor was encouraging youth participation with adventure based counseling (ABC) group techniques.

No exceptions were noted for this indicator.

2.06 Adjudication/Petitiion Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency policy number 2.06 was revised on 8/15/18 and was reviewed 8/18/18. This policy was approved by the CEO and Clinical Director. The policy and procedure contain the key elements of the QI indicator.

Sarasota YMCA shall have a case staffing committee to review cases that are in need of further intervention and additional guidance due to progress not being made. Specific reasons include; truancy, ungovernable, runaway or lockout, youth/family not engaged in services or those not making progress with the assistance of the assigned non-residential counselor. Case Staffing will be held when a written parental request for case staffing is submitted to any committee member and arranged within 7 working days.

Case staffing committee will consist of representatives from DJJ, school district representative, consultant responsible for case and the Sarasota YMCA clinical director. Other representatives may include; community representatives from areas of health, mental health and social services, local law enforcement, youth and parent/guardian or any person recommended/requested by the youth, parent/guardian or department. The non-residential counselor assigned to the case is responsible for coordinating the meeting. A referral to the case staffing committee can be made any time the youth is truant, ungovernable, runaway or if the non-residential counselor is unable to assist the youth/family. The youth and family will be notified two weeks before the scheduled case staffing meeting via certified mail. In addition, notification is sent to the home via regular mail. Referrals are dated the day they are received. A confidential file is prepared and contains the referral form, a copy of the notification letter and the recommendations made by the committee. Copies are given to the assigned counselor. The counselor will contact the family at least 5 working days prior to the scheduled meeting. A case staffing will be scheduled within seven business days in the event the request was made by a parent. Within 3 days of the case staffing committee a letter listing the recommendations made is sent to the parent. Service plans are then revised to include Case Staffing recommendations.

A total of 3 case staffing files were reviewed. All 3 of the case staffings were initiated by staff. All files reviewed sent notification to the family and the staffing committee no less than five working days prior to the staffing. All files had a local school district representative, a DDJ representative or CINS provider and the clinical director of the Sarasota YMCA. One case staffing file had a mental health representative present and one case staffing file had a law enforcement representative. Youth/families were provided with a new or revised plan for services in all three cases. A written report was provided to parent/guardian within seven days of the staffing outlining recommendations and the non-residential counselor completed a review summary prior to the court hearing in all three files reviewed. In 1 of 3 files reviewed, the Sarasota YMCA worked with the circuit court for judicial intervention for the youth/family.The program has an established case staffing committee and it is apparent there is regular communication with committee members. The program also has an internal procedure for the case staffing process, including a schedule for committee meetings.

No exceptions were noted for this indicator.

2.07 Youth Records

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency's policy 2.06 was last revised 8/15/18 and was last reviewed on 8/18/18. The policy was approved by the CEO and Clinical Director.

The Sarasota YMCA will maintain youth files which contain pertinent information regarding youth/family. The information gathered is confidential and this is identified on each file. Staff will maintain confidential files for all the information gathered upon meeting with youth. Records are maintained neatly and orderly for ease of accessing information. The procedures include signed and dated forms that are provided in both the shelter and non-residential program. The procedure also includes color coding of files and order of files. It is also indicated that files are transported from one office to another in a locked case.

Seven files were reviewed, 4 open and 3 closed. All files were locked in a secure room that is accessible to program staff. All shelter records that are transported are locked in an opaque container that is marked confidential and all files reviewed were maintained in a neat and orderly manner. Four of 4 non-residential files have confidential marked on the file. One of 3 shelter files have confidential marked on the file. All clinical files have confidential marked on the file.

The policy/procedure does not state the confidential transportation container is marked confidential. The cabinet the residential files are kept in was not marked confidential; however, during the QI review, staff printed a confidential label and placed it on the cabinet upon notification mentioned. The locked bag used for transporting the non-residential files is not marked confidential and the cabinets the closed non-residential files are kept in is not marked confidential.

2.08 Sexual Orientation, Gender Identity/Expression

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written draft policy, # 2.08, for Indicator 2.08, Sexual Orientation, Gender Identity, and Gender Expression. The policy was implemented in September 2018 and was approval by the CEO and Program/Clinical Director.

It is the policy of Sarasota Y to treat all youth with respect, provide a safe and therapeutic environment, necessary accommodations, and referrals to qualified professionals for supportive services regardless off the youth's actual or perceived sexual orientation, gender identity, or gender expression.

Per the agency's procedures:

a. Youth will be addressed by their preferred name and gender pronouns.

b. Staff, service providers and volunteers will be informed of the policy and procedures and are prohibited from engaging in any form of discrimination or harassment of youth based upon their actual or perceived sexual orientation, gender identity, or gender expression and/or attempt to change them.

c. Youth will be identified in the logbook and all public-facing documents by their preferred name and gender pronouns.

d. All room assignment decisions will be made on a case-by-case basis and align with their gender identity with documentation assessing to suitability. Safety and security for each youth will be taken into consideration when making a decision regarding room assignment. Youth will not be housed in isolation solely based on sexual orientation, gender identity, or gender expression.

e. Hygiene products, undergarments, and clothing will be provided that affirms their gender identity/expression.

f. Staff is prohibited from discussing youth's sexual orientation, gender identity, or gender expression with other youth in services without the documented consent from the youth.

g. A form will be presented to the youth for his signature allowing the sharing of their personal story if they so choose.

h. Harassment, verbal abuse, or intimidation by staff towards any youth based on the youth's sexual orientation, gender identity, or gender expression must be reported to the DCF Abuse Hotline. 1-800 96 ABUSE (1-800-962-2873}

i. If youth are in need of specialized support or services relative to their sexual orientation, gender identity, or gender expression, the service provider is required to refer these youth to services, or request assistance from the Florida Network in identifying qualified resources and providers.

j. Appropriate signage will be displayed indicating the program is a safe space for all youth regardless of actual or perceived sexual orientation, gender identity, and gender expression.

A review of the policies and procedures indicated protocols are in place to address all of the requirements of the indicator. During a tour of the facility, “hate free” rainbow signs were posted in the lobby, dining room, and youth lounge. The program also has laminated copies of the “I Provide Safety Support and Respect” booklet accessible in the lobby and youth lounge for youth, staff/volunteers to read. The Program Director conducted SOGIE training in September 2018 and January 2019 for staff to familiarize them with the SOGIE policy guidelines outlined in FN policy #5.08 and sign in sheets were provided to document receipt of the training. There are no current volunteers in the program to receive the training. The program served two youth during the annual review period who met the criteria for the indicator. Documentation on all forward facing and the two youth files (1 open, I closed) reviewed demonstrated the youth are addressed by pronouns, name, and gender they prefer and room assignment is made accordingly. Three youth surveyed indicated the feel safe in the shelter and staff do not discuss youth's sexual orientation, gender identity, or gender expression with other youth in services and/or attempt to change them.

There are no exceptions noted for Indicator 2.08.

Standard 3: Shelter Care

Overview

Rating Narrative

Sarasota Y shelter primarily serves youth from Sarasota and DeSoto Counties and is accredited by the Council on Accreditation through 6/30/21. The Department of Children and Families license was issued on 6/1/18 for twenty (20) beds. In addition to CINS/FINS, the shelter also provides services to youth referred by the Department of Children and Families. The Sarasota YMCA shelter facility is located in central Sarasota near the intersection of Bahia Vista Street and Tuttle Avenue. The shelter is adjacent to the YMCA's gymnasium which provides access to recreational opportunities for youth during their shelter stay. The shelter building includes: a day room, girls and boys dorm style bedrooms, an industrial kitchen, dining room, and laundry room. The shelter Director and staff offices are also located in the building as well as a multipurpose activity/computer room. On the exterior, youth have access to a large deck and open courtyard area with basketball hoops.

The Sarasota Y residential team is comprised of nineteen (19) Behavior Coaches, including seven full-time and twelve part-time/ PRN positions. In addition, there is also a full-time Program Director, Program Coordinator, Residential Manager, and a Case Manager. The Behavior Coaches are responsible for processing new admissions and providing orientation of youth to the shelter, the supervision of youth, and for maintaining inventories on all sharps and medications. The dormitory is divided into two separate areas, one for the boys and one for the girls. There are 2 large bathrooms, one for each gender.

3.01 Shelter Envonment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure that was reviewed by the Acting CEO, and the Program Director in July 2018. The policy meets the requirements for the QI indicator.

The provider’s procedure requires that a safe, clean, and well-maintained environment is maintained by adhering to the following:

Health and Fire Safety Inspection completed annually.

The building treated for insects on a monthly basis.

The shelter has a contract with a local landscaping company to maintain the grounds.

Bathrooms and showers cleaned daily as part of youth chores.

Walls, doors, and windows checked for graffiti or damage daily.

All agency vehicles and staff vehicles will be locked. The agency vans contain all of the required major safety equipment.

Upon arrival to the program, each youth is assigned their own bed and provided with clean sheets, blanket, and a pillow. The youth are given a new sweat suit at intake to change into while their clothes are being washed and/or dried.

Bed assignments are determined through an initial classification process.

Proper lighting is provided throughout the shelter. The lighting is checked during daily shift perimeter and weekly facility checks.

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

Youth participate in life skill-building groups five nights each week. At least three afternoons each week, the child will have the opportunity to participate in “adventure-based” counseling groups.

Youth are provided with at least one hour of physical activity on a daily basis. Youth are also given the opportunity to participate in religious services on a volunteer basis. Alternative activities will be provided for youth who do not wish to participate in religious services.

Homework time or tutoring is offered daily Monday-Friday. The Y Shelter daily programming schedule is posted in the kitchen and the living room in view of all youth and staff.

The use of physical intervention is never used to gain behavior compliance. If staff determine that physical intervention is necessary to prevent harm to one or more individuals, the staff is training in Managing Aggressive Behavior (MAB). Staff are expected to utilize minimal amount of force necessary to prevent harm to anyone. Law Enforcement should be contacted when possible to avoid physical intervention. If the situation escalates too quickly then law enforcement would need to be contacted immediately after the intervention.

A tour of the facility was conducted by the reviewer and the facility was observed to be clean, neat, and well maintained and all required inspections were current. The agency is accredited by the Council on Accreditation through 6/30/21. The Department of Children and Families license was issued on 6/1/18. Fire Inspection was completed on 1/25/19 by Sarasota County Fire Department but was cited due to the living room emergency light needing repair/replace. Re-inspection is scheduled for 2/26/19. During the review, the living room emergency light was tested and found to be operational. Cintas Fire Inspection completed/serviced on 1/31/19. Fire Sprinkler Systems inspection completed on 6/25/18. Piper Fire Protection annual fire alarm test and inspection was completed on 1/11/19. Food Establishment Inspection Report was completed on 12/2018. Department of Health Sanitation Certificate was issued on 10/01/18. The most recent pest control inspection was completed on 2/2/19. All of the required inspections were completed in a timely manner.

The shelter furnishings are in good repair; bathrooms/ showers are clean and functional. The bedrooms were clean with covered mattress, pillows, and linens. The youth each have a locker in the bedroom and a place in the staff office to store additional locked items. No graffiti was observed during the review and lighting was adequate in all areas. There are two washing machines and two dryers which are in very good condition. Both dryer filters were free of lint and the dryer had a written notice on it to remind staff to clean the lint filters after each use. The grounds of the facility were very well maintained and free of debris or hazards. The kitchen contained all needed equipment with separate dining tables for male and female youth. Just outside the kitchen is a very large outdoor dining area with picnic tables for eating outside when weather permits. The agency also has a room for youth to complete homework/study/tutoring. The room is equipped with numerous books, educational materials, three computers, television for watching DVD's. The room also serves as a music room with a piano, guitars, organ, and small drums. There is a very large living room which has two large televisions and video games. The room also contains colorful pictures that are displayed throughout the shelter. The living room has youth artwork displayed also. Just outside the living room is a large outdoor recreational area with two basketball goals. The youth also have the opportunity to participate in evening recreation at the YMCA which is located next door to the shelter.

During the tour of the facility, the doors to each room were secured and the staff maintained control of the shelter keys. At the beginning of each shift, the staff document in the program log book which set of keys by assigned number are in their possession. A room map and egress plan were observed in each room. The program daily schedules are located in the kitchen and living room on very large laminated posters hanging on the walls for easy viewing. The grievance form and grievance box are located in the living room. The common areas of the facility including bedrooms and bathrooms were free of contraband and accessible hazardous materials. The outside garbage containers and dumpster were covered and closed.

There are three separate locked chemical storage areas in the building: the kitchen, boy's bathroom and laundry room. The facility maintains a MSDS binder that contains a list of 18 chemicals approved for use in the facility. All 18 chemicals had matching MSDS sheets in the binder. The chemicals were stored in locked areas and inventoried a minimum of one time per week on a consistent basis.

No exceptions were noted for this indicator.

3.02 Program Orientation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure that was reviewed by the Acting CEO and the Program Director in July 2018. The policy meets the requirements for the QI indicator.

The procedure states that each youth is given a copy of the client handbook and the parent/guardian is given a copy of the parent handbook at intake. The program's policies are reviewed and each youth and staff initial off on the intake checklist which contains numerous items including but not limited to the following: client rights, grievance procedures, abuse hotline contact procedures, visitation, mail, telephone procedures, a tour of the shelter, contraband items, emergency procedures/evacuation routes, dress codes, medical and mental health care, suicide prevention procedures, elopement policy and consequences and the general rules of the program. The youth are also given information on the point system, required chores, and the shelter services available. The personal belongings of the youth are searched at intake and all children are "wanded" with a metal detector prior to being allowed into the general population. Youth are subject to random search upon returning to shelter from school or other outings. However, no "skin search" or "pat down" searches are ever permitted. If contraband is suspected to be in a dormitory, two staff members will search lockers and dressers.

The reviewer read the agency handbook which is very comprehensive and includes the information on the following topics: dress code, supervision of youth, daily schedule, religious services, educational services, life skills, groups, house meetings, counseling, confidentiality, mail, telephone, visitation, chores, personal hygiene, medical care, recreational activities, transportation, and grievance procedures, abuse/neglect reporting, fire and other emergencies, search procedures, goal setting, behavior program, levels, points, and privileges. The handbook explains the overall rules of the program including the "Cardinal Rules" which are battery, destruction of property, possession of weapons or drugs/alcohol, theft, and sex crimes. During the review, a new youth intake was completed. Shortly thereafter, a staff member was observed completing a shelter orientation and tour with the youth.

A total of three (3) shelter files were reviewed (2 open and 1 closed). All files reviewed identified when suicide prevention was indicated. All files reviewed contained the youth and parent signatures verifying they received a copy of the program handbooks.

No exceptions were noted for this indicator.

3.03 Youth Room Assignment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure that was reviewed by the Acting CEO and the Program Director in July 2018. The policy meets the requirements for the QI indicator.

Procedure states the screening form and the risk assessment form will be contained in the intake packet. Information will be obtained from the parent/guardian and the child. Classification information will include: physical characteristics, gang affiliation, current alleged offense, delinquency history, exposure to trauma, level of aggression, attitude at admission, prior sexual behaviors, medical and mental health issues, disabilities, suicide risk, and gender identity will be taken into consideration. Staff will use the preferred gender pronoun of the youth's choosing.

Staff will review the intake packet to assess any perceived risk and then assign youth to appropriate sleeping quarters. Youth who are deemed to exhibit "special needs" will be assigned specific alerts as appropriate and delineated in policy 4.04.

A total of three (3) shelter files were reviewed (2 open and 1 closed). All files reviewed identified specific room assignments taking into consideration the specific youth issues listed below to ensure the safety of all youth. The youth were in the assigned bed and/or room as identified in the youth file. The intake process includes an initial classification process that takes into consideration youth history, exposure to trauma, age, gender, gender identification, history of violence, physical size, gang affiliation, sexual acting out behaviors, staff observations at intake, and information obtained by collateral contacts. The appropriate alerts including suicide prevention were documented in all three files. The two (2) open files with alerts also had corresponding codes that were correctly listed on the dry-erase board in the staff control room. One open file contained documentation which confirmed that gender identity was taken into consideration and staff documented the youth's preferred name and utilized the gender pronoun of the youth's choosing.

No exceptions were noted for this indicator.

3.04 Log Books

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure that was reviewed by the Acting CEO and the Program Director in July 2018. The policy meets the requirements for the QI indicator.

The procedure states the staff will sign in to the Digital Communication Log when they come on shift which is date and time stamped automatically. Staff will complete entries under their name and sign the digital log also. Staff must document they have read entries of at least the prior two shifts. Staff will record acceptance of keys and complete youth headcounts in the digital log. Staff members will sign-out at the end of their shift.

The log book will indicate the security level of the facility and the current program status. Entries on each shift will document group activities, incidents, headcounts, intakes, discharges, outing, absconds, perimeter checks, and general information regarding the youth and facility. Entries should be brief, professional and include full signature of staff. All recording errors are struck through digitally with a single line and signed by staff making the correction. Log entries which could affect the safety and security of the program will be highlighted. Log books are retained for at least three years. The shelter has three digital log books (two are kept in the staff office and one is kept in the Director's office). The Director and other management staff will review the log book each shift worked and note corrections needed, recommendations, and required follow-up. Management entries must be digitally signed and highlighted in pink. The shelter utilizes the FNYFS Active Note Key that has hashtags and specific color codes.

The reviewer interviewed a program manager regarding documentation requirements of the electronic log books and review of written codes, highlighted entries, and required color fonts. The manager was very familiar with all of the various color codes and was able to show specific log book entries of the various color codes. For example, sight and sound documentation is highlighted in green, intakes and discharges were observed to be highlighted in yellow, group notes were highlighted in orange, all management entries were highlighted in pink. The manager provided a sheet that provides the various codes, highlight colors, and entries that require a specific color. For example, all medication entries were observed to be documented in red font and runaway entries documented in blue font. The log books were reviewed and verified to contain safety and security issues, supervisor reviews with recommendations when needed, supervision and headcounts, incidents with required staff and youth involved, reviews of previous two shifts by oncoming staff. Errors were observed to be struck through with a single line, staff signature and date stamped.

No exceptions were noted for this indicator.

3.05 Behavior Management Strategies

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure that was reviewed by the Acting CEO and the Program Director in July 2018. The policy meets the requirements for the QI indicator.

Procedure states the level system is explained to each youth at intake. It is also written in the youth handbook along with the level privileges and restrictions. The level system will use daily point sheets for each resident. The points determine the youths' eligibility for moving up a level and will serve as the main factor in determining weekend recreational and non-recreational status. Points are tallied on a daily basis by the third shift staff. Staff are trained in Behavior Management and Crisis Intervention. Behavior Coaches will discuss all inappropriate behaviors with residents, assist youth in examining their decision-making, and assist with devising a plan for future growth. Poor choices are seen as an opportunity for teaching and for change. Consequences for more serious behavior violations will result in "major" disciplines that require supervisory review. Consequences will be delivered on an individual basis and will not include group punishment. Residents may also be rewarded through achieving Master's level privileges and special outings. Staff will not employ physical intervention techniques unless the safety of the resident, other residents, or staff is involved. Staff will be trained in verbal de-escalation techniques. Youth are also trained on the "five second rule" wherein all youth will quickly exit the room when another youth is causing a disturbance. Disciplinary measures do not deny youth any of the following: regular meals or snacks, clothing, sleep, physical or mental health services, educational services, exercise, correspondence privileges, or contact with parents/guardians, attorney, juvenile probation officer, or clergy. The shelter will not use "room restriction", confinement, or any other unsupervised disciplinary sanctions at any time.

The reviewer interviewed staff and reviewed the resident handbook regarding the behavior management program. Staff advised that all youth participate in the program and are assigned a point card upon admission. The Behavior Coaches give points daily for various skills the youth perform/exhibit such as: going to bed on time, keeping room clean, morning and evening hygiene, chores completed, school attendance with satisfactory behavior at school, completion of homework, appropriate language, volunteering, cooperation, safety and various other skills. The shelter promotes four major expectations of the youth, which are respect, honesty, caring, and responsibility. The youth earn points through appropriate behaviors and can achieve levels I, II, III, and a Master's level. The youth are provided a copy of the level privileges for levels 0 through Master's. Youth are encouraged to display appropriate behaviors in order to earn additional privileges and to make positive choices.

No exceptions were noted for this indicator.

3.06 Staffing and Youth Supervision

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure that was reviewed by the Acting CEO and the Program Director in July 2018. The policy meets the requirements for the QI indicator.

Procedure states the staff schedule is posted in the staff office and that staff members are expected to cover their shift if unable to make it to work by using the PRN phone list. If the employee has an emergency, the staff member will call the on-call manager who will attempt to find coverage using the PRN list. If no one is available to cover the shift, staff members may be required to stay over or someone from the management team (male or female, as needed) will cover the shift. During sleeping hours, youth will be observed by staff at least once each 10 minutes. Observations, which will be noted in real time (the time the observation actually occurred) will be documented in the appropriate log. Youth who are at risk of harm to self or others will receive supervision as directed by policy and procedure 4.02 Documentation regarding these youth will be maintained as directed by that same policy and procedure. Youth who are on bed rest due to illness or physician's orders are observed at least once every 10 minutes and documented on the bed rest sheet in real time. After completion of bed rest, the sheet will be put in the resident's file.

Reviewer was able to view the staff schedule located in the staff control room as well as the staff PRN Behavior Coaches on-call list. The Program Director and Program Coordinator were interviewed regarding staffing which they confirmed compliance with staffing ratio of at least one staff to six residents during awake hours and at least one to twelve during sleep period. The interviewed staff advised that on numerous occasions the shelter has not been able to maintain a male and female on all shifts. There were two primary issues identified by the Program Coordinator that were contributing to this issue: two full-time employees were recently terminated and all of the management employees are male. The Program Director advised that there is a current advertisement to hire one staff to replace one of the two vacancies. One PRN staff member will be moved to full time. The binder containing staff schedules was reviewed and there were 33 instances of the same sex staff on shifts. The time period reviewed was 11/26/18 through 2/3/19.

The reviewer selected three random dates/times of overnight video surveillance. The following video footage was observed: 1/19/19 at 12:02 am, 12:11 am, and 12:28 am., 1/26/19 at 3:10 am, 4:01 am, and 4:10 am., and 12/17-18 at 11:00 pm, 11:11 pm, and 2:50 am. The staff on shift were observed on video completing bed checks within the required time frames. The reviewer also noted that the logbook entries had corresponding times in which the bed checks were completed.

The staff schedules were reviewed from 11/26/18 through 2/3/19. During that time period there were 33 instances of same sex (female) staff member on shift.

3.07 Special Populations

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure 3.07 for Special Populations that addresses all of the key elements of the CQI indicator. The policy was last updated July 2018 and was approved by the President of the Sarasota YMCA and the Shelter Director.

The policy indicates that Sarasota Y does not generally serve Staff Secure youth but has the ability to comply with the contract requirements if necessary. Sarasota Y also serves youth who meet the criteria for domestic violence respite, probation respite, and domestic minor sex trafficking, The Sarasota Y does not provide intensive case management services and does not participate in the Family/Youth Respite Aftercare Services. The program has specific procedures that meet the requirement for the intake, orientation, assessment, case planning, and aftercare – as well as established criteria for documentation, supervision, data entry, services, and communications related to the special populations it serves. Domestic Violence Respite, Domestic Minor Sex Trafficking, and Probation Respite services are provided for youth ages 10 through 17 who have been charged with an offense of domestic violence (including youth who have previously adjudicated for other issues) specifically designed to provide a safe alternative to secure detention for youth with pending or adjudicated charges for domestic violence. The procedures describe general description of services, youth eligibility, youth referral/determination procedures, length of stay limits on youth to be served, services to be provided for domestic violence and probation respite referrals, and transition to CINS/FINS, if applicable. Requirements specify that youth are provided services consistent with other CINS/FINS program requirements and address their specific needs including service plans that identify outcomes that address ways to reduce violence in the home. The procedures include all the elements required by the indicator.

The only special population served by the provider during this review period was for three (3) Domestic Violence Respite youth. One of the 3 youth was discharged within 24 hours and was not reviewed for practice due to the brevity of the intake. A review of 2 applicable files was conducted. All of the requirements were met in each file reviewed. The length of stay did not exceed 21 days for neither youth. The youths' files showed evidence of case management and counseling needs being addressed on the service plan. Services provided to the two youth are consistent with all other general CINS/FINS program requirements.

No exceptions were noted for this indicator.

3.08 Video Surveillance System

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure that was reviewed by the Acting CEO and the Program Director in July 2018. The policy meets the requirements for the QI indicator.

Procedure indicates the video surveillance system will have the capacity to retain video photographic images for a minimum of 30 days. The video surveillance system records date, time, and location. In addition, the resolution of the cameras enable facial recognition. There is a back-up capability for the cameras that allows the cameras to remain operational during a power outage. The shelter has 16 operational cameras in the shelter. There are 8 cameras on the interior and 8 cameras on the exterior of the facility. The cameras are placed in general locations where youth congregate and where visitors enter and exit. There are no cameras in the bathrooms or sleeping quarters. The procedure outlines the location of every inside and outside camera. The video surveillance system is accessible to the Program Director, Residential Manager, Residential Counselor, and Case Manager. The Program Director has off-site capabilities to view cameras. A supervisory review of the video is conducted every 14 days. The results of the reviews are documented in the log book. The reviews assess shelter activities and include a random sample of overnight shifts. All cameras are visible to youth and staff. The parents and youth are notified of the presence of the cameras at intake when they sign the Informed Consent document. In addition, there is written notice posted on the premise for the purpose of security. All video recordings will be made available for third party review after a request from program quality improvement visits and/or when an investigation is pursued after an allegation of an incident.

The Reviewer observed the written notice of video recording posted outside the front door of the facility. The youth and families are also provided written notice of video surveillance in the Informed Consent form. The 16 video cameras are visible and observed to be located in common areas of the building both inside and outside and in accordance to the agency's policy 3.08. The management team has access to the video surveillance system that is located in the Program Director's office. There are no cameras located in bathrooms or youth bedrooms. The camera system can capture photographic images including facial recognition and is able to store for a minimum of 30 days. The system has a backup in the event of a power outage. The agency maintains a binder with forms to verify supervisory review of video at least every 14 days and the form allows the supervisor to record the date of review, identify which camera is viewed, the staff members on camera, any issues noted and action taken. Management staff are completing video surveillance reviews at least every 14 day and on many occasions more frequently. There are numerous reviews of random dates of overnight shifts.

No exceptions were noted for this indicator.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

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

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

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

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

4.01 Healthcare Admission Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a current policy and procedures in place which addresses healthcare admission screening for all youth placed at the program. The program’s policy number is 4.01 and was revised in August 2017 and reviewed by the shelter director and the program President in July 2018. The policy and procedures follow the Florida Network of Youth and Family Services quality improvement standards.

The agency uses a CINS/FINS intake form completed by the behavior coaches at the time of the youth’s admission and the intake form addresses the youth’s healthcare needs at admission. The form specifically gathers information on the following youth medical needs; current injury, current illness, current health conditions, any recent hospitalizations, medications, mental health disorders, allergies, dietary restrictions, and specific physical health conditions. The nursing staff reviews each youth’s healthcare screening form and completes a nursing review form entitled nurse review of healthcare admission screening.

A review of two opened and one closed youth residential records were reviewed for the completion of a healthcare admission screening at the time of admission. All three records contained a completed CINS/FINS intake form and a nursing assessment. The intake form and the nursing assessment screened each youth for current medications, existing medical conditions, allergies, recent injuries or illness, observation for evidence of illness, injury, pain, or physical distress, and observation of presence of scars, tattoos, or other skin markings. One of the three youth was identified as having a current injury, which required wound care. All three reviewed youth records revealed all youth were screened for currently prescribed medications; however, two of the three youth were applicable for taking medications upon admission and the medications were listed on the youth’s admission screening form.

There were no exceptions noted in the three reviewed records.

4.02 Suicide Prevention

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a current policy and procedures in place addressing suicide prevention and intervention and the program’s policy number is 4.02. The policy was revised in August 2017 and reviewed by the shelter director and the program President in July 2018. The policy and plan follow the Florida Network of Youth and Family Services quality improvement standards.

The agency's policy provides specific guidelines for staff to use when dealing with suicidal youth. The policy indicates all youth are screened at admission for being at risk of suicide. If a youth is found to be at risk for suicide, they are placed on sight and sound supervision and their behavior is documented at a minimum of thirty-minute intervals. The policy further indicates clinical staff are to complete an Assessment of Suicide Risk on youth who are at risk for suicide and then conduct a follow-up assessment, if necessary. The policy also outlines how the program would handle mental health crisis situations.

Upon a youth's admission to the program they are screened using the CINS/FINS intake forms. If the youth has any positive responses on the seven suicide questions they are placed on precautionary observation until they can be seen by a clinician. The youth's behaviors will be monitored by staff every thirty minutes and documented on a precautionary observation log at the time of observation. Youth at risk for suicide are maintained on precautionary observations until a clinician completes an Assessment of Suicide Risk and places them on standard supervision or elevated supervision. A youth on elevated supervision can only be stepped down from that status when the clinician completes a follow-up assessment and places the youth on standard supervision. The agency uses a yellow dot on the side of each record to indicate the youth is on precautionary observations.

A review of three youth residential records indicated each youth was screened for suicide risk using the CINS/FINS intake form. All three youth records indicated all the youth were at risk for suicide and two of the three records contained documentation the youth were placed on precautionary observation by the screener and an observation log was completed. All three youth were seen by a clinical professional and had an Assessment of Suicide Risk (ASR) completed and the clinician placed all three youth on standard supervision. Two of the three records contained precautionary observation logs indicating the youth was monitored at thirty-minute intervals; the third record did not have a precautionary observation log because the clinician conducted the Assessment of Suicide Risk prior to the completion of the intake process. All three ASRs were completed by a licensed mental health counselor (LMHC), whose licenses were clear and active within the state of Florida and they both expire on March 31, 2019. A review of the program's electronic log book indicated all three youth's status on precautionary observation was documented in the log book and there was documentation to show each youth received an assessment of suicide risk when they were placed on standard supervision.

There were no exceptions noted in the three reviewed records.

4.03 Medications

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy and procedures in place outlining medication administration and the policy was last revised in July 2018. The agencies policy number is 4.03 and it was last reviewed and signed by the shelter director and program President in July 2018. The policy and plan follow the Florida Network of Youth and Family Services quality improvement standards.

At the time of admission to the program, if a youth is prescribed medications, the parent/guardian must provide the medication in the original prescription container with a label on the bottle completed by a pharmacy. The program will verify all prescriptions brought in for a youth and the verification will be documented on the medication transfer receipt. For each youth receiving medications a medicine distribution log is completed and included in the medication log. A photograph of each youth will be attached to each youth's medication distribution log (MDL). Information concerning common medication side effects and precautions of each prescription are to be clearly documented on the MDL. All youth taking medication will have a red dot next to their name on the program's census board indicating they are taking medication and will have the medication information documented on their alert log maintained in their record.

The program's policy is to have nursing staff act as the primary administer of medications to youth when they are on-site. The program contracts with a company called CSI to provide three rotating nurses who come to the facility to provide medication services to the youth in the morning and evening hours. The program has a list of individuals who have been trained to provide medications to the youth in the nurse's absence. The program's policy requires all medication refusals be documented with an 'R' on the MDL and the reason for the refusal is to be written on the MDL form.

The program maintains all youth medications, and controlled medications, in a Pyxis Med-Station 4000 medication cabinet. The program maintains four over-the-counter medications in a locked box in drawer in the locked staff office. The program has two site-specific Super Users for the medication station. The program does not store oral medications with injectable and topical medications. The program does not accept youth currently prescribed injectable medications, except for Epi-pen's. The program is required to have a medication refrigerator to store medications which are required to be kept cold. The program is required to maintain a perpetual inventory with a running balance for controlled medications, and a weekly inventory for over-the-counter, sharps and syringes medications.

The program's policy indicates prescription medications which have been discontinued, expired or have been abandoned by the client will be disposed of by crushing them and putting them in coffee grounds. Medicine disposal will be viewed and documented by at least two staff members including a supervisor.

There is a monthly review of medication practice through the Knowledge Portal reports entitled User Summary by Transaction Type and Discrepancy Audit Summary Report.

The agency has three rotating registered nurses who come to the program to provide medication administration to the youth in the morning, and evening hours. If a youth requires a medication in the middle of the day a trained program staff will assist the youth in self-administration of medication. The program has five management staff, five full-time and ten part-time staff trained to assist the youth in self-administration of medication.

The agency has a Pyxis Med-Station 4000, which is used for the distribution of medications to the youth. The medication station is maintained in the administration area of the program. The program has two super users for the medication station and they are the shelter director and case manager. The program maintains narcotics, and controlled medications in the pixel med-station. The program maintains oral medications separate from injectable and topical medications. The program has a mini-refrigerator in the locked staff office for the storage of medications which require refrigeration. The program also maintains the four over-the-counter medications in a locked box in the locked staff office. The over-the-counter medications are inventoried weekly and the program had documentation to support the over-the-counter medications were inventoried weekly for the last six months, with one exception. The over-the-counter medications were not inventoried during the week of November 11, 2018 through November 17, 2018. Each youth's prescribed medication has a perpetual inventory on the medication distribution logs (MDL). A review of three youth's MDL's indicated each youth's prescribed medications had a current perpetual inventory.

A review of three youth records indicated each youth entered the shelter with one or more prescribed medications. Each youth's record contained a completed medication verification form which indicated the staff contacted the prescribing pharmacy to verify the youth's medications. A review of three youth's MDL indicated they had received their medication(s) as prescribed; however, there was one youth who consistently refused to take an afternoon medication and each refusal was documented on the MDL with the letter 'R' and an explanation was given on the back of the MDL.

A review of the program's medication log book further indicated the program had no incidents of medication disposal in the six months prior to the review; however, there were two incidents of medication disposal since the last annual review. A review of the two incidents indicated the medication which was being disposed of, the person the medication was prescribed to, the reason for the disposal, date and time of disposal, quantity disposed of, method of disposal and the forms were signed by the person disposing of the medication and the witness. Both medications were crushed and disposed of in coffee grounds.

A review of the agencies Pyxis report binder indicated the program reviews medication practices monthly through the Knowledge Portal reports. The program's binder contained the following monthly reports for the six months prior to the annual review: summary of all transaction activity, user summary by transaction type and discrepancy audit summary report.

The over-the-counter medications were not inventoried during the week of November 11, 2018 through November 17, 2018.

4.04 Medical/Mental Health Alert Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy and procedures in place outlining the program's medical and mental health alert process and it was revised in December 2018. The agencies policy number is 4.04 and it was last reviewed and signed by the shelter director and President in December 2018. The agency's policy and procedures for medical and mental health alert follow the Florida Network of Youth and Family Services quality improvement standards.

The program uses a colored dots/check mark alert system which indicates if a youth has medical concerns, behavioral concerns, mental health concerns, substance abuse concerns, or no concerns at all. The program uses a blue dot to indicate medical concerns, yellow dot to indicate suicide risk/sight and sound, red dot to indicate medications, orange dot to indicate sharps restriction, purple dot to indicate runaway risk, red check mark to indicate mental health concerns, green dot to indicate allergies, black dot to indicate substance abuse and a brown dot to indicate physically aggressive behaviors. The agency also maintains a shelter alert system log for each youth. The log has each youth's name at the top of the form and their admission date. The log further indicates what type of alert each youth has, the reason for the alert, a referral column and a spot for resolution of the alert.

The agency also maintains a client board in the staff office which indicates all youth currently residing at the facility and has corresponding color dots/check marks next to their names indicating each youth's specific alerts/concerns.

A review of two open and one closed youth residential records were reviewed for compliance with the program's alert process. All three records contained documentation on the admission form indicating each youth required one or more alert. One youth's admission record indicated they should have a red check mark and a yellow dot; a review of the internal alert board indicated the youth had a red check mark next to their name,

which indicated a mental health issues. A review of the youth's shelter alert log indicated the youth has a history of post-traumatic stress disorder and anxiety. The youth's alert log also indicated the youth was no longer at suicide risk and the youth was no longer on sight and sound supervision because an assessment of suicide was completed, and the youth was no longer at risk.

A second open youth record was reviewed, and the youth's admission form indicated the youth should have a blue dot, orange dot, red dot, red check, green dot and a black dot. A review of the shelter's internal alert board indicated the correct check mark and dots were placed next to the youth's name. The internal alert board indicated the youth has a medical condition, sharps restriction, medication, mental health history, allergies, and substance abuse alerts. All the alerts were also documented on the youth's alert log maintained in the youth's record.

A third closed youth record was reviewed, and the youths' admission form indicated the youth should have a blue and red dot. The youth also would have had a yellow dot; however, the record indicated the youth received an assessment of suicide risk and was removed from suicide alert. A review of the youth's record confirmed the youth would had the red and blue dots while they were at the program; however, the youth was no longer at the shelter and the internal alert board could not be compared to the youth's record.

There were no exceptions noted in the three reviewed records.

4.05 Episodic/Emergency Care

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy and procedures in place outlining the shelters policy for episodic and emergency care and the policy was last revised in July 2018. The agencies policy number is 4.05 and it was last reviewed and signed by the shelter director and President in July 2018. The agency's policy and procedures for episodic and emergency care the Florida Network of Youth and Family Services quality improvement standards.

The agency has a policy and procedures to address youth episodic and emergency care. The policy provides staff with specific guidelines to ensure client safety by providing rapid and appropriate emergency medical and dental care.

The agency policy indicates direct care staff will maintain current training in cardiopulmonary resuscitation, first aid and use of the knife-for-life. The program is required to maintain a suicide response kit in the staff office and first aid kits in the kitchen, staff office and all vehicles. All kits are to be inspected weekly to ensure the stock is complete and expired items are replaced.

Parent/guardians are required to transport all youth to any medical appointments and if a youth needs emergency medical treatment arraignments will be made of the youth to go to the emergency room.

Instances of first aid will be documented in the first aid log, and emergency care will be documented on the episodic emergency care log. Both instances will be documented in the clients record and in the communication log. When a youth returns from emergency care shall receive verification of receipt of medical clearance, discharge instructions, and follow-up care are documented in the youth's record.

The shelter shall also complete incident reports on any youth who leave the shelter for off-site emergency services.

A review of three youth residential records indicated all three youth required off-site medical services, and none of the youth required emergency off-site services. Two of the three reviewed records indicated the program staff contacted each youth's guardian to take the youth to seek medical services for their ailments. Each youth's record reflected the youth was returned to the shelter with medication and their off-site medical care was logged on the program's episodic medical log. Both records contained documentation the program completed an incident report for each incident of off-site care.

The third record indicated the youth was taken on an outing with their guardian and returned with a prescription for a medical condition. The program did not have prior knowledge of the medical issue; however, they did log the incident in the program's episodic medical log. Two of the three off-site medical incidents required an internal incident report be completed by the program and there was evidence the reports were completed. The third incident did not require an incident report because the program did not have any prior knowledge of the youth's medical issue and did not initiate the off-site medical care. Each youth's medication was verified prior to the youth receiving the medication.

The agency did not have any incidents of emergency off-site care during the review period.

The program maintains four knife-for-life kits and they are maintained in the staff office off the youth's living room and each of the program's three vans have a knife-for-life. The program maintains four first aid kits. Each of the three program vans have a first aid kit; there is one in the kitchen and one in the staff office.

One of the program's behavioral coach conducts weekly inspections of first aid kits and there was documentation to support the first aid kits were inspected weekly for the entire six-month review period with two minor exceptions. The kits were not inspected the week of September 23

through September 29, 2018 and September 9, 2018 through September 15, 2018.

A review of four pre-service and three in-service staff training records confirm all staff have completed training in cardiopulmonary resuscitation and first aid training

There were two weeks where the first aid kit in the staff office were not checked. The weeks which were missing are September 23 through September 29, 2018 and September 9, 2018 through September 15, 2018.