Florida Network of Youth and Family Services
Quality Improvement Program Report

Review of YFA New Beginnings - Brooksville
Residential Program

November 14 – 15, 2018

Compliance Monitoring Services Provided by

Quality Improvement Review

YFA New Beginnings – November 14 – 15, 2018
Lead Reviewer: Ashley Davies

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

Percent of indicators rated Satisfactory: 85.71%
Percent of indicators rated Limited: 14.28%
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 & Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petition Process	Satisfactory
2.07 Youth Records	Satisfactory
2.08 Sexual Orientation, Gender Identity, Gender 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 & Special Populations

3.01 Shelter Environment	Satisfactory
3.02 Program Orientation	Satisfactory
3.03 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	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%

Overall Rating Summary

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

Rating Definitions

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

Satisfactory Compliance	No exceptions to the requirements of the indicator; limited, unintentional, and/or 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.

Reviewer

Members

Ashley Davies, Consultant-Forefront LLC, Florida Network of Youth and Family Services

Gwen Nelson, Regional Monitor, Department of Juvenile Justice

Cyntoria Thomas, Program Manager, Thaise - Jacksonville

Raylene Coe, Street Outreach Coordinator, Crosswinds

Raymond Ballinger, Residential Program Manager, LSF SW Oasis

FLORIDA NETWORK of youth and family services

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Methodology

This review was conducted in accordance with FDJJ-1720 (Quality Assurance Policy and Procedures), and focused on the areas of (1) Management Accountability, (2) Intervention and Case Management, and (3) Shelter Care/Health Services, which are included in the Children/Families in Need of Services (CINS/FINS) Standards (July 2018).

Persons Interviewed

☒ Chief Executive Officer
☐ Chief Financial Officer
☐ Program Coordinator
☒ Direct – Part time
☐ Volunteer
☒ Clinical Director
☒ Counselor Non-Licensed
☐ Advocate
☐ Nurse – Full time

☐ Executive Director
☒ Program Director
☒ Direct – Care Full time
☐ Direct – Care On-Call
☐ Intern
☒ Counselor Licensed
☒ Case Manager
☒ Human Resources
☒ Nurse – Part time

☐ Chief Operating Officer
☒ Program Manager
2 # Case Managers
2 # Program Supervisors
_____ # Food Service Personnel
1 # Healthcare Staff
_____ # Maintenance Personnel
_____ # Other (listed by title): _____

Documents Reviewed

☐ Accreditation Reports
☒ Affidavit of Good Moral Character
☒ CCC Reports
☒ Logbooks
☒ Continuity of Operation Plan
☒ Contract Monitoring Reports
☐ Contract Scope of Services
☒ Egress Plans
☒ Fire Inspection Report
☐ Exposure Control Plan

☒ Table of Organization
☒ Fire Prevention Plan
☒ Grievance Process/Records
☐ Key Control Log
☒ Fire Drill Log
☒ Medical and Mental Health Alerts
☒ Precautionary Observation Logs
☒ Program Schedules
☐ Supplemental Contracts
☐ Telephone Logs

☒ Vehicle Inspection Reports
☐ Visitation Logs
☒ Youth Handbook
7 # Health Records
5 # MH/SA Records
13 # Personnel /Volunteer Records
7 # Training Records
6 # Youth Records (Closed)
6 # Youth Records (Open)
_____ # Other: _____

Surveys

4 # Youth
3 # Direct Care Staff
0 # Other: _____

Observations During Review

☐ Intake
☐ Program Activities
☐ Recreation
☐ Searches
☒ Security Video Tapes
☒ Social Skill Modeling by Staff
☒ Medication Administration
☒ Census Board

☒ Posting of Abuse Hotline
☐ Tool Inventory and Storage
☒ Toxic Item Inventory and Storage
☐ Discharge
☐ Treatment Team Meetings
☐ Youth Movement and Counts
☒ Staff Interactions with Youth

☒ Staff Supervision of Youth
☒ Facility and Grounds
☒ First Aid Kit(s)
☐ Group
☐ Meals
☒ Signage that all youth welcome

Comments

Additional Comments regarding observations, other important findings of interest, etc.

Strengths and Innovative Approaches

A full time Residential Supervisor, Gina Diaz, has joined the team. Gina has helped with onboarding and training of new Youth Development Staff (YDS). This has helped increase census and capacity at the shelter.

A full time Counselor, Tara Shock, has also joined the team. She has been a huge asset to the program. Tara has received all the required trainings and is managing a full caseload. She and veteran Counselor, Erica Trendell, are leading "Why Try" group twice a week.

They have eight full time YDS and nine part time YDS.

The shelter received a $1000.00 donation from a parent of a former community youth. She was so thankful for the help NBYS provided to her child and family she wanted to provide a gift to help fund more activities and support for the youth they serve.

Hernando County Sherriff's office has been a huge partner to the NBYS team. They have come out and completed K-9 demonstrations for the youth, participated in their "Cook for Kids" event on multiple occasions, they have signed up for quarterly events with the youth. HCSO has also become very active participants on their Leadership counsel and have already indicated they will be providing the shelter with Thanksgiving and Christmas dinner, as well as, Christmas gifts.
HCSO will be taking the youth out as the Holiday approaches for the "Shop with A Cop" event.

Suncoast Credit Union has become a committed partner to the shelter as well. They have come out for "Cook for Kids" on a few occasions and recently donated the supplies and time to paint all the dorm rooms.

The shelter has a Fall Festival event scheduled for 11/20/18. They will have games, face painting, and other events for the youth to participate in. Sister shelters RAP and George Harris will also be bringing their kids to participate in the fun.

Standard 1: Management Accountability

Overview

At the time of this onsite program review, the Youth and Family Alternatives (YFA) New Beginnings residential program employs a Shelter Manager, a Residential Supervisor, an Office Specialist, two Youth Development Specialist (YDS) Shift Leaders, two Residential Counselors, a Registered Nurse, and seventeen Youth Development Specialists that are both full-time and part-time. There were five Shift Lead positions vacant and two YDS positions vacant. The agency operates a Risk Prevention and Management Team Meeting that reviews various issues quarterly. This team is comprised of various YFA staff members. Youth and Family Alternatives, Inc. is accredited by the Council on Accreditation (COA).

1.01 Background Screening of Employees/Volunteers

☒Satisfactory ☐ Limited ☐Failed

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

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

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

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

The program hired twelve staff since the last on-site Quality Improvement Review. The twelve staff were background screened and determined to be eligible for employment. The program had one staff requiring a five-year re-screening during this review period. The staff was rescreened thirty days prior to the staff's anniversary date. The Annual

Affidavit of Compliance with Level 2 Screening Standards was submitted on January 29, 2018.

Exceptions:

No exceptions are noted for this indicator.

1.02 Provision of an Abuse Free Environment

☒Satisfactory ☐ Limited ☐Failed

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

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

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

There were four youth surveyed. All four youth reported they knew the Abuse Hotline was available for them to call if they wanted, however, all four stated they have never

needed to make a call. All four youth stated staff treat them professionally and they have never heard staff use threats or intimidation on them or any other youth. All four youth felt safe in the shelter.

There were three staff surveyed. Two of the three staff reported they have been trained on abuse reporting; however, all three staff reported they were aware they needed to report any suspected abuse to the Abuse Hotline. All three staff reported they have never heard a staff deny a youth access to the abuse hotline. Two of the three staff reported they have never heard another staff use inappropriate language in front of the youth and one staff reported they have. This staff reported it was only on one occasion and was not directed towards a youth.

Exceptions:

There was a total of twenty-six grievances in the last six months. Although all grievances were resolved, nineteen did not have the date of the resolution documented by staff.

1.03 Incident Reporting

☒Satisfactory ☐ Limited ☐Failed

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

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

There were thirty-one CCC reports in the last six months. All were reported within the two-hour time frame. Twenty-two CCC calls were medical related incidents, four youth-on-youth batteries, four contraband searches, and one abscond. All incidents were documented in the program's log book. There was documentation all grievances were successfully closed, and any follow-up actions required by the CCC were completed.

Exceptions:

No exceptions are noted for this indicator.

1.04 Training Requirements

☐Satisfactory ☒ Limited ☐Failed

The agency has a policy on Training Requirements. The policy was last reviewed on March 31, 2017 and signed by the Chief Operating Officer and Vice President of Prevention Services.

There were a total of seven staff training files reviewed.

There were two staff training files reviewed only for training completed during the first 120 days of employment. Both staff received all required trainings with the exception of one training each.

There were two staff training files reviewed for training completed during the staff's first year of employment, including required trainings completed during the first 120 days of employment. One staff had 44 of the required 80 hours of training for the first year with two months left in the training cycle to receive the additional training hours. This staff did not receive four trainings that were required in the first 120 days of employment. The other staff had only receive 28 of the required 80 training hours for the first year and only had one month left to receive additional trainings. This staff did not receive eight trainings required in the first 120 days of employment.

There were three staff training files reviewed for annual training requirements. One staff had seven hours of the required 40 hours of annual training with only one month left to receive additional trainings. Another staff had six hours of the required 40 hours with three months left to receive additional trainings. The last staff had 22 of the required 40 hours with two months left.

Exceptions:

Two staff reviewed for first year training requirements were not on-track to receive the full 80 hours of training during the first year of employment. Both staff were also missing trainings required during the first 120 days of employment.

Two staff reviewed for annual training requirements were not on track to receive the required 40 hours of training for the year.

The agency maintains training in an on-line database. At the time of the review the agency was in the processing of switching from one system, Relias, to another system, Paylocity. This made it very difficult to review training hours for each staff. Three different systems (Relias, Paylocity, and DJJ Skillpro) had to be reviewed in order to track all trainings for the last year. Neither system, Relias nor Paylocity, tracks DJJ Skillpro training, so this training must be reviewed separately. In addition, neither

system keeps a tally of training hours for the year, so this has to be manually added up for each employee in the three different systems and then added together for a total number. Each employee does not have an annual training hours tracking form documenting all trainings received and total number of hours. Supporting documentation was not consistently found for each training each employee received. In some cases, documents would be scanned into the system and saved and in other cases the Shelter Manager had some sign-ins sheets maintained in a file from various different trainings. Supporting documentation was inconsistently found for the files reviewed.

1.05 Analyzing and Reporting Information

☒Satisfactory ☐ Limited ☐Failed

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

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

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

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

Exception

No exceptions are noted for this indicator.

1.06 Client Transportation

☒Satisfactory ☐ Limited ☐Failed

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

All staff transporting youth must be approved by the Human Resources Department. Drivers must complete the "Monthly Trip and Mileage Log" each time they use the program vehicles. Drivers must answer each of the questions on the log including the name of the driver, date, and time, the availability of safety equipment, client initials traveling in the vehicle, the origin and destination of the trip, any tolls incurred, and the odometer readings. The driver must ensure the shelter phone on the vehicle to communicate with the program. Staff should take an approved third party on transports, whenever possible. Third parties are approved program staff, volunteers, or interns. Staff will make every attempt to avoid single party transport situations; however, when

this cannot be avoided staff will ensure that their supervisor or designee is aware and this will be documented in the logbook. Staff must consider the client's history and recent behaviors before transporting. Staff must ensure youth are seated in the back row of the vehicle during a single party transport. Staff who are concerned about any safety issues during a single party transport will maintain an open line of communication with the shelter throughout the transport. The program has a list of approved drivers that is sent out monthly from the program's Human Resources (HR) Office. The Human Resources Department uses a system called Checkr to randomly runs driver's license checks on employs and flags the employ if the license comes up invalid. All drivers are covered under the company's insurance policy.

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

Exception

No exceptions are noted for this indicator.

1.07 Outreach Services

☒Satisfactory ☐ Limited ☐Failed

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

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

The program's community outreach policy and procedures provide for staff to participate in educating the community about program services. Staff members encouraged to join state, county, and district boards. Participate in community forums on issues of youth and families. The staff members are encouraged to attend DJJ circuit meetings.

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

Exceptions:

No exceptions are noted for this indicator.

Standard 2: Intervention and Case Management

Overview

The agency is contracted to provide residential and non-residential CINS/FINS services to youth and families residing in Citrus, Hernando and Sumter Counties. The non-residential services are provided at the agency's office, local schools, and at the offices of other community-based organizations. The nonresidential component consists of a non-residential master's level Program Director and five full-time Counselors.

The program screens and assesses each youth and family referred for intervention services to determine what, if any, services are needed. Services include screening, intake, and assessment of the youth and family, case management services, determination of needed services, development of case service plans, referrals to services identified in the service plan, crisis intervention services, and follow-up contact at 180 days after the termination of the agency services.

2.01 Screening and Intake

☒Satisfactory ☐ Limited ☐Failed

The agency has a written policy and procedure that was revised 2/14/17 and signed off by the Chief Operating Officer and Vice President of Prevention Services. The policy addresses all the elements of the indicator.

The provider's procedure requires the requires the Program Supervisor/Director will ensure a counselor contracts the family to conduct the initial screening no later than seven working days. An eligibility screening is completed upon request for services and is available to families 24 hours a day. If a counselor is not available, the Centralized Intake Screening Form will be completed by a Youth Development Staff or Support Staff. If it is determined the youth is in need of crisis, mental health or substance abuse services, the on-call supervisor will be contacted to assist with the family's immediate needs. For non-emergencies, the referral form and Centralized Intake Form may be given to the Program Director to determine if an intake will be scheduled or if youth will be placed on the waiting list. Upon intake youth and family will receive available services options, rights and responsibilities, possible actions occurring through the involvement of CINS/FINS, Shelter Handbook (for sheltered youth) and a description of the grievance process.

There were twelve files reviewed, six Residential and six Non-Residential files.

All six of the residential files reviewed showed that an eligibility screening was completed within seven calendar days from the day of referral.

The reviewer confirmed documentation was present in each of the files indicating that youth and parents/guardians received written information about the service options available, rights and responsibilities of youth and their parents/guardian and a parent/guardian brochure.

Each of the program's files reviewed also contained parental and youth acknowledgment of receipt of information about the possible actions that could occur through involvement with CINS/FINS services, as well as the procedures involved with filing a grievance.

Of the six Non-Residential files reviewed, four were screened within seven days of the referral. The two remaining files were screened approximately two weeks after the referral; however, both files had documentation in the case notes the Case Manager attempted to contact with the parent/guardian within seven days to complete the screening.

All six files had a signed Acknowledgement of Receipt of Rights and Responsibilities and Receipt of Notice of Information Practices, by the parent and youth.

Exceptions:

No exceptions are documented for this indicator.

2.02 Needs Assessment

☒Satisfactory ☐ Limited ☐Failed

The agency has a policy in place titled Needs Assessment. The policy was last reviewed 2/14/17 and signed by the Chief Operating Officer and Vice President of Prevention Services.

The program's procedural policy provides that its CINS/FINS Programs will conduct a full Needs Assessment, to be initiated in a timely manner, for each youth and family participating in services. This assessment evaluates a variety of issues faced by the family, not just the presenting problem represented by the youth. Assessments are to be completed within 72 hours of admission. If a more intensive assessment is determined to be needed, a referral will be completed and documented in the case file. An updated needs assessment shall be conducted every 6 months or when otherwise indicated. The Needs Assessment will be completed within two face-to-face contacts following the initial intake if the youth is receiving nonresidential services. Needs Assessments are completed by bachelor's or master's level staff and signed by a supervisor. If the suicide risk component of the assessment is required (as a result of

suicide risk screening), it must be reviewed (signed and dated) by a licensed clinical supervisor or written by a licensed clinical staff.

There were twelve files reviewed, six Residential and six Non-Residential files.

All six of the Residential files reviewed contained a Needs Assessment initiated within 72 hours of each youth's admission into shelter care. Each Needs Assessment form appears to have been completed by a bachelor's level or master's level staff member as indicated by their signature on the Needs Assessment form and each was signed by their Supervisor.

All six Non-Residential files reviewed had a Needs Assessment completed within two to three face-to-face contacts. The Assessments were conducted by a bachelor's or master's level staff. All six Needs Assessments were signed by a supervisor upon completion.

None of the twelve files demonstrated an elevated risk of suicide as a result of the

Needs Assessment.

Exceptions:

No exceptions are documented for this indicator.

2.03 Case/Service Plan

☒Satisfactory ☐ Limited ☐Failed

The agency has written policy and procedures that addresses the key elements of the QI Indicator for Service Plan Development and Service Monitoring. The policy was last reviewed on 2/14/17 by the Chief Operating Officer and Vice President of Prevention Services.

The program's procedural policy outlines that all client case records shall contain a service plan. The service plan is a statement of goals, proposed actions and objectives developed in partnership with the youth and family. Service plans will be individualized and will include specific strategies for interventions, services and resources with a timeline for service delivery. An extension of the Service Plan is the Aftercare Plan and will be developed similarly to the development of the Service Plan. Service plans will not focus solely on the youth.

The program's procedures provide that if the CINS/FINS program is unable to provide needed services, a written referral shall be made by the counselor. For mental health or substance abuse referrals, the counselor is to refer to either a licensed or certified substance abuse mental health provider or to the local community mental health center.

The program's procedures require that the service plan and the After-Care plan will be developed with the youth and, if possible, the parent/guardian at the time of the Needs Assessment and no later than seven (7) working days following completion of the Needs Assessment. Furthermore, the program requires that if the service plan cannot be signed by the youth or the parent, the counselor must document the reason for unavailability and will make efforts to review and obtain a signature as soon as possible.

In accordance with this indicator, the program requires service plans to be reviewed every thirty days at a minimum for the first three months by the assigned counselor and parent or guardian and every three months thereafter. These reviews shall be documented and highlighted in yellow in the youth's file on the Chronological Contact Sheet and Progress Notes. At the end of 90 days or at any time there are significant changes in the youth's progress and goals, a new Service Plan must be developed with the youth and family. The Service Plan and aftercare plan are reviewed and signed by the program director.

There were twelve files reviewed, six Residential and six Non-Residential files.

All six of the residential files reviewed showed that a Treatment Plan was developed for each youth within seven (7) working days of the Needs Assessment completion. In fact, all but one file showed that the Treatment Plan was developed within a day of completing the Needs Assessment, while one was developed two days after such completion. Each Treatment Plan appeared to be individualized and prioritized to the needs and goals identified by each youth's Needs Assessment and provided details as to the service type, frequency, location for provision of services, and date of initiation, as well as the person(s) responsible, target dates for completion and any actual completion dates.

Treatment Plans in the three (3) closed residential files all contained the signature of the counselor and supervisor. While all but one also contained the youth's signature. However, two of the three Treatment Plans in the closed residential files reviewed lacked a parent/guardian signature.

All six Non-Residential files had Service Plans that were developed within seven working days of Needs Assessment. All Service Plans had Individualized and prioritized needs and goals identified by the Needs Assessment. All Service Plans had: service type, frequency, location, persons responsible, target dates for completion, signature of youth, signature of counselor, signature of supervisor, signature of parent/guardian, and date plan was initiated. All files documented a review every thirty days as needed.

Exception:

Exception was noted for the consistent lack of signatures on the Treatment Plans in all three of the open residential files reviewed.

2.04 Case Management and Service Delivery

☒Satisfactory ☐ Limited ☐Failed

The agency has written policy and procedures that address the key elements of the QI Indicator for Case Management and Service Delivery, as well as, Family Involvement. The Case Management and Service Delivery policy was last reviewed on 2/14/17 by the Chief Operating Officer and Vice President of Prevention Services.

The program has established procedural policies to ensure that all clients will be assigned a counselor to assist in the provision of needed or assigned services. The program encourages families to be engaged in assessment, planning, implementation, monitoring and follow-up care. To this end, the program staff and both residential and non-residential counselors will encourage family input and involvement in decision-making for the youth and family. Each youth's assigned counselor is to ensure delivery of services either through direct provision or referral.

The program outlines that Case management includes: establishing referral needs and coordinating referrals coordinating service plan implementation; monitoring youths/family's progress; providing support for families; monitoring out of home placement; referrals to the case staffing committee; recommending and pursuing judicial intervention; accompanying youth and parent/guardian to court hearings; referral to additional services; continued case monitoring; and case termination with follow-up.

The program requires that youth assessed as needing substance abuse treatment be referred for further assessment and treatment and that such substance abuse referrals must be made within five (5) working days of the identification of need. The program outlines that it is the responsibility of its Non-Residential counselor to monitor the family's compliance with the referral and to assist the family in acquiring the assessment. The program requires that if a comprehensive substance abuse assessment is not completed within 30 calendar days of the referral, reasons for the delay must be documented in the youth's case file. Furthermore, the program indicates that youth will be provided with basic substance abuse education during face-to-face contacts and that literature for substance abuse prevention and awareness of signs and symptoms are to be given to youth and their parents during the CINS/FINS assessment. The program requires that its CIN/FINS counselor utilize diligent efforts to engage the family in the solution of the youth's issues which lead to referral for Residential or Non-Residential services and that those efforts may require school or home visits in addition to telephone contact or correspondence or other venues as requested by the family. Engagement will be strength based and designed to develop a partnership with the

family. The program outlines that if the Counselor is unsuccessful in engaging the family in services, s/he will document engagement efforts and review the case with the Program Director.

There were twelve files reviewed, six Residential and six Non-Residential files.

Each of the six residential files reviewed indicated that a counselor/case manager had been immediately assigned to prepare and coordinate each youth's Treatment Plan and monitor their (and their family's) progress in the services provided by the Program. The assigned counselor/case manager monitored each youth in the shelter's out-of-home placement and made referrals and helped coordinate referral services based on the counselor's on-going assessment of the youth's and their family's problems and needs.

The three closed files contained termination notes and discharge summaries prepared by the counselor/case manager and, two of these files were appropriately subject to 30 day and 60-day follow-up contacts that were documented by the Program.

All six Non-Residential files reviewed documented a counselor was assigned to the case. All six files documented referrals were made for additional services as needed. All files documented the youth/family's progress towards goals was monitored and support was provided to the family and youth as needed. There was no need for out-of-home placement or referrals for case staffing in any of the files reviewed. All 30 and 60-day follow-ups were completed as needed and were kept in a separate binder.

Exception:

No exceptions are documented for this indicator.

2.05 Counseling Services

☒Satisfactory ☐ Limited ☐Failed

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

The program has established procedural policies to ensure that an array of services will be provided to youth and their families. The program requires that its services be based on the needs of the family so as to preserve the unity and integrity of each family and to prevent the youth from entering the juvenile justice system. Youth and families receive counseling services, in accordance with the youth's case/service plan to address needs identified during the assessment process. The program's counseling services are

reflected in, and each case file includes: coordination between presenting problem(s); needs assessment; case/service plan; case/service plan reviews; case management and follow-up; maintain individual case files on all youth and adhere to all laws requiring confidentiality; and maintain chronological case notes on the youth's progress. The program also maintains an ongoing internal process to ensure clinical review of case records, youth management, and staff performance regarding CINS/FINS services.

There were twelve files reviewed, six Residential and six Non-Residential files.

In all twelve youth files reviewed, the youth's presenting problems were appropriately addressed in the Needs Assessment, Treatment Plan and Reviews. The counselors maintained case notes for all services provided and each youth's progress in the Program was meticulously documented. The reviewer noted that there appears to be an on-going internal process to ensure clinical review of case records and staff performance. The youth and families appeared to receive the individual and/or family counseling services outlined in their Treatment Plan. The reviewer notes that the shelter provides group counseling to residential youth at least five days a week and that these are documented in the Group Log as being at least a half hour in length, with a clear facilitator and topic or subject matter that is informational, developmental or educational. The youth appear to have an opportunity to engage in these sessions as documented in both the Group Log and the individual progress notes of each residential youth.

Exception:

No exceptions are documented for this indicator.

2.06 Adjudication / Petition Process

☒Satisfactory ☐ Limited ☐Failed

The program has a written policy and procedure that addresses all of the key elements of this indicator. The policy was last reviewed on February 15, 2017, and signed by the V.P. of Prevention Services and the Chief Operating Officer.

According to the program's procedural policy, it is the responsibility of the agency to request a case staffing committee. The case staffing committee may be reconvened for individual cases or maintained as a standing committee. However, in accordance with this indicator, should a parent of an active CINS/FINS youth request a case staffing in writing, the committee shall convene a staffing within seven working days (excluding weekend and holidays). A case staffing committee should be convened to review a case of family or child who is in need of services or treatment if:

1. The family or youth is not in agreement with the services or treatment offered,
2. The family or youth will not participate in the services or treatment offered,

3. The agency counselor needs additional assistance in developing a case plan,
4. The family or youth have not demonstrated substantial progress in achieving goals specified in the service plan,
5. The services or treatment selected have not addressed the problems and needs of the Family or youth or
6. The parent/guardian requests, in writing, that a case staffing committee meeting be convened.

Case staffing committee must meet at locations which are central and convenient to the families and participants. If the family attends the case staffing they will receive a copy of the plan.

A total of three Non-Residential files were reviewed for Case Staffing.

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

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

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

Exception:

No exceptions are documented for this indicator.

2.07 Youth Records

☒Satisfactory ☐ Limited ☐Failed

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

According to the program's procedural policy, the program maintains confidential records for each youth containing relevant information about the youth and specific information about his/her treatment at the program. The program requires that all such records be marked "confidential" and kept in a secure room or locked in a file cabinet that is marked confidential, which is accessible to program staff. All records that are transported are locked in an opaque container that is marked confidential. Youth records are maintained in a neat and orderly manner so that staff can quickly and easily access information.

There were twelve youth files reviewed for this indicator. All files were marked "confidential". The Residential files were kept in a locked file room within locked file cabinets that were also marked "confidential". This room was inaccessible to the youth. For the transportation of the Non-Residential files the agency uses a solid black, opaque, locking bag that is marked confidential.

Exception:

No exceptions are documented for this indicator.

2.08 Sexual Orientation, Gender Identity, Gender Expression

☒Satisfactory ☐ Limited ☐Failed

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

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

expression. Youth will be identified in the logbook and all public-facing documents by their preferred name and gender pronouns. Youth are to be assigned a room aligning with their gender identity, or the program will provide specific documentation as to why other room assignment was determined to be suitable. Youth will be provided with hygiene products, undergarments, and clothing that affirms their gender identity or gender expression.

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

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

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

Exception:

No exceptions are noted for this indicator.

Standard 3: Shelter Care and Special Populations

Overview

The New Beginnings Youth Shelter is located in Brooksville, Florida. It is one of three shelters that Youth and Family Alternatives operates in the state. The other two residential youth shelters are located in New Port Richey and Bartow. The New Beginnings shelter is a well-designed facility that is clean, nicely furnished, attractively landscaped, and well maintained. There were no signs of graffiti, property damage, or any hazardous or dangerous conditions during this site review. A comprehensive tour of the facility was conducted to determine the environmental conditions of the facility and the living conditions for the youth. This residential shelter operates twenty-four hours a day, 365 days a year and is licensed to serve up to twenty-four residents for runaway and emergency shelter services. The youth shelter is contracted to serve both CINS/FINS youth and children placed by the Department of Children and Families (DCF). The youth shelter utilizes effective documentation practices in the agency's program logbook. At the time of this on-site Quality Improvement (QI) review, the shelter had twelve CINS/FINS youth. The shelter has had no Staff Secure, Domestic Minor Sex Trafficking, Probation Respite, or Family/Youth Respite Aftercare Services (FYRAC) youth since the last on-site review; however, has served Domestic Violence youth.

3.01 Screening and Intake

☒Satisfactory ☐ Limited ☐Failed

The agency has a titled Shelter Environment that addresses the requirements of the indicator. The policy was effective 9/13/13 and last updated 2/15/17 by the Chief Operating Officer and Vice President of Prevention Services.

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

The Residential Supervisor or designee conducts weekly inspections of the physical plant utilizing the Physical Plant Checklist and Daily Room Check list and attends to areas needing attention. The Residential Supervisor or designee maintains a log to note areas needing attention and facilitates needed repairs and maintenance as needed.

Random facility checks will be conducted by the Program Director, Residential Supervisor, or Team Lead to ensure that all buildings are always in presentable condition. The Shift Lead or designee will conduct a formal daily inspection of the wings at least three times a day. Room checks include ensuring: beds are made and free of

clothing; clothing is properly stored; furniture is in good repair; program is free of infestation; bathroom and showers are clean and functional; there is no graffiti on walls, doors or windows.

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

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

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

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

Exception:

No exceptions are noted for this indicator.

3.02 Program Orientation

☒Satisfactory ☐ Limited ☐Failed

The agency has a policy in place to ensure all youth are appropriately oriented to services upon intake into the facility or program. The policy is titled Program Orientation and was effective 9/13/13 and last updated 2/28/17 by the Chief Operating Officer and Vice President of Prevention Services.

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

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

The Client Orientation Process includes the following:

* Identification of key staff and their roles ·

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

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

* Room assignment ·

* A review of the daily program schedule ·

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

* A review of program goals and the services available ·

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

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

* A review of the religious activities ·

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

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

* A review of how to access mental health services ·

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

* Review of linen exchange

At the time of the review, six files were reviewed. The review consisted of three open files and three closed files. It was noted that in one of the files there was no Orientation Checklist to indicate all aspects of the orientation process was conducted. All other files contained evidence of youth being provided a comprehensive orientation and a Youth Handbook. During the orientation process the handbook is reviewed with youth and program expectations and client's rights are explained and discussed. Information on disciplinary action, the grievance procedure, activities, contraband, and the behavior management system is part of the discussion.

Exception:

It was noted that the agency identifies the "buddy system" as an additional orientation step in their procedure. However, documentation of utilizing the "buddy system" was missing from three of the six files reviewed.

3.03 Room Assignment

☒Satisfactory ☐ Limited ☐Failed

It is the policy of Youth Family Alternatives, Inc. to ensure all youth are protected in the shelter/residential program. All youth shall be interviewed upon admission to determine the most appropriate unit/sleeping room assignment. The policy is titled Youth Room Assignment and was effective 9/13/13 and last updated 2/28/17 by the Chief Operating Officer and Vice President of Prevention Services.

During the initial screening and intake process staff will complete all forms appropriately indicating that all pertinent information has been obtained. Agency policy indicates "there are to be no blanks on any agency form". Staff is to complete the Admission Sleeping Assignment form to be reviewed with the Shift Leader or designee when assigning a youth to a room. Consideration of special needs, behavioral history, age,

maturity level including identification of youth susceptible to victimization, individual needs, general physical stature, gang affiliation, current alleged offenses, level of aggression, attitude, sexual misconduct, demonstration of emotional disturbance mental health, and exposure to trauma is given when assessing a youth for a bed assignment.

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

Exception:

No exceptions are noted for this indicator.

3.04 Log Books

☒Satisfactory ☐ Limited ☐Failed

The agency has a policy in place titled Logbooks. The policy was effective 9/13/13 and last updated 2/28/17 by the Chief Operating Officer and Vice President of Prevention Services. It is the policy of Youth Family Alternatives, Inc. to maintain log books in its shelter facilities to document daily activities, events, and incidents in the program. Additionally, the logbooks are to be reviewed by direct care and supervisory staff at the beginning of each shift.

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

The agency has a logbook policy in which safety and security issues are documented. The agency uses a highlight system which is consistent and easy to follow. The highlight system helps to distinguish and track significant activity. The occurrence of one

to one transport, fire drills, youth movement, and critical incidents was documented throughout logbook. Each activity is documented in a different color. Supervisory review is documented weekly in purple and used to provide evidence of the review.

Exception:

No exceptions are noted for this indicator.

3.05 Behavior Management Strategies

☒Satisfactory ☐ Limited ☐Failed

The agency has a policy in place titled Behavior Management System. The policy was effective 9/13/13 and last updated 2/28/17 by the Chief Operating Officer and Vice President of Prevention Services. Youth crisis shelters shall use proactive behavior management techniques that emphasize positive and preventive measures in the management of youth behavior. Restrictive behavior management in the form of physical restraint may be used only in an emergency and only as a means to protect a youth from imminent harm to self or others. Seclusion, mechanical, and chemical restraint is strictly prohibited.

The program has a written description of the Behavior Management System (BMS), and it is explained during program orientation.

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

Upon completion of orientation level, which requires setting a weekly goal, youth advances to the Education level. While on the Education level, emphasis is placed on youth's ability to demonstrate skills learned on the Orientation level as well as to actively engage in educational activities, outings, and groups. Upon completion of the Education level, youth advance to the Graduate level of the program. Once a youth is placed on Graduation level, the expectation is to enhance demonstration of the skills learned on the previous levels of the program and start exemplifying the characteristics of a role model. The final level of the program is Collegiate. While on the Collegiate level, youth are expected to exemplify the characteristics of a role model and serve as peer leaders.

Additionally, youth putting the six pillars (Responsibility, Respect, Caring, Citizenship, Fairness, and Trustworthiness) into practice affords them the opportunity to start earning money (Monopoly money) to buy the desired items from the "New Beginning Box."

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

Exception:

No exceptions are noted for this indicator.

3.06 Staffing and Youth Supervision

☒Satisfactory ☐ Limited ☐Failed

The agency has a policy in place titled Staffing and Supervision. The policy was effective 9/13/13 and last updated 2/28/17 by the Chief Operating Officer and Vice President of Prevention Services. It is the policy of Youth and Family Alternatives, Inc. that shelter programs are appropriately staffed to ensure adequate supervision of youth, and safety and security of youth and staff.

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

The staff schedule is maintained at the staff station and is emailed to all staff. There is also a Shift Coverage protocol in which the expectation is for staff to attempt to secure

coverage from another staff member for their shift. In the event they are unable to secure coverage, the Program Manager will be responsible for getting coverage and maintaining compliance. A staff list with phone numbers is located at the staff work desk in case additional coverage is needed. Staff schedules reviewed for the last six months reconciled with the program's logbook revealed that on numerous occasions the agency was unable to staff the program with male staff. The program provided documentation to support efforts to hire male staff over the last review period (six months). Six individuals were reportedly offered employment, accepted, and failed to complete the process for various different reasons. The dates of the offers were: 5/10/18; 7/18/18; 7/31/18; 8/10/18; 8/24/18, and 10/8/18. At the time of the on-site review the agency provided documentation of on-going efforts to hire male staff.

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

Exception:

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

3.07 Special Populations

☒Satisfactory ☐ Limited ☐Failed

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

The shelter provides services to both male and female youth ages 10 to 17 who meet the criteria and a certain exception can be made on a case by-case basis. There is a

description of services. The services that are offered may be altered to the client's needs. Shelter staff are appropriately trained and complete training for the Florida Network. If YFA determines a referred youth is not appropriate for DV respite service, the shelter may decline the referral and contact the youth's Juvenile Probation Officer (JPO) and JPO Supervisor to review the referral if they are available. The services can be rejected due to youth's history of fire setting behavior, sexual offenses, need for acute inpatient care, or safety risk to other youth or staff.

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

Youth who receive FYRAC services may be referred following a residential shelter stay, an arrest, or from a Probation Officer. All FYRAC referrals must have prior approval from the Network Office. Youth and Family may participate in services for thirteen sessions or ninety consecutive days of service, unless an extension is granted by DJJ circuit Probation staff.

The only population served in the last six months at the shelter was Domestic Violence (DV) respite youth. There were no Probation Respite, Domestic Minor Sex Trafficking (DMST), Staff Secure, or FYRAC files to review.

There were three files reviewed for youth receiving DV respite services. Youth admitted to DV respite placement have a pending DV charge and have evidence of being screened by JAC/Detention or JPO. DV youth were discharged within twenty-one days and not transitioned to CIN/FINS or Probation Respite. The provider initiates the youth's Service/Treatment Plan addressing goals focusing on aggression management, family coping skills, or other interventions design to reduce re-occurrence of violence in the home, after seven days of admission. There was one of the three files reviewed that did not have a Service Plan; however, the client was discharged seven days after coming to the shelter.

Exception:

No exceptions are noted for this indicator.

3.08 Video Surveillance System

☒Satisfactory ☐ Limited ☐Failed

The agency has a policy in place titled Video Surveillance System. The policy was effective 9/13/13 and last updated 2/28/17 by the Chief Operating Officer and Vice President of Prevention Services. The agency will utilize video surveillance technology at each of their crisis shelters as a means to provide a secure environment, protect its facilities, and enhance the safety of youth, staff, and visitors. Such technologies, however, will be used only to meet the agency's critical goals for security and in a manner that is sensitive to interest of privacy, free assembly, and expression. Video surveillance of public areas will be limited to uses that do not violate the reasonable expectation of privacy as defined by law.

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

There is a written notice that is posted on the premises for security. Cameras are in the interior and exterior general locations of the shelter where youth and staff congregate and where visitors enter and exit. The system can capture and retain video photographic images, including facial recognition, and are stored for a minimum of thirty days. No cameras are placed in bathrooms or sleeping quarters. The agency has a backup server which operates during the power outage.

A list of designated personnel who can access the video surveillance system is maintained. A designated personnel review of the video is conducted a minimum of every fourteen days and noted in the video review log book. The agency has a process for a third party requesting to review the footage. This process is permitted only by the approved personnel.

Exception:

No exceptions are noted for this indicator.

Standard 4: Mental Health/Health Services

Overview

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

The agency also utilizes a Suicide Risk Assessment instrument that is conducted on youth that indicate a positive "hit" on the CINS Intake form and EIDS. The agency does not have a licensed staff member that works primarily at the New Beginnings youth shelter location. The shelter has access to a Licensed Mental Health Counselor (LMHC), who works for the agency, who reviews all suicide risk assessments and consults and reviews with staff regarding youth placed on elevated or sight and sound supervision status. All YDS staff members at the youth shelter are trained on the suicide risk screening process and utilize the CINS Intake form to screen for potential risks prior to placing all youth on sight and sound supervision status.

The shelter has a part-time Registered Nurse (RN) who oversees the medication administration process. The shelter utilizes an effective general alert system that informs direct care staff of the youth's health, behavior, or mental health status. Alerts are documented on the census board.

4.01 Healthcare Admission Screening

☒Satisfactory ☐ Limited ☐Failed

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

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

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

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

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

In four of the seven files, the CINS/FINS Intake Assessment was not completed in its entirety. Two out of the four forms were not signed by a supervisor. One form did not include a date when the supervisor signed it. On three of the four forms the Physical Health section was left blank. It was inconsistent across the files reviewed as to how this section was being completed.

In some of the files items would be circled or "none" or "NA" would be documented to indicate the section had been reviewed with the youth and there were no applicable conditions. In other files this section would be left blank if there were no applicable conditions. This made it difficult to determine if the section had been reviewed in these files.

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

Exception:

In four of the seven files, the CINS/FINS Intake Assessment was not completed in its entirety. Two out of the four forms were not signed by a supervisor. One form did not include a date when the supervisor signed it. On three of the four forms the Physical Health section was left blank. It was inconsistent across the files reviewed as to how this section was being completed.

In some of the files items would be circled or “none” or “NA” would be documented to indicate the section had been reviewed with the youth and there were no applicable conditions. In other files this section would be left blank if there were no applicable conditions. This made it difficult to determine if the section had been reviewed in these files.

4.02 Suicide Prevention

☒Satisfactory ☐ Limited ☐Failed

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

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

At time of admission if the youth responds positively to any of the first six questions on the CINS/FINS Intake form Youth Development Staff (YDS) will complete the Evaluation of Suicide Risk among Adolescents (EIDS), as an additional screening tool. YDS will

then score the EIDS and mark it on the EIDS Summary form. YDS will will review the EIDS with on call if a counselor is not on site.

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

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

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

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

There were five youth files reviewed. In all five files the suicide risk screening occurred at intake using the six questions on the CINS/FINS Intake form. Two of the screening forms were not signed by a supervisor. All five files also documented the Evaluation of Imminent Danger of Suicide (EIDS) was completed on each youth. All five youth were placed on sight and sound supervision until an Assessment of Suicide Risk could be completed. All five files documented the Assessment of Suicide Risk was completed by the counselor within twenty-four hours or seventy-two hours if over the weekend. All the assessments documented a telephone consultation with a Licensed Mental Health Counselor (LMHC) from a sister shelter. Supervision of the youth was not changed until after this telephone consultation took place. The LMHC signed all the assessments the next time on site. The counselor maintained clear and consistent documentation regarding who the Licensed professional was and the exact time youth was removed from sight and sound. The staff maintain five-minute observations of the youth while on suicide precautions. These observations were documented for all five youth with the exception of a three-hour gap for one youth and an eight-hour gap missing for another

youth. There was also one observation sheet from another youth that was not reviewed by the supervisor nor dated. All other observation sheets documented a shift supervisor review.

Exception:

No exceptions are documented for this indicator.

4.03 Medications

☒Satisfactory ☐ Limited ☐Failed

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

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

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

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

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

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

Staff members have access to the Nursing Drug Guide to research most current information regarding medication side effects and interactions. Inventories of controlled

medications are completed shift to shift. A perpetual inventory is maintained on all medications in the youths individual Medication Log sheet.

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

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

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

The RN runs a monthly KPI report, discrepancy report at least twice weekly, and an inventory verification report two to three times per month. These reports are discussed during the monthly staff meetings. In the last six months there have been four discrepancies and all four were closed out by the end of the staff members shift.
All youth medication is stored in the Pyxis Med-Station. Each medication is stored in its own separate bin within the Med-Station so topical medications are always stored separately. Only the youth's prescription medication is stored in the Pyxis Med-Station. Medication storage will start in drawer two and once that drawer is full will continue into drawer three and so on. Drawer one is used for agency keys and credit cards that staff are required to sign out. Drawer five is used for over-sized medications. The shelter has a system in place for refrigeration of medication if needed; however, there was no medication that required refrigeration during the time of review. There was documentation the RN checks the temperature of the refrigerator at least once per week and documents the actual temperature on the weekly medication inventory sheet. The temperature consistently stayed between 36-46 degrees Fahrenheit.

Agency did not have any sharps other than metal lice combs. These are counted at least once weekly. Controlled medications are counted each shift and a list of all current controlled medications is maintained in a purple binder for inventory documentation. At the time of the review the shelter had one controlled medication. There was documentation this medication was inventoried each shift and each inventory was initialed by two staff members. A red binder is kept in the medication room which has all current Prescription Medication Log sheets for all youth on medication. There were seven youth taking prescribed medications at the time of the review. All Prescription

Medication Log sheets were reviewed for all seven youth. According to the Logs all youth received medications as prescribed. A running, perpetual inventory was maintained for all these medications when given. The RN also completes an inventory of all medications in the shelter at least one time each week. All Prescription Medication Log sheets documented the youth's name, allergies, doctor name, pharmacy, prescription number, reason for the medication, the medication name, instructions, dosage, possible side effects, beginning count, and documentation each time the youth received the medication. There is a picture of the youth located in front of the Log sheets. The RN reviews these Log sheets each time on-site and keeps a log of any corrections made to the sheets or any missing information added to the sheets. The shelter does not have any over-the-counter medications. All medications in the shelter require a prescription.

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

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

Exception:

No exceptions are documented for this indicator.

4.04 Medical/Mental Health Alert Process

☒Satisfactory ☐ Limited ☐Failed

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

At intake assessment a "medical alert" and an "allergy" label will be placed in respective order on the top left-hand corner on each case record identifying each youth's medical condition or allergy. Youth Development Staff completing the intake documentation are to post the name of any youth with a medical alert or allergy on the Allergy, Medical and Risk Alert Board in the Medication Room, in the front of the file, and note the codes on the census boards. Youth Development Staff are to document any special dietary needs and/or food allergies. Due to confidentiality rules/laws specific documentation of alleged HIV status as reported by a youth to staff is prohibited. In the event a youth requires emergency medical care, upon return to the facility the shelter will keep in the file a

verification of receipt of medical clearance, discharge instructions and any follow up care that may be required. Staff will also ensure the “Medical Alert” and/or “Allergy” labels are updated to reflect any changes as appropriate.

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

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

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

Exception:

No exceptions are documented for this indicator.

4.05 Episodic/Emergency Care

☒Satisfactory ☐ Limited ☐Failed

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

All staff are to have current training in CPR/ First Aid and the use of Knife for Life. The location of the Knife for Life, Wire cutters and First Aid Kits are indicated on the egress charts. Healthcare simulations are conducted on at least a quarterly basis. These are to be conducted on each shift and on various emergency situations. All instances of first aid and emergency care are documented as required. All deaths or serious adverse medical events shall undergo root cause analysis within the risk management process of the Critical Incident Review Team. The emergency preparedness/Disaster Plan ensures all staff are informed of potential emergency situations. The assigned counselor/Therapist is to contact the parent/legal guardian to make arrangements for

and transportation to appointments for general medical care. In the event a Parent or guardian is unwilling or unable to transport a youth the Youth Development Staff will provide transportation. In an emergency event, the shelter will follow chain of command. However, any staff aware of a medical or mental health emergency situation is required to call 911 immediately.

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

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

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

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

Exception:

No exceptions are documented for this indicator.