Florida Network of Youth and Family Services Quality Improvement Program Report

Review of YFA-George W Harris

on 01/16/2019

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	Satisfactory
3.07 Special Populations	Satisfactory
3.08 Video Surveillance System	Satisfactory

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

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

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

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

Rating Definitions

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

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

Review Team

Members

Marcia Tavares, Lead Reviewer, Consultant, Forefront LLC

Susan Yang, Program Support Services Coordinator and Compliance, Boys Town of Central Florida

Marvin Bliss, Regional Monitor, DJJ

Julie Edison, Training and Development Manager, Hillsborough County Children Services

Andrea Johnson, Quality Management Specialist, Children's Home Society of Florida

Persons Interviewed

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

0 Case Managers
0 Program Supervisors
0 Health Care Staff

0 Maintenance Personnel
0 Food Service Personnel

0 Clinical Staff
0 Other

Documents Reviewed

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

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

Surveys

3 Youth 3 Direct Care Staff

Observations During Review

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

Comments

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

Strengths and Innovative Approaches

Rating Narrative

YFA George W. Harris (GWH) Shelter is located at 1060 US Hwy 17 South, Bartow, Florida. The shelter is licensed for 24 beds by the Department of Children and Families effective through December 19, 2019. The shelter facility is located on a large campus that includes its administrative/staff offices and the residential facility. The GWH program is the agency's Children In Need of Services/Families In Need of Services (CINS/FINS) program in Bartow, Florida which is sub-contracted with the Florida Network of Youth and Family Services (Florida Network) to provide temporary residential and non-residential services to youth and families in Hardee County. Services are provided to male and female youth under the age of eighteen.

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

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

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

Since the last review by DJJ on 1/24/18, the part-time Registered Nurse position turned over. The current RN was hired on 10/30/18. In addition, the program has hired five more YDS, 4 of which are now full time and 1 PT (one of the five transferred from another YFA office).

YFA GWH is in the second year of a three year Basic Center Grant with the Department of Health and Human Services. Two additional staff, funded through the Basic Center Grant, are the Outreach Worker and the Life Skills Specialist. The Outreach Worker position turned over in August. The Life Skills Specialist will complete her first year by the end of January 2019. The program had a recent counselor vacancy in December 2018 and the counselor will begin next week the last week in January.

On June 25, 2018, fundraising reached the necessary goal of $18,000 to replace much needed furniture in both the dining room and the great room, along with some items in the dorm area.

Standard 1: Management Accountability

Overview

Narrative

YFA-GWH is under the leadership of Glenn Parkinson, Residential Director. The management team consists of a Non-Residential Program Director, two Non-Residential Program Supervisors, a Youth Development Specialist Team (YDS) Leader, and two Office Specialists. In addition to the Youth Development Specialist Team Leader, the residential component of the program is staffed by 2 counselors, 6 Shift Leaders, 6 fulltime (FT) YDS (4 funded by DJJ, 2 by Basic Center), 4 part time (PT) YDS, a contracted Registered Nurse, and 2 positions funded by Basic Center grant: an Outreach staff and a Life Skills staff. The program had four vacant positions at the time of the QI review for 3 PT YDS and 1 non-residential counselor. The Non-residential CINS/FINS Family Help component serves the Polk, Hardee, and Highlands counties and is staffed by a program director, a program supervisor, 6 counselors, 1 Intensive Care Manager, and an Office Specialist.

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

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

1.01 Background Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The provider's Background Screening Policy and Procedure, SH 1.01, effective 9/13/2013 was last reviewed on 3/30/17 and signed by the COO and VP of Prevention Services. SH 1.01 meets the requirement of the indicator regarding the screening of all new employees/volunteers prior to hire/start date, 5-year re-screening of employees and volunteers, and the annual submission of the Affidavit of Compliance with Good Moral Character Standards to the Background screening unit by January 31st each year. The provider was in the process of revising SH1.01 and HR230 during the QI Review and the unsigned draft policies with revision dates of August 2018 were also reviewed onsite.

YFA SH 1.01 procedures require all new staff and applicable volunteers to complete a background screening that includes DJJ, FDLE, local law enforcement, civil court records, FDLE Sexual Offender/Predator database check, and motor vehicle check. Applicants and volunteers will be live scanned fingerprinted by the HR department if they were not previously live scanned. The applicant completes DJJ BSU 003 PREA Acknowledgement form and Live scan BSU Form 002 which are maintained on file by HR. In addition to the DJJ background screening, the provider also conducts a drug screening for all new hires. The agency will request federal criminal checks for all employees, interns, and volunteers within 12 months of their background screening anniversary/expiration dates. By or before January 31st of each calendar year, the agency will complete and submit the Annual Affidavit of Compliance with Level 2 Screening Standards to DJJ.

A total of eleven background screening files were reviewed for 8 new hires and 3 staff eligible for 5 -year rescreening during the review period. All of the new employees were background screened with eligible results obtained prior to the hire date.

There were three staff eligible for 5-year re-screenings during the QI period; two of the three 5-year re-screenings were completed prior to their 5 year anniversaries.

The provider completed the Annual Affidavit of Compliance with Level 2 Screening Standards and submitted it to the Department of Juvenile Justice Background Screening Unit on January 2, 2019, prior to the January 31st deadline.

The agency uses HireSelect® to screen new candidates prior to employment, a web-based system that provides pre-employment testing in minutes through the company Criteria Pre-Employment testing. The HireSelect® online tool includes various aptitude and basic skills testing and offers real time scoring emailed to the provider and also stored in the Results section of their HireSelect account. Score reports for each test are different, but most skills and aptitude tests include both a raw score (number of questions answered correctly) and a percentile ranking that indicates how well someone did relative to other test-takers. An implementation date for using HireSelect was not confirmed by the provider and as of the date of the onsite visit, the provider did not have a written policy in place for its use of the HireSelect pre-assessment tool with regards to selection/suitability criteria and agency protocol.

A review of the current policy SH1.01 revealed contracted providers are not included in the list of individuals that are required to be background screened by the provider as required by indicator 1.01.

The current policy and procedures reviewed does not include evidence of utilization of a specific pre-employment assessment that is administered to candidates during the application process, prior to employment, to determine suitability that includes a pass rate, score, or measure for suitability. However, the reviewer was informed of the tool used and provided access to a link to validate the function of the tool.

The 5year re-screening was requested late for one applicable staff DOH 7/8/2013. The clearinghouse and DJJ Livescan screening eligibility determination date was 1/25/2019 but should have been completed by or before 7/8/2018.

1.02 Provision of an Abuse Free Environment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedures (SH 1.02) in place that address the key elements of the CQI indicator. The policy and procedure were effective, reviewed and revised February 13, 2016, and signed by the Chief Operating Officer.

All professional/clinical staff are required to follow the Code of Ethics and Standards of Practice set by the American Counseling Association (ACA). Upon hire, employees receive an employee handbook which includes the agency's Code of Conduct that outlines the agency's guidelines for professional and ethical behavior. The employee handbook describes some examples of unacceptable conducts that maybe be subject to disciplinary action. Employees are expected to maintain a safe work environment which complies with federal and safety requirements.

Staff are required to refrain from using profanity, threats or intimidation in the presence of youth or on agency grounds. Management is to act immediately upon any reports of physical and/or psychological abuse, verbal intimidation, use of profanity, and/or excessive use of force. All employees are to contact the abuse registry upon gaining knowledge of actual or suspected child abuse, neglect, or exploitation. The alleged abuse report is reported to the Central Communication Center and follow- up to such incidents made in accordance with agency procedures. Youth admitted into the program are provided a youth orientation. During the orientation, youth are provided with information in regards to his/her rights and the grievance process.

The agency has the policy and procedure in placed to report on all allegations of child abuse or suspected child abuse, neglect, or exploitation to the Florida Abuse Hotline. The Florida Abuse Registry Hotline number, rights and responsibility, and other relevant numbers are visibly posted on each wing of the dormitory and the common area. Employees are mandated to report all known or suspected cases of abuse and/or neglect. The agency retains the record of child abuse report. Upon intake, youth are oriented about the abuse reporting procedure. During youth survey, youth responded that the staff reviews this information during the orientation process. Youth also responded that they were never stopped or delayed in making the call to the abuse hotline. The Florida Abuse Registry number is also included in the youth handbook. A total of eight abuse allegations were reported and reviewed during the onsite visit. None of the allegations were against staff for physical and/or psychological abuse, verbal intimidation, use of profanity and/or excessive use of force. Six staff files were randomly selected: three first-year staff and three in-service training files. All of the six staff completed training on child abuse reporting.

The Shelter Handbook directs the youth to ask the staff member for "Grievance Report" form and give the completed grievance form to any staff member. Then staff will give the grievance form to the Residential Supervisor instead of depositing it in the grievance box. Per QI indicator 1.02, direct care workers shall not handle the complaint/grievance document unless assistance is requested by youth. Per the agency's grievance policy and procedure, youth are allowed to submit to any staff. Per the Residential Director, the program has not received any grievance in the year 2018.

The agency has the procedure in place in which management takes immediate action to address incidents of policy/procedure violation. On 10/23/18, a male youth had "cheeked" the scheduled medication and gave to one of the residents. The investigation was completed and it was determined that the YDS did not follow the safety protocol. Therefore, the residential supervisor and director followed up and delivered a disciplinary action to the YDS.

The policy and procedure indicate that Direct Care Workers shall not handle the complaint/grievance document unless assistance is requested by youth. However, the shelter handbook instructs the youth to give the completed grievance form to any staff member.

There were no exceptions to this indicator.

1.03 Incident Reporting

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

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

All designated incident types are to be reported to the Central Community Center (CCC) within two (2) hours of the affected facility, office, or program learning of the incident. Employee who observes or has knowledge of a critical discovery notifies the Program Director immediately. An employee who observes or has knowledge of a non-critical incident must notify a supervisor on duty immediately. Events shall be documented in the house Logbook. Property damage shall be reported to the Program Director. The Program Director notifies the Vice President of all critical incidents and accidents. Employee shall notify the youth's guardian of any incident involved. The Risk Prevention and Management Team shall conduct a quarterly review of the monthly reports to determine trend and pattern data. The CQI council may devise a Corrective Active Plan for implementation and follow up by program management if appropriate. The Critical Incident Review Team (CIRT) shall contact a review of potential critical incidents and accidents and conduct a review of all critical incidents that involve the threat of or actual harm to a client, restraint, serious illness/injury, and death.

Between 7/1/2018 and 1/15/19, there were thirty (30) reportable incidents reported to the Central Communication Center (CCC) classified as the following types: missing facility keys, contraband recovered/discovered, medical-transport, battery on staff, violation of policy rule, missing youth property. The program notified the Central Communication Center no later than two hours after the reportable incident occurred or within 2 hours of the program learning of the incident except for one incident, that occurred on 12/25/18 (missing facility key), which was notified on 12/27/18. The agency completed follow-up communication tasks instructions as required by the CCC.

Staff called in the CCC to provide an update with outcomes (Emergency Room Visit). The agency utilizes a form called CINS/FINS incident/Complaint Report Form. The form contains the date of the incident, time of the incident, date of CCC notified, time CCC notified, type of incident description, list all persons involved, individual/agencies notified, reporting person, and reviewer of the incident. All of the incidents were documented on incident reporting forms. Incidents were also documented in the program logs. The Program Director reviews the form and notes any comments if needed. The referrals are documented on progress notes. The provider maintains a binder with all of the non-reportable and reportable incidents.

There were no exceptions to this indicator.

1.04 Training Requirements

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedures that address all of the key elements of the CQI indicator. The policy training requirements (SH 1.04) were effective 9/13/13, reviewed 2/13/14 and signed by the Chief Operating Officer and Vice President of Prevention Services.

The provider offers a wide array of training opportunities to all staff including the utilization of an online training system called "Relias". Staff are responsible for completing assigned trainings on Relias. The agency requires all CINS/FINS staff to complete the DJJ training within the first 120 days of hire. All CINS/FINS staff who work in direct contact youth are required to complete eighty (80) hours of training during the first year of employment and (40) forty hours of training each year after.

The topics required to be completed within the first 120 days of hire are:

1. New Hire Orientation
2. Program Orientation
3. Child Abuse and Incident Reporting Procedures
4. Managing Aggressive Behavior (MAB) (Residential Only)
5. CINS/FINS Core
6. Suicide Prevention
7. Signs and Symptoms of Mental Health and Substance Abuse
8. CPR and First Aid (every 2 year thereafter)
9. Behavior management
10. Understanding Youth/Adolescent Development
11. Title IV-E
12. Medication Distribution for Non-Licensed Staff (residential only)
13. Assessment of Suicide Risk (counselors only)
14. Ethics (every two years)
15. PREA
16. Information Security Awareness
17. Serving LGBTQ youth
18. Cultural Diversity

19. Fire Safety Equipment (Every two years)

20. Human Trafficking Identification

21. Confidentiality

22. Trauma Informed Care

23. Advancing Youth Development

The following on-going trainings are required for staff to complete annually: child abuse, crisis management, CINS/FINS Core, suicide prevention, signs and symptoms, medication distribution for non-licensed staff. Staff are also required to complete CPR and first aid, Ethics, PREA and Fire Safety Equipment every two (2) years.

The agency maintains the staff training files that include required training by hire date, training topics, training provided by, date of completion, training hours, and total training hours. Certificates of completion are maintained in the training file.

Six staff training files were randomly selected: three first year and three in-service employee training files. All three of first year training files had exceeded the required 80 training hours: 168.25 hours, 155.75 hours, and 178.25 hours. There was evidence that staff completed required training within 120 days of hire and DJJ-Skill Pro training. However, all of the three staff members completed Universal Precaution training after 120 days of hire. Two staff members were hired on 3/28/18 and this training was completed 12/18/18. One staff member was hired on 5/30/18 and the training was completed on 12/18/18. Upon review, one staff member did not have documentation of completion of the DJJ Skill Pro-Human Trafficking. She had in fact taken it on 4/9/18 (date of hire 3/26) but failed to turn in the updated transcript to update her training record. None of these three staff members completed Cultural Humility as of the date of the QI visit but still have time to complete the training. It is recommended for staff members to complete this training by 3/28/19 (2 staff) and 5/30/19 (1 staff member).

All three in-service staff had exceeded the 40 hours of training required annually. In addition, all of the required annual/refresher training topics were completed by all three staff. There was no non-licensed clinical staff hired since the last on site QI visit.

There was evidence that staff completed required training within 120 days of hire and DJJ-SKillPro training. However, all of the three staff members completed Universal Precaution training after 120 days of hire. Two staff members were hired on 3/28/18 and this training was completed on 12/18/18. One staff member was hired on 5/30/18 and the training was completed on 12/18/18. One staff member did not complete Human Trafficking training on SkillPro. In addition, none of these three staff members completed Cultural Humility training as of 1/17/19.

1.05 Analyzing and Reporting Information

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has multiple policies and procedures that outline its Continuous Quality Improvement (CQI) process (QI 300, revised 9/5/18), CQI Teams (QI 310, 12/7/18), and Data Collection and Evaluation (QI 350,9/1/18). In addition, the agency has a comprehensive CQI Plan for FY 2018-2019 that describes the agency's CQI structure, committees, stakeholders, CQI cycles, data collection and analysis, reporting, and corrective actions.

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

YFA appoints staff at various levels to participate in the CQI process on five CQI teams in addition to the Executive Committee. The teams are as follows: Outcomes Measurement, Risk Prevention, Stakeholder Involvement, Safety, and Peer Review. The Executive Committee has taken on the role of training and employee retention. Each team has an appointed team leader who is responsible for coordinating team meetings quarterly. The Director of QI and Risk Prevention maintains a calendar and a log of all team meetings. Agendas for all team meetings are maintained respectively along with meeting minutes. The CQI teams are responsible for providing updates and recommendations to the Executive Committee on a quarterly basis regarding areas outlined in the purpose and goals for each team. Quarterly reports are to be written for each team. Annual reports are also required from each CQI Team and are due by July 31 for the FY activities.

The VP of QI and QI Coordinators are responsible or coordinating case record reviews for all of the agency's programs statewide. Due to the size of the agency, the number of programs (12) and number of youth served, the CINS/FINS program has a formal case record review once per year (50 files res/non-res) and follow up within 90 days. In addition, the VP of QI will conduct quarterly record reviews of 5-10 files randomly selected. Upon completion of case record reviews, the results are aggregated and a report is submitted to the VP of QI to be presented to the Chief Administrative Officer and VP of Programs; quarterly review reports are sent to the Program Directors. Reviewed the last annual Peer Record Review reports and most recent quarterly review conducted (1st quarter of FY) for the Residential and Non-Residential programs. Deficiencies were addressed and communicated to the Program Directors.

Incidents, accidents, and grievances are reviewed quarterly by the Risk Prevention Committee and Safety Committee. The committees are

responsible for reviewing incidents, accidents, and grievances for each program and report to the leadership team. The Risk Prevention Committee is facilitated by the VP of CQI and meets quarterly.

Practice: One meeting was held for the current FY. However, quarterly data was compiled for the period through August, and through November 2018. The Incident Report Rollup contains the aggregated monthly report of incidents, accidents, and grievances (if applicable) for the agency's programs.

Consumer surveys are administered by the program staff and entered into Netmis as well as aggregated Stakeholder Involvement Team. The team meets quarterly to review findings of the satisfaction reports and reports their findings to VP of QI who communicates results to the leadership team. Strengths, weaknesses, and goals are reviewed and documented in the minutes and discussed at the meetings. The Stakeholder Involvement Team met quarterly on 10/09/18 and 1/15/19. Copies of the agendas and minutes for these dates were reviewed.

Outcome data is reviewed quarterly by the Executive Committee. Meetings are held the 4th Monday each month. During the QI period meetings were held each month with the exception of December in which the Strategic Planning Meeting was held. Executive Committee meetings include a review of shelter data packets including outcome Measurements, financials, and hire/retention data. Monthly data captures select outcomes for the CINS/FINS program such as elopement, the average length of stay, completers, execution of 30 and 60 day follow-ups, and satisfaction with the program. Benchmark outcomes data are reviewed by the Residential Director upon receipt and deficiencies are addressed immediately and communicated to staff via staff meetings as necessary. Monthly reports are generated by the committee and submitted to the VP of QI to be discussed at leadership meetings. Evidence of monthly data and agendas showing discussion of outcomes data was observed on site.

Executive shelter meetings are held every 2 months (participants include: VPs, Data staff, CFO, COO, IT, HR, QI) to discuss a variety of topics related to legislative changes, QA, monitoring schedule, fiscal, external information sharing, policies and procedures, trainings, development, HR, data, retentions, and outreach and interagency agreements. Agendas and sign in sheets were reviewed for the meeting held 7/30/18, 8/27/18, 9/24/18, and 12/4/18.

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

There are no exceptions noted for this indicator.

1.06 Client Transportation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedures on Client Transportation. The policy SH 1.06, Client Transportation, was effective 1/13/16 and reviewed 2/14/17 by the Chief Operating Officer and Vice President of Prevention Services. The policy and procedures address the key elements of the QI indicator.

Approved agency drivers are agency staff approved through Human Resources. All authorized drivers are documented as having a valid Florida driver's license and covered under Youth and Family Alternatives' insurance agent. Program Directors are to ensure staff who are uninsured are not permitted to drive agency vehicles or transport a client. Prior to starting all employees must have a drug screen, local law enforcement check and notarized the "Affidavit of Good Moral Character." Staff are to utilize the "Monthly Trip and Mileage Log" each time they use the agency vehicles whether they are transporting clients are not. Staff shall document in the log: the name of the driver, date and time, whether the safety equipment is available, client initials traveling in the van, the origin and destinations of the trip, any tolls used, and the odometer readings at origin and destination. Staff are to take the shelter phone when providing transportation and check in with the shelter once they arrive at the final destination. Staff are to take an approved third party that involves the transport of a youth, whenever possible. The third party is authorized agency staff, volunteers or interns. Staff are to make every effort to avoid single party transportation; however, in the event that single party transportation must be done, the supervisor or designee is aware and this is documented in the log. In addition, in the case of single-party transportation, staff are to take into consideration the client's history and recent behaviors before transporting. Any safety issues/concerns during a single party transport will maintain an open line of communication with the shelter throughout the transport.

The agency has a policy including exceptions in the event that a 3rd party is not present in the vehicle while transporting. Approved agency drivers documented as having a valid Florida driver's license and are covered under the company insurance company. There are total of 21 employees on the approved driver list. The provider has a total of three (3) vehicles for this location.

There is documentation of use of vehicle called "Monthly Trip and Mileage Log" that notes the name of the driver, date and time, mileage, number of passengers, the purpose of travel and location. The provider notes the odometer readings at origin and destination. The provider also has a log binder called, "Single Party Transportation Log" that notes the name of the driver, date, time of departure from the shelter, time of arrival to the destination, time of arrival back to shelter, supervisor approval initials, phone link to the name of staff. The Residential Shelter Supervisor stated that the supervisor's awareness of single transportation would be noted in the program log book. Although the single transport log includes a supervisor's initial indicating approval, there was no evidence that the supervisor is aware and consented prior to transport as the time of the approval could not be verified in the program log book and is not indicated on the "Single Party Transportation log".

There was no evidence that a program supervisor is aware prior to transport and consent is documented accordingly and the time of the approval could not be verified in the program log book or "Single Party Transportation log".

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

1.07 Outreach Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a Community Outreach and Education policy and procedures for outreach services and inter-agency agreements. The policy and procedures were reviewed on 3/27/2017 and were signed by the CEO and Board Chair.

Staff are assigned responsibility for community education by seeking opportunities to communicate the agency's mission, role functions, strengths, and needs confronting children and families. Agency staff are responsible for participating on state, county, and district boards as appropriate. Agency staff are encouraged to participate in community forums that deal with issues of youth and families. Staff are to inform the community of services to truants, runaways, youth at risk of abuse, and neglect, ungovernable youth and their families through public speaking, and community meetings. Staff are encouraged to participate in the United Way of Day of Caring and provision of tours and information to corporations and community not-for-profit agencies. Staff are interacting with various community organizations, school personnel and student groups. Staff are to disseminate information regarding services available to children and families in the community. CINS/FINS programs attend the local DJJ circuit meetings and keep a copy of the meeting agendas, minutes, and sign-in sheet for records. CINS/FINS programs keep a record of inter-agency agreements.

The provider participates in local DJJ board and council meetings to ensure CINS/FINS services are represented to increase public safety by reducing juvenile delinquency through prevention, intervention and treatment services.

The agency maintains a log book, "Harris Youth Shelter Prevention/Outreach", with all of the meeting agenda and notes. Outreach staff member and Program Director regularly attends these meetings.

The provider has inter-agency agreements with various community service agencies, police agency, medical providers, education providers, mental and substance abuse providers. The agency has inter-agency agreement and Memorandum of Understanding (MOU) with various providers include but not limited to: Polk County School Board; District School Board of Pasco County; Highlands County School Board; Lake Wales Charter Schools; Citrus County School Board; Sumter County School Board; Pasco Juvenile Assessment Center; Mid-Florida Center; Behavioral Health Division of Winter Haven Hospital; Agency for Community Treatment Services, INC.; National Runaway Switchboard; Family Resources, INC.; and Lighthouse for the visually impaired and blind, INC.

There were no exceptions to this indicator.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

The program provides centralized intake and screening twenty-four hours per day, seven days per week, and every day of the year. Trained staff are available to determine the immediate needs of the family and youth. Each youth at the program receives an initial eligibility screening, CINS/FINS Intake Assessment, a needs assessment, and a service plan. The case management/counseling component consists of a total of 17 counseling positions (15 Non-residential and 2 Residential) and an LCSW. The counselors are responsible for completing assessments, developing case plans, providing case management services, and linking youth and families to community services. Additionally, case management, individual, family, and group counseling services, substance abuse prevention education, and referrals to local community agencies are provided as needed.

The shelter program provides critical temporary shelter care services to youth meeting the criteria for CINS/FINS, DV and Probation Respite, Staff Secure as well as Domestic Minor Sex Trafficking (DMST). During the review period, the program did not serve any youth meeting the criteria for staff secure, Probation Respite, or DMST.

The program meets the needs of the youth while in care with the ultimate goal of reunification with their families. The facility has 24 beds available for both male and female youth in the CINS/FINS program and twenty-four hour awake supervision is provided for youth residing in the shelter.

As needed, YFA-GWH coordinates the Case Staffing Committee, a statutorily-mandated committee that develops a treatment plan for habitual truancy, lockout, ungovernable, and runaway youth when all other services have been exhausted or upon request from the parents/guardians. The Case Staffing Committee can also recommend the filing of a CINS Petition with the court. Non-residential counseling services are provided by qualified Bachelor and Master's level staff who have access to a licensed Clinician. Case file reviews revealed that the counselors monitor the youth's and family's progress in services, provided support for the families, and monitored the out-of-home placement as applicable.

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

2.01 Screening and Intake

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written Screening and Intake Policy that contains the key elements of the QI Indicator. The policy and procedure reference number is documented as SH 2.01 with an effective date of 9/13/13. The Chief Operating Officer and the Vice President of Prevention Services last reviewed the policy on 2/14/17.

The Policy and Procedure states the agency will provide intake to families 24 hours a day at which time they will receive available service options, client rights and responsibilities, possible actions occurring through involvement with CINS/FINS services, as well as a description of the grievance process.

During the screening process the information gathered is used to assess the needs of the youth as well as eligibility criteria. The agency's procedure indicates the screening must occur within seven (7) calendar days of referral by a trained staff person using the NETMIS screening form. If during the initial screening process a counselor is unavailable, the Centralized Intake Screening Form will be completed by a Youth Development Staff (YDS) or Support Staff Worker (SSW). If a youth is determined to be in need of crisis mental health or substance abuse services, appropriate management staff are notified immediately.

During the QI review, three (3) open residential files and seven (7) non-residential files (6 open, 1 closed) were reviewed. The files provided verification of practice for the above-mentioned policies and procedures. All reviewed files contained completed screening and intake forms and provided documentation that both youth and parent/guardian received client rights and responsibilities, available services, and grievance procedures.

There were no exceptions to this indicator.

2.02 Needs Assessment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written Needs Assessment Policy that contains the key elements of the QI Indicator. The policy and procedure reference number is documented as SH 2.02 with an effective date of 9/13/13. The Chief Operating Officer and the Vice President of Prevention Services last reviewed the policy on 2/14/17.

The policy and procedure states a Needs Assessment must be initiated in a timely manner (within 72 hours of program admission) for each youth/family participating in shelter services. The Needs Assessment must be completed within two to three face to face contacts following the initial intake for youth receiving non-residential services. The Needs Assessment uses multiple sources to gather data to assess client needs, provide a baseline to measure effectiveness of services, and the family's ability to implement learned skills through interventions. If necessary a referral is completed for clients needing a more intensive assessment and this is noted in the client file. Assessments are on-going and are conducted every 6 months or otherwise noted.

The policy and procedure states the needs assessments must be completed by a Bachelor or Master's Degree level staff and should be signed by a supervisor. If the suicide risk component is identified as a result of the needs assessment, it must be reviewed, signed, and dated by a licensed clinical supervisor or written by licensed clinical staff.

Ten (10) files were reviewed, 4 non-residential (1 closed, 3 open), 3 residential, (3 open), and 3 case staffing (open- non residential).

All files reviewed contained all of the required assessment items and met all required time frames. All reviewed assessments were conducted at the Bachelor or Masters level and were all signed by a Supervisor.

Three (3) open residential files and seven (7) non-residential files (6 open, 1 closed) were reviewed. All files reviewed contained all of the required assessment items and met all required time frames. All reviewed assessments were conducted by a Bachelor or Masters level and were all signed by a Supervisor.

Two (2) of the seven (7) files reviewed indicated an elevated suicide risk on the needs assessments and appropriate procedures were followed in accordance with agency policy and procedures. The assessment tool was completed and reviewed by a licensed clinical supervisor/staff within 24 hours of completion.

There were no exceptions to this indicator.

2.03 Case/Service Plan

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written Case/Service Plan Policy that contains the key elements of the QI Indicator. The policy and procedure reference number is documented as SH 2.03 with an effective date of 9/13/13. The Chief Operating Officer and the Vice President of Prevention Services last reviewed the policy on 2/14/17.

The policy and procedure state that all case records contain a service plan. The service plan is a statement of goals, proposed actions, and objectives developed in partnership with the youth and the family. Each service plan is individualized by the client and includes specific strategies for interventions, services, and resources with a timeline for service delivery. An extension of the service plan is the Aftercare Plan that will be developed similarly to the development of the service plan.

The agency agrees to develop a service plan within seven (7) working days following completion of the needs assessment and based on individual needs gathered at intake and screenings.

Case/Service Plans will contain the following information:

- An individualized, mutually agreed upon plan goal
- Type of intervention
- Frequency of service
- Location of treatment or services needed
- Realistic time frames for completion

- Designates responsibilities of the youth, family and program
- Interventions prioritized by urgency and importance
- Date plan initiated and length of service
- Support networks and improving existing networks
- Expected behavioral changes
- Signatures of all participants including youth and parent
- Signatures of Program Director

Case/Service Plan reviews will be formally reviewed by the counselor/therapist and the parent/guardian (if available) at a minimum of every thirty (30) days for the first three months, and every six (6) months thereafter for progress in achieving goals and objectives.

If the youth or family is unavailable or unwilling to review the Service Plan with the counselor, the counselor may review the case with his/her supervisor. The counselor will document all efforts to engage the youth and family in reviewing the service plan in the chronological Contact form and Progress Notes.

Three (3) open residential files and seven (7) non-residential files (6 open, 1 closed) were reviewed. Each file contained a comprehensive individualized service/case plan. Each plan contained at a minimum, date of initiation of plan, needs and goals, Type, frequency, and location of services provided, responsible individuals, realistic target and completion dates, and required signatures.

There were no exceptions to this indicator.

2.04 Case Management and Service Delivery

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written Case Management and Service Delivery Policy that contains the key elements of the QI Indicator. The policy and procedure reference number is documented as SH 2.04 with an effective date of 9/13/13. The Chief Operating Officer and the Vice President of Prevention Services last reviewed the policy on 2/14/17.

The policy and procedure states the agency will assign each youth a counselor who will follow the youth's case to ensure service delivery throughout case management process.

The case management process includes:

• Establishing referral needs and coordinating services based on on-going needs assessment

• Coordinating service plan implementation

• Monitoring youth/family progress in services

• Providing support for families

• Monitoring out-of-home placement, if necessary

• Providing referrals to case staff, if necessary to address youth/family issues

• Recommending and pursuing judicial intervention in selected cases (non-judicial)

• Accompanying youth/families to court hearings or appointments, if applicable.

• Provide referrals for additional services

• Provide continued case monitoring and review of court orders

• Case terminations with follow-up

For cases involving substance abuse services youth are referred for further assessment and/or treatment. The agency agrees to provide diligent efforts to engage the family in solution services and will document engagement efforts in client files.

All files reviewed contained assessments and service plans complete with all required indicator data. The referrals in each file were complete and service engagement clearly documented. In addition, each file contained evidence of program staff monitoring youth/family progress in services. Three (3) case staffing files were reviewed and provided evidence of program staff addressing issues identified through assessments and monitoring of youth/family needs.

There were no exceptions to this indicator.

2.05 Counseling Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written Counseling Services Policy that contains the key elements of the QI Indicator. The policy and procedure reference number is documented as SH 2.05 with an effective date of 9/13/13. The Chief Operating Officer and the Vice President of Prevention Services last reviewed the policy on 2/15/17.

The policy and procedures states the agency will provide youth with services based on youth/family needs in an effort to preserve the family unit and keep the youth out of the juvenile justice system. Youth receive counseling based on individual service plans. Shelter program provides both individual, family, and group counseling sessions held at a minimum of five (5) days per week, based on established group process procedures.

Non-residential programs provide services designed to provide necessary interventions intended to stabilize the family unit, minimize out-of-home placement, provide aftercare services for youth returning home from shelter services, and prevent youth from involvement in the delinquency systems.

YFA Counseling services:

Reflect all case files for coordination between presenting problems, psychological assessment, case service plan, case service plan reviews, case management, and follow-up;

Maintain individual case files on all youth and adhere to all laws regarding confidentiality;

Maintain chronological case notes on the youths progress; and

Maintain an on-going internal process that ensures clinical review of case records, youth management, and staff performance regarding CINS/FINS services

Three (3) open residential files and seven (7) non-residential files (6 open, 1 closed) were reviewed. Each file contained evidence of counseling services to reflect case coordination, case service plans, case service reviews, case management, and follow-ups. Counseling services were also documented in progress notes as well as in youth case service plans. All ten (10) files reviewed were clearly marked and maintained confidentially in accordance with the agency policy and procedure and met network indicator requirements. Chronological notes were thorough and clearly documented in all reviewed files.

A review of sign-in sheets and group notes, provided evidence of group session/counseling dates, participants, and goals/objectives.

There were no exceptions to this indicator.

2.06 Adjudication/Petitiion Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written Adjudication/Petition Process policy that contains the key elements of the QI Indicator. The policy and procedure reference number is documented as SH 2.06 with an effective date of 9/13/13. The Chief Operating Officer and the Vice President of Prevention Services last reviewed the policy on 2/15/17.

The policy and procedure state the agency accepts responsibility to maintain a case staffing committee. The committee may be convened on an individual basis or maintained through a standing case staffing committee protocol. The composition of the case staffing committee is based on the needs of the youth/family. Should a parent of active CINS/FINS youth request a case staffing in writing, the committee shall convene within seven (7) working days of the request. (Excluding weekends and holidays)

The agency is responsible for notifying the appropriate case staffing participants. The child, family, and staffing committee are contacted within five (5) working days of meeting commencement notifying dates and times. Families are contacted the day before the meeting as a reminder to the family. All contacts with the child/family are to be documented on the Chronological contact form and copies maintained of all

correspondence in youth files. All meetings are held in locations convenient to the family.

Case staffing meetings with a parent/guardian and child should be convened to review the case of any family or child who is need of treatment or services if:

- The family or youth is not in agreement with the services or treatment offered
- The family or youth will not participate in services or treatment offered
- The agency counselors need additional assistance in developing a case plan
- The family or youth have not demonstrated substantial progress in achieving service plan goals
- The services or treatments selected have not addressed the problems and needs of the youth/family
- The parent/guardian request, in writing, that a case staffing committee meeting be convened

The staffing committee should be comprised at a minimum of the following:

- State Attorney Representative
- Alternative Sanctions Coordinator
- Representatives from health, mental health, substance abuse, social, or educational services
- The youth parent/guardian
- Any persons recommended by the child, family, or CINS/FINS program

If families attend the case staffing, they are provided a copy of the plan. Counselors are required to document case plan receipts for parents in attendance. If a parent is not in attendance of case staffing a copy is sent to the parent/guardian outlining interventions and recommendations within seven (7) seven working days of case staffing committee.

Three (3) case staffing files were reviewed. Each of the 3 files documented a written request from a committee member. Progress notes outlined case staffing events and copies of court proceedings. Copies of case staffing notes, service plans, court reports, correspondence letters (certified mail copies), and recommendations from committee participants are located in the youth files as well as in binders labeled CINS Case Staffings/Court. Each file contained the required documentation and met the required timeframes. Additionally, the committee exceeded the minimum staffing compilation of members and a list of those participants is maintained in the Staffing binder.

There were no exceptions noted for this indicator.

2.07 Youth Records

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written Youth Records Policy that contains the key elements of the QI Indicator. The policy and procedure reference number is documented as SH 2.07 with an effective date of 9/13/13. The Chief Operating Officer and the Vice President of Prevention Services last reviewed the policy on 2/15/17.

The agency policy and procedure states that all pertinent youth treatment information should be maintained in a confidential filing system. All youth files require a confidential stamp, must be neatly maintained for easy access to program staff, and must be kept in a secure room or locked filing cabinet only accessible to essential program staff. Records that require transport must be done in a locked opaque container marked confidential.

All youth files are kept confidential in a locked room. Ten (10) youth records were reviewed and provided evidence of files maintaining neat organization and were easily accessible to program staff.

All reviewed files were marked confidential and for files requiring transport were locked in a container marked confidential.

There were no exceptions to this indicator

2.08 Sexual Orientation, Gender Identity/Expression

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written draft policy, Shelter 2.08, for Indicator 2.08, Sexual Orientation, Gender Identity, and Gender Expression. The policy was implemented in October 2018 and is pending approval by the President/CEO and COO.

YFA believes that all youth must be treated with respect, provided necessary accommodations, and be referred to qualified professionals for supportive services regardless of 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 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.

c. All staff, service providers and volunteers 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.

d. Staff will report to the CCC (Central Communications Center) all allegations of harassment or abuse by staff or youth of any youth based on their actual or perceived sexual orientation, gender identity, or gender expression.

e. 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}

f. All staff, service providers, and volunteers are prohibited from attempting to change a youth's sexual orientation, gender identity, or gender expression, including, but not limited to referrals for conversion therapy, or other similar interventions.

g. All staff, service providers, and volunteers who have intentional contact with youth will have knowledge of this policy and the terms referred to within this policy.

h. 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.

i. Areas in which youth reside or are served will have signage indicating the program is a safe space for all youth regardless of actual or perceived sexual orientation, gender identity, and gender expression.

The residential program will adhere to the following procedures:

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

b. Youth are to be assigned a room aligning with their gender identity, or the program will provide specific documentation as to why other room assignment was determined to be suitable.

c. All room assignment decisions will be made on a case-by-case basis. Safety and security for each youth will be taken into consideration when making a decision regarding room assignment.

d. Youth will not be housed in isolation solely based on sexual orientation, gender identity, or gender expression.

e. Youth will be provided with hygiene products, undergarments, and clothing that affirms their gender identity or 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, a "hate free" rainbow sign and "Being Out, Being Safe" LGBTQ poster were posted in the youth lounge and a copy of the "Being Out, Being Safe" poster was also posted in the lobby. The program also distributes the "Being Out, Being Safe" brochures published by the National Runaway Safeline, to youth during life skills group discussion and make them available for guests in the lobby of the shelter. The program provides training/educational material, "I Provide Safety Support and Respect", for staff/volunteers to read and acknowledge receipt during hire and/or prior to providing volunteer service.

The program has not served any youth during the annual review period who met the criteria for the indicator. However, staff interviewed during the visit stated youth meeting the criteria is addressed by pronouns, name, and gender they prefer and room assignment is made accordingly.

There were no exceptions noted for this indicator.

Standard 3: Shelter Care

Overview

Rating Narrative

YFA-GWH Shelter program provides temporary residential shelter care for male and female youth identified to be at-risk. The program has adequate space for all indoor and outdoor activities and is equipped with two separate residential quarters, one for each gender. The dormitories, kitchen, restrooms and common areas were observed to be clean during the visit. Each bedroom is furnished with beds, pillows, and bed covering and storage for youth belongings. Youth have access to a large yard for outdoor activities.

All youth who are admitted to the program receive a copy of the Shelter Handbook and an orientation to the facility. During the admission process, each youth receives a new CINS/FINS intake screening to identify any medical, mental health, and/or substance abuse condition and this information is provided to the assigned clinical staff. The program provides individual, group, and family counseling, as needed. Group sessions are scheduled at least five times per week. Interagency Agreements have been established for the provision of substance abuse, mental health, and medical services. Case management and counseling services to youth in the Residential program are provided by Bachelors and Master's level counselors under the supervision of a Licensed Clinical Social Worker.

Shelter Care is designed to assure that all youth are safe and well cared for while residing in the shelter. This standard includes the shelter environment including the building, grounds, and vehicles; the orientation of youth to the program including the shelter rules and regulations and their room assignment; the maintenance of logbooks for keeping a detailed description of all shelter actions and activities 24/7; the behavior management system used to both maintain a physically secure environment but to also influence youth to make healthy choices both in and out of the shelter; supervision of youth throughout the day and night within 3 daily shifts and offering a continuum of care; service delivery to special population; and finally, video surveillance for the purpose of accountability on all staff, youth, visitors and other personnel and to use in the event of allegations of mishandling of any situation. The Department of Children and Families has licensed GWH as a Child Caring Agency, with the current license for 24 beds, effective until December 19, 2019.

3.01 Shelter Envonment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency policy S.H. 3.01 meets the requirement of the indicator and was last reviewed on 2/15/17. The Chief Operating Officer and Vice President of Prevention Services signed the policy.

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

During the tour of the facility, an inspection of the shelter environment was conducted. During the tour, the furnishings were observed to be in good repair (recently received new dining furniture and sofas) and the facility was free of insect infestation. The grounds and landscape are well maintained. Bathrooms and shower areas were found to be clean and functional; however, one youth shower in the male hall was noted to have water seeping from the top of the shower head. No graffiti was discovered. Interior areas –Bedrooms – Room 8 had metal clips for badges in the closet. Room 4 and 10 had hygiene items to include, shampoo, skin lotion, cologne. Lighting throughout the facility is adequate.

The Disaster plan was updated July 1, 2018 for the 2018-2019 fiscal year. The Fire Safety Inspection was completed on 11/8/18 by the Bartow Fire Department with no violations noted. The Water-Based Fire Protection Systems Inspection (Sprinkler System) was inspected on 1/9/19 and a few deficiencies noted and corrected include items under the Wet System Inspection (sprinkler heads, cover plates) and the electric alarm bell which was not operating properly. The Water-Based Fire Protection Systems (Hydrant) was inspected with no deficiencies noted. The Annual Exhaust Hood Fire Suppression System (kitchen) was inspected on 11/9/18 with no deficiencies noted. The Fire Inspection and Testing Report completed 10/16/18 with no deficiencies noted. The Fire Alarm Inspection and Testing Report was inspected on 7/5/18 with no deficiencies noted. The Residential Group Home Inspection Report was completed on 12/17/18 with one violation (lighting in laundry room). Residential Group Home Inspection Report dated 12/17/18 noted one deficiency (lighting in the laundry room). Lighting has been corrected but could not locate the date of correction. The lighting was recently corrected. Terminex inspected the facility on 2/15/18. It was noted there were no issues with insect infestation. The agency has a current DCF Child Care License that is valid until December 19, 2019. The agency also received their COA accreditation through 10/31/20.

Fire Drills completed monthly – 3 fire drills took over 2 minutes (10/24/18- 3 minutes, 9/24/18,- 3 minutes, 9/10/18 - 6 minutes).

There were no exceptions for this indicator.

3.02 Program Orientation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency policy S.H. 3.02 meets the requirement of the indicator and was last reviewed on 2/28/17. The Chief Operating Officer and Vice President of Prevention Services signed the policy.

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

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

There were three residential files (2 closed, 1 open) reviewed for this indicator. All reviewed files met the minimum requirements for this indicator. All 3 youth were oriented within the first 24 hours of admission. The procedures are well documented. Client orientation is completed within twenty-four (24) hours. Youth admitted to the shelter go through a new client orientation process consisting of 21 areas, encompassing all the required documents on the Client Orientation Checklist.

3.03 Youth Room Assignment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure, SH 3.03 - Youth Room Assignment, that meets the requirement of the indicator. The agency's policy S.H. 3.03 was last reviewed on 2/28/17. The Chief Operating Officer and Vice President of Prevention Services signed the policy.

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

There were three residential files (2 open, 1 closed). All reviewed files met the minimum requirements for this indicator. All three youth's files documented a review of the youth's history, status and exposure to trauma, age, gender, history of violence, disabilities, physical strength/size, gang affiliation, risk of suicide, sexually aggressive or reactive behavior, gender identification, alerts, collateral contacts, and initial interactions/observations. Youth determined to be a potential threat are assigned in bedrooms closer to the staff monitoring station and are separated from other youth.

There were no exceptions to this indicator.

3.04 Log Books

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure, SH 3.04 Log Books. The policy was last reviewed on 2/28/17 and signed by the Chief Operating Officer and Vice President of Prevention Services. The policy ensures that logbooks in the shelter are to document daily activities, events, and incidents in the program. A new policy draft is pending signatures regarding updates to S.H. 3.04 pertaining to the policy and procedures for Electronic log books.

The procedures are documented for: highlighted logbook entries that could impact security and safety of the program, date and time of incident, event or activity, names of youth and staff involved, brief statement of pertinent information, and staff making entry with date and time of signature. The program indicates logbooks are retained for a period of no less than three years. The Program Director or designee shall review the logbook every week and make a note in the logbook as to any corrections, recommendations, and follow up required. The oncoming supervisor and YDS staff shall review the logbook for the previous two shifts.

There are three logbooks that were reviewed for the past six months. One logbook is utilized for the main program documentation and procedures and the other two logbooks were used for the male and female dormitories. Log Book criteria was adhered to per the policy and procedures; however, it was noted that the male youth log book contained many blank spaces which should always be crossed out with a line through it. It was observed that one staff had scribbled out 3 entries on 1/11/19 while conducting bed checks. The staff did not follow the log book requirement to strike out the error and initial. The Program Director reviewed the facility logbook weekly and noted any follow up needed.

It was reported during the entrance interview that there are three electronic log books of which only one is working so the agency is still using their three hard copy log books and one electronic log book simultaneously. Communication regarding NoteActive problems was noted by an email dated 1-7-19 by the Office Specialist to NoteActive regarding the need for a 2nd tablet. It was reported that the two tablets were deemed inoperable back in December of 2018 and that the Program Director will need to speak with NoteActive to obtain additional tablets or troubleshoot existing problems. An email dated 1-17-19 confirmed that a new Electronic log tablet will be mailed to the facility by NoteActive.

There were no exceptions for this indicator.

3.05 Behavior Management Strategies

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure, RM 780- Behavioral Management. The policy was last reviewed on 4/18/17 and signed by the President/CEO and Board Chair. The policy ensures the agency's use of proactive behavioral management techniques that emphasizes positive and preventative measures in the management of the youth behavior.

The procedure reviewed identifies three levels associated with the Advancing Youth Development (AYD) Curriculum: Orientation (7 days), Education (7 days) and Graduation (unlimited). Each level will have its own requirements and goals in developing youth and promoting positive behavioral choices and healthy decisions among program participants. Each level during the youth's placement at the residential facility will focus on twelve key areas to promote positive youth development. There are five areas with specific targeted behavioral goals that are consistent with the six identified character development issues from the Character Counts Curriculum.

The youth advance by levels and behavior is positively reinforced in the shelter. The BMS uses a variety of awards/incentives to encourage participation and completion of the program. Physical restraint is used only in emergency or crisis situation and only after less restrictive interventions has proven in effective. In addition, staff is trained in Managing Youth Behavior (MAB) and utilize the Why Try Curriculum although Why Try is not specifically noted in the policy. Shift Leaders and Supervisor/Shift Leaders provide feedback to staff and informal evaluation of their use of the BMS. The youth also use "reflection" time to discuss directly with the Residential Supervisor their concerns with the Behavior Management systems in place.

There were three residential files (2 closed, 1 open) reviewed for this indicator. It was confirmed that staff does explain the (BMS) during program orientation and obtain receipt of acknowledgement in the consumer handbook.

There were no exceptions to this indicator.

3.06 Staffing and Youth Supervision

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure SH 520 - Staffing levels and On-Call/Scheduling that addresses all of the key elements of the QI indicator and was last reviewed by the Chief Operation Officer and Vice President of Prevention Services dated 2/28/17.

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

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

The agency is equipped with functional surveillance that includes 20 functioning cameras that are well positioned in the interior/exterior of the facility for adequate monitoring of youth whereabouts. Two of the cameras require repair by the front right side of the agency's parking lot. The system's recording was functional and stores the data back-up for 30 days.

Four random selection of overnight checks was conducted and verified staff's observation and documentation of bed checks every 15 minutes. One part-time staff was observed to have a pattern of bed checks (6) that far exceeded the 15 minute checks. On a separate night, the same identified staff was still slightly over 15 minutes and this was attributed to logging the bed check entry into the electronic log and then conducting the physical bed checks.

On one of the four random overnight bed checks reviewed, one staff was observed to have exceeded the bed check requirement was on 1/14/19 as follows:

Bed check conducted 12:26 a.m.

Bed check conducted 12: 47 a.m. (21 minutes interval)

*Staff noted that late entry was attributed to doing laundry.

Bed check conducted 1:55 a.m.

Bed check conducted 2:13 a.m. (18 minutes interval)

Bed check conducted 3:46 a.m.

Bed check conducted 4:13 a.m. (27 minutes interval)

Bed check conducted 5:46 a.m.

Bed check conducted 6:05 a.m. (19 minutes interval)

On a separate night, the same identified staff was still slightly over 15 minutes on bed checks

The provider failed to provide at least one staff on duty of the same gender as the youth on each work shift including all overnight work shifts. Over the course of the past six months reviewed, there was a minimum of one or more shifts observed for each week where both male and female staffing was not present on each shift when a youth of both genders were in the program.

3.07 Special Populations

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure (SH 660) that addresses all of the key elements of the QI indicator 3.07. The most recent policy has a revision date of July 2018 and is pending approval by the CEO and COO. However, the current policy does not reference Intensive Case Management (ICM) as one of the special populations served by the program.

The provider has established procedures for each of the special populations served. The procedure states that the shelter shall provide services to special populations defined as Domestic Violence Respite, Domestic Minor Sex Trafficking, Probation Respite, and Staff Secure for youth ages 10 through 17 who have been charged with an offense of domestic violence (including youth who have previously adjudicated for other issues) specifically designed to provide a safe alternative to secure detention for youth with pending or adjudicated charges for domestic violence. These services will be provided primarily to youth who reside in Citrus, Hernando, Sumter, Pasco, Hardee, Highlands and Polk Counties. Youth from counties other than those listed may be served with the prior approval of the Network.

The procedures describe a general description of services, youth eligibility, youth referral/determination procedures, limits on youth to be served, and services to be provided for domestic violence referrals. Procedures for domestic minor sex trafficking referrals, probation respite referrals, and staff secure referrals include youth eligibility, youth referral/determination, and services to be provided. Requirements specify that

youth are provided services to address their specific needs, such as Domestic Violence Referrals have service plans that identify outcomes that address ways to reduce violence in the home.

Non-Residential, family/youth respite aftercare services (FYRAC) shall be provided to youth between the ages of six (6) and eighteen (18) years of age referred, following a Domestic Violence arrest on a household member and/or youth on probation, regardless of adjudication status, at risk of violating. These are youth referred by DJJ in need of more intense family stabilization.

Intensive case management services will be provided to youth ages 6-17 who are chronically truant/ungovernable, are court involved or likely to entire the petition process and may require more intensive and lengthy service provided by designated staff trained to provide intensive case management. Procedures are in place to meet the requirement for referral sources, direct and collateral contacts, completion of Child Behavior Checklist and self-report assessments, staffing, coordination of services, and discharge.

During the review period, the program did not serve any youth meeting the requirement for Domestic Minor Sex Trafficking or FYRAC.

Three files were reviewed for Domestic Violence Respite DV Respite. All three youth were referred for domestic violence charges by the JAC/Detention Screener. Their stays in the DV Respite placement lasted no longer than 21 days, consequently, none were transitioned to the CINS/FINS shelter. The case plans addressed the issues of anger management and coping skills to help reduce the reoccurrence of violence in the home. Other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements.

Three files were reviewed for Probation Respite referrals. Staff are updating the youth in the Referrolator. The length of stay is determined by assessing the needs of the youth; all three youth were discharged before being in shelter 30 days. There is evidence of case management and counseling services to address needs identified. All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements.

Three active/open files were reviewed for ICM. The three youth served under the Intensive Case Management contract must met the following criteria: 1) all three youth were referred by case staffing committee. Two of the three files demonstrated the youth and family had six direct contacts and six collateral contacts per month. The Child Behavior Checklist (CBCL) was completed within 14 days of intake in all three cases. An approved self-report assessment was completed within 2 weeks in 2 of the 3 cases; the youth refused to complete the assessment in one of the cases and the counselor noted it in the progress notes. An email was sent to the Florida Network informing them of the youth who did not receive 6 contacts for the respective months. There was evidence of a self-report assessment conducted every two months for the three youth. The case plans address the issues of truancy and case management services demonstrated effort of the staff to engage the family and access supports when needed.

One applicable file was reviewed for Staff Secure. There is evidence the youth staff secure placement met the legal requirements outlined in Chapter 984 F.S for being formally court ordered into staff secure services. Per the residential supervisor, specific staff is assigned during each shift to monitor the location and movement of the staff secure youth at all times. However, there was a period of time for four out of 15 weeks where staff assigned was not noted on the staff schedule or in the program logbook. The Team Leader identified this deficiency and addressed it via a corrective action entry in the logbook for assigned staff to be noted in the logbook. In response to the corrective action, it was observed that staff assigned to the staff secure youth was indicated on the staff schedule consistently but not consistently noted in the logbook on the overnight shift. There was evidence of written reports provided to the court regarding the youth's progress in the non-residential file.

Additional findings:

The reviewer noted during this review that the current policy does not reference Intensive Case Management (ICM) as one of the special populations served by the program.

Per the residential supervisor, the specific staff is assigned during each shift to monitor the location and movement of the staff secure youth at all times. However, there was a period of time for four out of 15 weeks where staff assigned was not noted on the staff schedule or in the program logbook. The Team Leader identified this deficiency and addressed it via a corrective action entry in the logbook for assigned staff to be noted in the logbook. In response to the corrective action, it was observed that staff assigned to the staff secure youth was indicated on the staff schedule consistently but not consistently noted in the logbook on the overnight shift.

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

3.08 Video Surveillance System

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure, RM 660- Video Surveillance. The policy was last reviewed on 4/7/17 and signed by the President/CEO and Board Chair. The policy ensures that the shelter provides a secure environment, protects its facilities, and enhances the safety of youth, staff and visitors. The video surveillance is used to only meet YFA's critical goals for security and in a manner that is sensitive

to interests of privacy, fee assembly, and expression. Video surveillance of public area will be limited to uses that do not violate the reasonable expectation of privacy as defined by law. There is a revision of the policy dated 12/13/18 that is pending signatures from the President/CEO and Chief Operating Officer.

The procedure outlines 8 components required for the postings; usage of video recording/camera, cameras placed in general work areas (excluding bedrooms and bathrooms), limited staff access, and saving of video footage. The surveillance system is equipped with 22 cameras with 2 that are inoperable on the exterior of the facility. The surveillance system captures and retains video images recorded with day, time, and location and enables facial recognition. The system has a back-up battery that is automatically utilized during a power outage. Cameras are placed inside, as well as outside the building. Video surveillance is only accessible by designated personnel (Residential Supervisor, Program Director) and is to be reviewed a minimum of every 14 days and noted in a logbook and the Video Surveillance Log Binder.

Observation of the video surveillance noted that data was available up to 30 days. There is a written notice displayed at the front entrance of the facility and the staff maintains 2 logbooks: 1 for the girls and 1 for the boys. Video surveillance is only accessible by designated personnel (Residential Supervisor, Program Director) and is reviewed a minimum of every 14 days; the reviews are noted in the logbook and the Video Surveillance Log Binder. The staff shares an electronic log book to note entries and then match the entries in the hard copy log books. Random dates were reviewed of overnight bed checks. It was noted at times that bed checks varied sometimes for over a minute as staff would first enter the bed check entry electronically and then conduct the bed check.

The reviewer interviewed the Director and Residential Supervisor and discovered that 2 of the 22 cameras are not functioning. The Residential Supervisor also indicated there is no repair order in place at the time of this QI visit. It appears the cameras have been inoperable since the last 2018 QI visit.

There were no exceptions noted for this indicator.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

YFA-GWH shelter has written policy and procedures related to the admission, interviewing and room assignment of youth admitted into the program. Upon admission program staff completes the intake via an individual interview with the youth. An initial intake assessment is completed to determine the most appropriate room assignment in relation to the youth's needs and issues, the the current population of the facility, the physical space available, and staff's assessment of each youth's ability to function effectively within program rules and expectations. When making youth room assignment, consideration is given to each youth's physical characteristics, maturity level, history (including gang or criminal involvement), propensity towards aggression, and apparent emotional or mental health issues.

Staff receiving the youth at the time of admission notifies the program director, counselor, or team leader of any youth admitted with special needs, mental health issues, substance abuse issues, medical needs or security risk factors as well as those at risk of suicide.

At the time of this annual review the part-time licensed registered nurse (RN) position was filled and has been active since October 2018. The nurse works 2 10-hour days Monday – Friday each week.

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

The program uses the Pyxis Med-Station system for storage and distribution of medication and has 6 super users. Topical and injectable medications are stored separately from oral medications. A locked refrigerator is maintained for the sole purpose of storing medication requiring refrigeration. Medication distribution records for each youth are maintained in a binder which is stored in a locked medication cabinet in the locked medical room.

4.01 Healthcare Admission Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure that address all of the key elements of the indicator(SH4.01). The policy manual was last updated on January 24, 2018 and approved by the Chief Operating Officer.

The agency's procedure requires the use of the CINS/FINS Intake Assessment and the Health Screening Form to screen for mental health and medical. The Intake Assessment includes: The client's mental health, and acute medical conditions at the time of intake. The Intake Assessment also requires current medical treatment, medication, tuberculosis, physical health problems, allergies, recent injuries including head injuries within the past two weeks. Also included in the Intake Assessment is known illness, current pain or other physical distress, hemophilia, asthma, cardiac disorders, seizures disorders, pregnancy, diabetes, current/past substance abuse/mental health issues and any signs of current intoxication, physical illness requiring immediate medical attention. Policy and procedure include a referral process for necessary follow-up medical care by utilizing program staff, parents/guardians, Bartow Medical Center, EMS or family medical professional.

The procedure requires the Youth Care staff to complete the assessments upon intake unless the RN is on site, then she/he will complete the assessments. If the RN is not on site during the intake process, then she/he is required to review the completed assessment within five business days.

A review of three applicable files contained a CINS/FINS Intake Assessment and Health Screening completed at intake. Two of the three youth were taking prescribed medications at the time of intake. Medications were current and had a legible label indicating the person's medication was prescribed for, prescribed medication name, dosage and time frame to pass medications. All CINS/FINS Intake Assessments were reviewed by the RN within the five day requirement.

There were no exceptions noted for this indicator.

4.02 Suicide Prevention

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure that address all of the key elements of the indicator (SH4.02). The policy manual was last updated on March 31, 2017 and approved by the Chief Operating Officer.

The procedure requires the use of the CINS/FINS Intake Assessment for the initial screening for the risk of suicide. If the youth receives a hit or is identified as a suicide risk by answering yes to one of six risk screening questions, the screener is to screen the youth by using the Evaluation

of Imminent Danger of Suicide (EIDS). The youth care staff will then score and mark the results. The EIDS will be referred to the on-site mental health staff or on-call mental health staff if intake occurs after hours.

The procedure requires the Assessment of Suicide Risk to be completed by a licensed mental health professional or an unlicensed mental health professional under the supervision of a licensed professional. The assessment is to occur within 24 hours after the screening unless between the hours of 5 pm on Friday to 9 am Monday (weekends or holidays). A youth awaiting the Assessment of Suicide Risk must be placed on Constant Sight and Sound Supervision until seen by the licensed mental health professional or unlicensed mental health professional. A youth placed on sight and sound supervision will have their behavior observations documented every five minutes or less on the sight and sound form. The shift supervisor is to review the form at the end of each shift, complete a Monitoring/Progress note and place it into the youth's file. If a youth returns from a baker act facility, then the Assessment of Suicide Risk shall be completed under the same guidelines mentioned above.

Four applicable files were reviewed. All files contained the CINS/FINS Intake Assessment completed at the youth's intake. Four of four files contained the Assessment of Suicide Risk Assessment following hits for suicide risk on the CINS/FINS Intake Assessment; three of the Suicide Risk Assessment was completed by the non-licensed mental health counselor and reviewed and signed off by the licensed mental health counselor. One Suicide Risk assessment was completed by the licensed mental health counselor. Two of the four youth completed the intake process during weekend hours and were placed on site and sound supervision with the required five-minute checks being completed on the sight and sound supervision form. These two forms were reviewed by the supervisor at the end of each shift.

There were no exceptions noted for this indicator.

4.03 Medications

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has written policy and procedure (RM 785) that address all of the key elements of the indicator. Policy was reviewed on December 21, 2015 by the Chief Operating Officer and the Vice President of Prevention Services.

Policy and procedure require staff to verify medications with the youth and parent upon intake. They will ascertain the reasons for the medications, types of medications, and if the youth is taking medications as prescribed. If the RN is available, then she/he will conduct the process. Medications can only be accepted with a current prescription, patent specific label on the bottle. The label must identify the medication in the bottle, person prescribed, dosage and frequency requirements, prescribing physician, and expiration date. Policy requires the prescription to be within thirty days of the date prescription was filled. If over the thirty days, then the parent must get the prescription refilled. Policy requires the RN to supply information concerning common side effects and precautions and have the information available for staff. Policy requires the medications to be stored in the Pyxis Medication Station located inside the med room. The Pyxis Medication station is a secure cabinet with electronic computerized locking system that requires an individual passcode linked to a biometric thumbprint to open. The cabinet and med room is locked at all times and inaccessible to youth. Policy requires all medications needing refrigeration to be stored in the medical refrigerator located in the med room.

All medications are stored in the Pyxis medication station in separate drawers that contain individual locking cubes. Drawers are separated into oral medications, narcotics and topical. The facility does not use over the counter medications. If a youth is in need of an over the counter medication, the parent/guardian is contacted and is to take the youth to see a doctor. Any over the counter medication is to be prescribed and a prescription is filled. There were no refrigerated medications on site during the review. The refrigerator was maintained at proper temperatures with a thermometer inside. Medication counts were current and found to be accurate. There are fifteen staff trained to administrator medications and seven are Super-Users. A perpetual inventory is being maintained of all controlled substances and verified in the Pyxis Med station computer. Medication logs and inventories are maintained in the med room and checked daily on each shift. Two staff verify med counts and inventories. If the RN is onsite he/she will verify counts and inventories with a staff present. Sharps were being maintained in a locked cabinet with current inventories and counts being completed. Parenteral medications are administered by the RN only. As an alternative, if approved by the Program Director, a youth who has been self-administering (insulin) prior to being admitted may continue under supervision. At the time of review, there were no parenteral medications being used.

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

4.04 Medical/Mental Health Alert Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has written policy and procedure (SH4.04) that address all of the key elements of the indicator. Policy was reviewed on April 6, 2017 by the Chief Operating Officer and the Vice President of Prevention Services.

Policy and procedure require staff to be informed of: medical and mental health issues, allergies, and medications youth are prescribed. A medical Alert and Allergy label is to be placed on the youth file in the upper left hand corner identifying the medical conditions of the youth.

There is a medical alert board in the medication room which is updated following the youth's intake process. An allergy/special dietary needs board is posted in the kitchen and is current. A youth's special dietary needs or allergies is to be documented on the CINS/FINS Intake Assessment and Health Screening Form.

Three applicable files were reviewed and they contained documentation of the youth's allergies or medical/mental health conditions. The alert board in the medication room was found to be current. The alert board in the kitchen noted youth's dietary needs and food allergies for all youth currently in the facility. Staff were provided with information or instructions to recognize or respond to emergencies and care for medical/mental health problems.

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

4.05 Episodic/Emergency Care

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has written policy and procedure (SH4.05) that address all of the key elements of the indicator. Policy was reviewed on March 20, 2017 by the Chief Operating Officer and the Vice President of Prevention Services.

Policy and procedure require all staff to be current in CPR/First Aid and use of the Knife for Life. Policy requires the Knife for Life and First Aid kits to be located in four locations throughout the facility. Locations are the staff station, medication room, kitchen and storage room. The policy requires drills to be conducted on a quarterly basis. The Emergency Preparedness and Disaster Plan ensures all staff are informed of emergency situations.

The procedure requires staff to participates in quarterly emergency/disaster drills, maintain current CPR/First Aid and documentation and reporting procedures for emergent care. Staff are trained to contact 911 for medical/mental health emergencies. The policy requires all 911 emergencies to be reported after the event by contacting the Program Director or Residential Supervisor who will, in turn, make the appropriate contacts and reporting requirements, parents/guardians to be notified of the emergency situation as well. Shift staff are then required to document the emergent situation in the logbook.

Observations indicated that the knife for life and First aid kits were located as required by policy. These were found in the staff station, kitchen, medication room and storage room.

Twenty-three youth were transported to the emergency room, family doctor or emergent care since July 2018. Parents were notified in all twenty-three files. CCC reporting requirements were met in all twenty-three files. A review of twenty-three incidents occurring in between July 2018 and December 2018 were found to be documented in the logbooks as required.

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