Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Youth and Family Alternatives – RAP House
Residential Program

October 24-25, 2018

Compliance Monitoring Services Provided by

FOREFRONT

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	Satisfactory
1.05 Analyzing and Reporting Information	Satisfactory
1.06 Client Transportation	Limited
1.07 Outreach Services	Satisfactory

Percent of indicators rated Satisfactory: 85.71%
Percent of indicators rated Limited: 14.29%
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	Limited
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: 87.50%
Percent of indicators rated Limited: 12.50%
Percent of indicators rated Failed: 0.00%

Standard 4: Mental Health /Health Services

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

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

Overall Rating Summary

Percent of indicators rated Satisfactory: 85.71%
Percent of indicators rated Limited: 14.28%
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

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Nitara LaTouche – Operations and Management Consultant/Forefront Consulting LLC

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Quality Improvement Review
YFA – RAP House Shelter – October 24-25, 2018

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
- **1** # Case Managers
- **1** # Program Supervisors
- _____ # Food Service Personnel
- _____ # 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
- **0** # Health Records
- **0** # MH/SA Records
- 11 # Personnel /Volunteer Records
- **0** # Training Records
- **0** # Youth Records (Closed)
- 0 # Youth Records (Open)
- _____ # Other: _____

Surveys

- **5** # Youth
- 8 # 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
- ☐ Tool Inventory and Storage
- ☒ Toxic Item Inventory and Storage
- ☐ Discharge
- ☐ Treatment Team Meetings
- ☐ Youth Movement and Counts
- ☒ Staff Interactions with Youth
- ☒ First Aid Kit(s)
- ☐ Group
- ☐ Meals
- ☐ Signage that all youth welcome

Comments

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

- ☒ Posting of Abuse Hotline
- ☒ Facility and Grounds

Strengths and Innovative Approaches

Rating Narrative

The agency has an agency-wide internal quality improvement process that reviews the compliance and quality of the services being delivered at all youth and families served by YFA. The agency has a dedicated Data Analyst that has been in the position for about a year now to assist in facilitating analyzing the reporting information and collaborating with the program to identify areas of strength and opportunities for improvement.

The agency has an internal human resources department that processes all background screening, 5-year rescreening's and suitability assessments.

Standard 1: Management Accountability

Overview

Narrative

The Youth and Family Alternatives, Inc. (YAP) agency is a Residential and Non-Residential private non-profit service provider located in central southwestern region of Florida. Established in 1970, YFA (Youth and Family Alternatives, Inc.) is an agency that operates with over 300 staff that work to provide a broad array of human services to youth and families with the goal of enhancing a nurturing and safe environment for children. Specifically, the agency organization structure is comprised of a Program Manager, a Shelter Supervisor, an Office Specialist, three (3) Youth Development Specialist (YDS) Shift Leaders, two (2) Residential Counselors, a Registered Nurse, and 10-12 Youth Development Specialists, both full-time and part-time. The operation and services delivery of the agency utilizes internal quality improvement teams that review client files and the delivery of major residential and non-residential of program participants to monitor the overall quality, accuracy and completeness of the services provided. These internal QI teams include various YFA leadership, general management, residential and non-residential staff members. Additionally, this YFA location primarily provides services Pasco County and is currently accredited by the Council on Accreditation (COA).

1.01 Background Screening of Employees/Volunteers

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

The agency has a policy in place titled Background Screening of Employees/Volunteers. The policy was last reviewed on March 30, 2017 by the Chief Operating Officer and Vice President of Prevention Services.

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

All new hires must be live scanned fingerprinted by the Human Resources department. Once the agency receives the FDLE ”eligible” rating, this can be considered for the “FINAL” for the DJJ background screening. The agency must also complete a notarized Affidavit of Compliance with Level 2 Screening Standards that is required to be submitted to DJJ Background Screening Unit prior to January 31st each calendar year. All staff are required to be re-screened every five years. The agency will request federal criminal checks for all employees, interns, or volunteers within thirty days of their five year anniversary with the agency.

The agency conducts background screenings on all clients prior to extending an offer to hire. This process is completed by a separate Human Resources department within YFA. The YFA Human Resources department facilitates the background process to ensure that each staff member meets the background screening requirements for both the Florida Department of Juvenile Justice and Department Children and Families. At time of this onsite program review, all new hires had met the requirement to be in compliance and had evidence that each received a rating prior to being hired.

The agency is currently in the process of updating and reviewing their policies and procedures and will be developing a policy to address the suitability assessment pre-screening requirements and provided a draft example of the policy waiting for approval. The agency implemented a tool in September 2018 and is currently using an assessment tool called Customer Service Aptitude Profile, CSAP, that provides a score and overview in several areas for the applicant including sales success, motivation and achievement, work strengths, interpersonal strengths, and inner resources. 2 of the new hires brought on in September show evidence that they were screened using the new tool. The other new hires were hired prior to July 1st and 3 new hires were hired between July- August before the new tool was implemented.

11 new hire employee files were reviewed for this indicator. All 11 files showed evidence that the background screening was completed prior to the start date of hire. There were no staff members eligible for the 5-year re-screen criteria at the time of this review.
The agency submitted the Annual Affidavit of Compliance on January 29,2018 to the BSU within the required timeframe.

Exceptions:

No Exceptions noted in the indicator.

1.02 Provision of an Abuse Free Environment

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

The agency has a policy that is called Provision of an Abuse Free Environment. The policy does meet the requirements and it states that the agency shall provide an environment free of physical, psychological and emotional abuse. The policy was signed and dated on 2.13.16 by the Chief Operating Officer and the Vice President of Prevention Services.

The agency has a procedure that addresses the code of conduct that prohibits the use of physical abuse, profanity, threats or intimidation.

The procedure discusses the employees and volunteers obligation to immediately report all allegations of child abuse or suspected child abuse, neglect, or exploitation to the Florida Abuse Hotline. The procedure states that all youth that come into the program for shelter or other services are informed about the toll-free child abuse hotline number at the time of intake. It also states that youth have unimpeded access to self-report alleged abuse.

The procedure does not specify how they will maintain a record of the child abuse hotline calls, however, there is a child abuse log binder maintained onsite.

The procedure references policy AD500 for additional information on grievances, however, the grievance form was recently revised approximately a week prior to this onsite review and the updated grievance procedure is still being revised.

During the onsite review, an example of a draft policy named ‘Shelter 1.02 Provision of An Abuse Free Environment’ along with a supplemental policy to address any youth that

is not satisfied with the proposed resolution (CS530 which will replace AD500) was provided for review. These draft policies will provide guidance to staff on how to follow the grievance process that allows youth to grieve.

The procedure states that management will act immediately upon any reports of physical and/or psychological abuse, verbal intimidation, use of profanity, and/or excessive use of force.

There were 2 locked grievance boxes located in accessible locations for the youth. One was located near the front lobby and had a location for the forms in both English and Spanish. The second location was in the living room/lounge area.

The keys to the grievance boxes are kept with the Program Supervisor and the Program Director. The PS reports that they are usually checked on a daily basis. There is some inconsistencies with the grievance form 'final resolution' section and the majority were dated within 1-2 days of the date submitted, however, a few of the grievances were missing the date next to the signature line or were dated more than 7 days.

Fourteen (14) grievances were reviewed between March – August 2018. Four (4) grievances were specific to 1 staff member dated 7.5.18 that is no longer employed at program. These 4 grievances did not indicate agree or not agree on the form as to the resolution, but all noted that the staff member is no longer with the agency and signed by the Program Director on 7.6.18. One youth reported staff not counting her medication while prior to distributing it to her and reports having to remind this particular staff member when the medication was not taken, but this staff member is no longer with the agency. The remainder of the grievances were related to youth altercations that had to be resolved by the program's leadership team.

During the orientation, staff receive training on child abuse reporting and this was evidenced in the review of staff files.

The child abuse log binder is marked confidential and it is reported that should maintain all abuse hotline calls. It is recommended that this is addressed in the procedure so that there is a consistent practice that addresses how these are maintained. However, there does not appear to be a consistent practice with regards to how the records of these calls are maintained in the binder. It was discussed during an interview, some staff maintain copies of the abuse calls in the client file.

Youth surveyed indicates that they also are informed about the behavior system during orientation and are aware of the abuse hotline number. 1 youth reported being denied clothing and food but this appears it may have been a typo or misinterpretation as no additional explanation was given when prompted to explain further and another written response from this youth stated they have 'everything they need to feel safe'.

Survey results for 5 youth indicated that all youth feel safe at this shelter, adults are respectful when talking to youth, youth report having access to and are not stopped if they wanted to call the abuse hotline, and they report receiving medical care when needed. 1 youth reported hearing a staff curse when 'kids were being loud and the staff accidentally cursed'.

Exceptions:

There were no exceptions to this indicator.

1.03 Incident Reporting

☒Satisfactory ☐ Limited ☐Failed ☐Not Applicable

Rating Narrative

The Youth and Family Alternatives (YFA) agency has a policy called Incident Reporting. The current policy is categorized with all of the agency's risk management protocols. The Incident policy describes the types of incidents that qualify as reportable incidents. At the time of this onsite program review, the policy was last reviewed by the agency's president and CEO and board chair on October 20, 2015.

All three (3) YFA agencies are required to adhere to specific operational procedures related to all incidents required to be reported to the Department of Juvenile Justice's Central Communications Center (CCC). The YFA agency has procedures that require incidents be reported according to a specific protocol. The agency has four (4) major categories of reportable incidents. These categories include property damage, staff incident in accidents, client incidents and accidents and adverse media coverage or threats. The procedures also include incidents that require an immediate notification and incidents that require general notification. Procedures also include protocols for reporting incidents related to the Department of Juvenile Justice. The procedures also include other mandatory reporting requirements. The procedures also include the notification process for all incidents and accidents. Further, the procedures also include reviewing for trend analysis.

A review of the YFA RAP House incident reporting process was conducted onsite during this onsite program review to determine the agency's adherence to the incident reporting requirements. A review of all incidents reported to the DJJ Central Communication Center (CCC) in the last six (6) months was conducted on site. A total of twenty-three (23) incident reports were documented as having been officially reported and documented as being reported to the DJJ CCC. Of these incidents twenty-two (22) total incidents reported as being in compliance with the 2 hour reporting requirement. A

total of eight (8) incidents involved medication errors; eight (8) incidents involved medical injury or illness; three (3) incidents involved youth behavior; two (2) incidents involved absconding; one (1) involved complaint against staff; and 1 incident involved program disruption.

Exceptions:

The agency had a total of one incident (1) that was documented as being reported or documented in a manner not consistent with the incident 2 hour reporting requirement.

1.04 Training Requirements

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

The agency has a policy in place titled Training Requirements. The policy was last reviewed on March 30, 2017 by the Chief Operating Officer and Vice President of Prevention Services.

The agency provides a wide array of training opportunities to staff including the utilization of an online training system called Relias. Staff are responsible for completing their assigned trainings on Relias when required and for uploading any certificates into the system for approval. It is also staff's responsibility to track their training hours each year and ensure they are meeting the requirements of this policy. In addition to Relias staff are offered opportunities for in person trainings internally and externally.

The agency policy requires that all staff receive 80 hours of training during their first year of employment and 40 hours of training each year after. All new hires complete specific training as mandated by the Florida Network within 120 days of employment. The policy outlines the specific trainings to be completed during the first 120 days of employment, during the first year of employment, and after the first year of employment. The specific trainings listed in the agency policy to be completed during the first 120 days did not include Universal Precautions. It also did not state Suicide Prevention training needed to be two hours in addition to DJJ-SkillPro courses. The specific trainings listed for completion in DJJ-SkillPro did not include Human Trafficking 101 and just listed Suicide Prevention and not Suicide Prevention Part 1 and Suicide Prevention Part 2.

Trainings and details of trainings are kept in different electronic systems, which make it extremely difficult to get a true and accurate accounting of all the staff member trainings. There were three different systems used to verify trainings: Relias, DJJ-

SkillPro, and Paylocity. The agency has recently switched from using Relias to Paylocity to document trainings. As a result, for all training files reviewed both systems had to be reviewed in order to find all trainings completed. In addition, DJJ-SkillPro trainings are not documented in either system so that system had to be reviewed as well in order to capture all trainings. Training hours from all three systems had to be calculated in order to find the total number of training hours for the applicable staff. There was no one program or file that had all the information available. Training certificates had to be uploaded into the Paylocity system for each training each employee attended. For the most part a certificate was available for all trainings. However, there were no sign-in sheets or agendas for the trainings. It was reported that the individual who provided the training would be responsible for keeping that documentation.

There were eight files reviewed for training, four of the files were reviewed for training completed during the first 120 days of employment, two of the files were reviewed for training completed during the first year of employment, and the remaining two files were reviewed for annual training completed after the first year of employment.

First year: (Fernandes and Guzman)

158 and 173.5 hours

Neither had Understanding Youth/Adolescent Behavior

Both had Child Abuse Reporting; however, it was not completed in SkillPro as required.

Guzman had expired CPR and First Aid

Neither staff had Universal Precautions

Fernandes did not have Cultural Humility

Guzman did not have Information Security Awareness, EEO, PREA, Sexual Harassment, Suicide Prevention 1 and 2, or Human Trafficking in SkillPro. It was reported she has been locked out of SkillPro since 8/28/18; however, has had since 9/7/17 to complete these trainings.

Exceptions:

120 Days: (4 staff files reviewed with exceptions)

2 staff training files did not have Understanding Youth/Adolescent Development
1 staff training file had Understanding Youth/Adolescent Development but not in first 120 days. 2 staff files both had Child Abuse Reporting but not in SkillPro

In-service: (2 staff files contained the following exceptions)

44 and 71 hours
Both staff only had Suicide Prevention Part 1 in SkillPro
Staff file R had a lapse of 4 months in CPR and First Aid certification. Expired 6/24/18 and was just renewed 10/23/18.

1.05 Analyzing and Reporting Information

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

The program has a comprehensive CQI Plan that 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. 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.

The program created an incentive program to encourage staff to complete program requirements as a recognition for helping with the success of the program. The categories cover attendance, having less than 1 medication error a quarter, compliance with Paylocity in tracking time worked, reporting CCC reportable incidents timely to Shelter Manager and the CCC, and proper completion of youth intakes and screenings for placement. Any disciplinary action received during that quarter may disqualify an employee and the process also considers additional hours worked and no grievances as well as part of the consideration for earing points. Each quarter employees may earn points to obtain this monetary bonus incentive following their 90 day introductory period. The agency has other ways to boost staff morale including a 'Kudos' board to allow other staff members to acknowledge their peers or leadership can provide recognition for staff members.

The program showed evidence of quarterly stakeholder meetings that review customer satisfaction data which is gathered through various sources such as; google, facebook, and client surveys.

Outcome data and NetMIS report data is reviewed monthly on the 4th Monday of the month in a data meeting. The agency created a dedicated data analyst position approximately a year ago to focus on analyzing the data and this staff member is part of their internal Risk Prevention Team.

The program had documentation of 6 surveys where they achieved 67% satisfaction for the period of April – June 2018. There was no data for July- Sept period to review at the time of this review. The last peer review involved a comprehensive review of 25 youth records on 10/18/18 and the overall achievement was 88%.

The program holds monthly team meetings, supervisory reviews, communicates via emails in an effort to communicate areas of improvement with program staff. During team meetings they look at needs of the program or individuals and review training tools or host ne-on-one training to address needs.

The agency has an internal peer review process that involves the VP of Quality Improvement, Data Analyst, and Counselor staff to review files. The results are communicated to the program leadership via email with a summary of any deficiencies and specific details about any files that are missing information or non-compliant.

The program completes quarterly case record reviews using the internal peer review team and it has a roll up of incident reports that is analyzed but doesn't appear to be documented in a format that can analyze the trends or the data from quarter to quarter to track improvements or areas that may need specific improvement. However, there is clear documentation that results are being communicated to the program leadership to be addressed on case by case basis when the reviews are completed.

Exception

No exceptions were noted for this indicator.

1.06 Client Transportation

☐Satisfactory ☒ Limited ☐Failed

Rating Narrative

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

The agency's transportation procedures require that all staff be capable of transferring youth and approved as drivers through the human services verification process. The agency requires all staff to utilize a trip and mileage log each time they use a vehicle

whether they are transporting clients or not. Staff are required to take a shelter mobile phone with them when they are providing transportation. Staff are required to check in with the shelter once they arrived at their schedule destination.

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

The shelter has a list of approved drivers that are permitted to transport youth. All approved drivers have a valid Florida driver’s license and are covered under the agency's insurance policy.

The shelter maintains two separate logs for transports. The Single Party Transportation form documents all single client transports, it notes the date, client name, reason for trip/destination, if supervisor approval was received, supervisor initials, departure time and location, destination time and location, mileage to and from, and the staff name. The Monthly Mileage Transport Log documents all transports that occur, it notes the date, driver, safety equipment, number of youth, purpose, stops, odometer start and end, and any comments.

According to the Monthly Trip and Mileage Log there were thirty-four single client transports documented in the last six months. There were more than thirty-four single client transports documented on the Single Party Transportation Forms for the last six months, however; when comparing the two different logs some single client transports documented on the Single Party Transportation Form where not actually single client transports and documented multiple clients being transported on the Monthly Trip and Mileage Log.

Out of the confirmed thirty-four single client transports documented on the Monthly Trip and Mileage Log, sixteen where not documented on the Single Party Transportation Form so they did not document supervisor approval. In addition, four of the remaining transports were documented on the Single Party Transportation Form and was circled "yes" for supervisor approval; however, the column for the supervisor's initials was blank.

The Monthly Trip and Mileage Log was being filled out in its entirety for each transport documented.

Exceptions:

In the last six months there were thirty-four single client transports, sixteen did not document supervisor approval and four documented approval was obtained but did not document the supervisors initials.

The two logs used to document transports did not always correspond. One log would document a single client transport and the other log would document the same transport as a multi-client transport or one log would document a single client transport, but it would not be documented on the approval log.

May – 13
5/1, 14, 15, 16 – on log but not initialed by supervisor
5/14, 14, 15, 16, 23, 24 – not on approval log but documented as single youth on mileage log.

June – 3
6/13, 28, 29 - not on approval log but documented as single youth on mileage log.

August -7
8/22, 22, 24, 24, 30 - not on approval log but documented as single youth on mileage log.

September – 11
9/7, 17 - not on approval log but documented as single youth on mileage log

1.07 Outreach Services

☒Satisfactory ☐ Limited ☐Failed ☒Not Rated

Rating Narrative

The agency has a written policy CS400 that addresses Community Outreach and Education. The policy which was reviewed by the Chief Executive Officer and the Board Chair on 3/27/17 states staff shall seek opportunities to conduct ongoing community outreach and education to communicate the agency mission, role, function, capabilities and the strengths needs and challenges confronting children and families.

The agency's written procedure requires that all staff at all levels are formally assigned responsibility for community education. Additionally, agency staff is encouraged to participate on state, county and district boards as appropriate; as well as participate in community forums that deal with issues on youth and families and needs assessments

as appropriate. Furthermore, the agency's procedure is for the program to attend the local DJJ circuit meetings and keep a copy of the meeting agenda, minutes and sign-in sheet for their records. Moreover, the program will keep a record of inter-agency agreements and interact with community through various community organizations, professional organizations, school personnel and student groups. Finally, prevention goals will be met through various community interventions. Groups will be provided to local schools. Groups will be designated to act as an early intervention in order to keep children and adolescents from becoming involved with drugs and the juvenile justice system.

A program representative has attended DJJ Circuit Advisory Board Meetings, JAC Advisory Committee meetings and the Circuit 6 Provider Meeting the last two quarters and provided accompanying signature pages and agendas. Inter-agency agreements were provided as well as outreach forms capturing street outreach events and general events attended by Program Outreach Staff.

The program has evidence that they complete and participate in outreach services as evidence in the NetMIS report. Minutes and verification was provided for the Circuit Provider Meeting, JAC Advisory Council Meeting and Circuit 6 DJJ Advisory Board Meeting including agendas and signature sheets and handouts. The program also attends Drop In Meals on Monday, Wednesday and Fridays; and participate in the Adult and Youth Task Force for Homeless. They have a Homeless Coalition Partnership and are involved with the Metropolitan Ministries in their community.

The program has logged over 176 events of Outreach in the NetMIS system from April – August 2018 covering several zip codes.

Exceptions:

No exceptions were noted for this indicator.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

This specific YFA site provides non-residential CINS/FINS services to youth and families residing in Pasco and some surrounding areas in the region. The program consists of a Non-Residential Program Director, a Non-Residential Program Supervisor, and four Counselors. The agency provides residential counseling services, as well as non-residential services that are provided onsite through traditional non-residential

office locations and other local partnering schools, and community-based organizations. The agency delivers other residential Counseling (Shelter Services) and non-residential Counseling that includes Domestic Violence Respite, Family Youth Respite After Care (FYRAC) and

Probation Respite. The agency provides and individualized approach regarding its efforts to engage the families in the solution of the youth's challenges which lead to either residential or non-residential services.

2.01 Screening and Intake

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

The agency has a formulated policy that addresses vital components of the IQ indicators for Screening and Intake. The policy was last reviewed on 02/14/2017 and was signed by the Chief Operating Officer and Vice President of Prevention Services.

The provider's procedure indicates that the Program Supervisor/Director will warrant a counselor to contact the family to conduct an initial screening and document on the Centralized Intake Screening Form. The provider allows the option to complete the screening by phone or face to face and is to begin no later than seven (7) working days from the date the referral is received. The Eligibility Screening process is available to families 24 hours a day which include demographic information, presenting issues, immediate needs and eligibility criteria. If a crisis situation (e.g. suicidal/homicidal), substance abuse usage is determined there is support staff and an on call supervisor for further recommendations. In addition, a procedure is in place for non-residential programs allowing after-hours calls as well offering assistance with translation of languages. All screenings are entered into NETMIS with in three (3) business days.

A total of five (5) residential and five (5) non-residential files were reviewed. It was evident that the youth and parent/guardian were provided with available service options demonstrated in a CINS/FINS brochure available for both residential and non-residential services. For all files, all Rights and Responsibilities forms were signed by parent and child. However, (1) out of the (5) residential files is missing 1 out of the 3 signatures required (i.e. witness signature). The grievance procedures and outline of services are provided to youth and parent/guardian. All files had completed screenings within seven (7) calendar days.

Youth completed surveys were reviewed. Six (6) questions from the programs QA Survey were reviewed as they relate to standard 2.01. Four (4) out of the six (6) questions indicate an understanding of the grievance policy and satisfaction with the

process in place. Two (2) out of the six (6) questions indicate a lack of understanding of the policy/procedure.

Exceptions:

No exceptions are documented for this indicator.

2.02 Needs Assessment

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

The agency has a formulated policy that addresses vital components of the IQ indicators for Needs Assessment. The policy was last reviewed on 02/14/2017 and was signed by the Chief Operating Officer and Vice President of Prevention Services.

The agency's procedure addresses the Needs Assessment by providing a baseline measurement for effectiveness of services and the family's aptitude to implement skills learned through interventions. The Needs Assessment play a fundamental role in service development by assisting to develop an objective understanding of the family's strength's, needs, functioning, resources and understanding of their circumstances and specific opportunities. Staff is instructed to deliver and formulate the timeliest and appropriate service referrals specific to each youth and family situation. The Needs Assessment is to be initiated within (72) hours of admission. If a more intensive assessment is determined to be needed, a referral will be completed in a timely matter to assure youth's specialized needs are met. If the youth is admitted to shelter the non-residential counselor and the residential counselor shall partner to effectively deliver continuity of treatment. The Needs Assessment will be conducted every six (6) months or when otherwise indicated. The Needs Assessment will be completed within two (2) to three (3) face to face contact sessions following the initial intake if the youth is receiving non-residential services. The Needs Assessment are completed by a Bachelor's or Master's level staff and signed bus a supervisor. If a suicide risk is required, it must be reviewed and signed by a licensed clinical supervisor.

A total of ten (10) files were reviewed, five (5) residential files in which (3) were closed and (2) are open, and (5) non-residential files in which (3) are closed and (2) are open. All files reviewed indicated an initiation of the Needs Assessment within 72 hours of admission. All files reviewed were completed within the two to three face to face contacts as stated in the agency's policy and procedure following with commencing the initial intake process. All applicable files reviewed the Needs Assessment were

completed by a Bachelor's or Master's level staff member and signed by a supervisor. Out of the ten (10) files reviewed no indications of suicide ideation.

Exceptions:

No exceptions are documented for this indicator.

2.03 Case/Service Plan

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

The agency has a formulated policy that addresses vital components of the IQ indicators for Case/Service. The policy was last reviewed on 02/14/2017 and was signed by the Chief Operating Officer and Vice President of Prevention Services.

The agency's procedures comply with the requirements for Standard 2.03. The Service Plan addresses the specific needs identified in the needs assessment, centralized intake and NETMIS documentation and any other collaborative information. The Service Plan is individualized utilizing strengths and limitations identified by the youth and family. The Case Plan utilized by the agency includes: date the plan was initiated, identified needs and goals, type, frequency, location of service(s), person responsible, targeted dates, actual completion dates, signatures of youth, parent/guardian, counselors and supervisor. The Service Plan and Aftercare Plan will be developed no later than seven (7) working days following the completion of the Needs Assessment. If the Service Plan cannot be signed due to the parent or youth's unavailability, the counselor will document the reason for delayed signature(s) and will make efforts to obtain if possible. Treatment Plan goals are to be monitored and formally reviewed at a minimum, by the counselor/therapist and parent/guardian (if available) every thirty (30) days for the first three (3) months, and every six (6) months thereafter for progress in achieving goals and objectives. Reviews are documented under "Service/Treatment Plan Review", illustrating a date and staff initials. The procedure indicates reviews are documented and highlighted in yellow in the youth's file. The counselor will document all efforts to engage youth and family in reviewing the Treatment Plan. The Service Plan may be revised at any time there are significant changes however, at the end of ninety (90) days a new Service Plan must be developed with youth and family.

A total of ten (10) files were reviewed, five (5) residential files in which (3) were closed and (2) are open, and (5) non-residential files in which (3) were closed and (2) are open. One (1) of the residential files case plan was not completed within the seven (7) working days of the Needs Assessment (i.e. one day late). All applicable files case plans

complied with indicators requirements. One (1) out of the five (5) non-residential files did not indicate an actual completion date(s). All applicable files documented reviews within thirty (30) days. One (1) out of the non-residential files documented late reviews for the 60 & 90 days review (i.e. late by 6 days).

Exception:

No exceptions are documented for this indicator.

2.04 Case Management and Service Delivery

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

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

Program(s) procedure requires that each youth is assigned a counselor who will follow the youth's case and ensure delivery of services through direct provision or referral. This process of case management would include: (1) Establishing referral needs and coordinating referrals based upon ongoing assessment of youth/family's needs or problems, (2) Coordinating service plan implementations, (3) Monitoring youth/family's progress in services, (4) Monitoring out-of-state home placement, (5) Referral(s) to additional services, and (6) Case termination with follow-up.

Indications of substance abuse may be documented on the original referral, screening, NETMIS, Psychosocial or other collateral information. Non- Residential Counselors would use the SASSI instrument as an indication that the youth may need further assessment by a Certified Addictions Professional or Local Abuse Assessment Center. Responsibility of the Non-Residential Counselor to monitor the family's compliance with the referral and assisting the family in acquiring the assessment. Assessment must be documented within a 30-day calendar of the referral with reasons for documentation in the file. If youth is not in need of further treatment, they would be provided with basis substance abuse education during face to face contacts.

A total of ten (10) files were reviewed. All files are making referrals when necessary and are providing support for families and monitoring progress with services. Each file has an assigned Counselor or Case Manager. For Case Management and Service Delivery 9 (nine) of the applicable files (5 Non-Residential & 4 Non-Residential) met the requirements for the following: Having an assigned Counselor/Case Manager, Establishing referral needs and coordinating referrals to services based upon the on-

going assessment of youth's/family's problems or needs, Coordinating service plan implementation, Monitoring family/youth progress in services, Providing support for families, and Monitoring out-of-home placements. The 9 (nine) applicable files also covered referrals to the case staffing that addressed problems and needs of the youth/family, referring youth/family for additional services when appropriate, case monitoring's and court reviews, as well as 30- & 60-Day Follow-Ups after case closure. For the case termination notes 4 of the 10 files had some form of progress note stating that the youth was closed out of the program all together. 5 (five) youth are still open in the system and would not have a termination note with 1 youth not having a note at all be has been discharged from the program. 1 (one) residential file was opened on 10/23/18 with audit taking place on 10/24/18 and does not have all the applicable signatures from staff but are still within the compliance date off signing all paperwork.

QA Survey: Reviewed 6 Youth responses on the QA Survey. Out of 6 (six) total questions youth were asked if they are participating in services for mental health and substance abuse with 2 out of 3 stating "NO" and 1 stating "YES". Also of the 6 (six) total questions three were asked if they have a counselor with all three stating "YES"

Exception:

No exceptions are documented for this indicator.

2.05 Counseling Services

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

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

Youth and families receive counseling services, in accordance with the youth's case/service plan, address needs identified during the assessment process. Shelter provides individual; and family counseling, as well as group counseling sessions held a minimum of five days per week. Non-Residential Programs provide therapeutic community-based services designed to provide intervention necessary to stabilize the family in the event of a crisis, out of home placement, after care services for the youth returning to the home from any placement.

Ten (10) files were reviewed. All files reviewed demonstrated the following: A Need's Assessment, Initial Service Plan, Case Notes maintaining for all counseling services provided and documents of youth's progress, On-Going internal process to ensure

clinical reviews of case records and staff performance, as well as providing individuals/family's with counseling. Other applicable marks met by all 10 files included providing of group counseling at least 5 days a week, with a minimum of 30 minutes, Facilitators or Group Leaders for Counseling, Clear/Relevant Topics, and Opportunities for youth engagement.

Of the 10 files reviewed 2 (Residential) files had non-applicable benchmarks for service plans, and having youth and family's receive counseling services in accordance with the Service Plan. All other files met the requirements to demonstrate that the needs assessment, case plan and applicable reviews met the needs with regards to counseling services. 1 youth was expelled from the program before either of these objectives could be met. The other youth has just been opened and program is still within its compliance window of establishing these goals with youth. All files showed evidence that the program provides individual and family counseling.

QA Survey: Reviewed 9 Youth QA Surveys. Three (3) youth were surveyed on if the program ask them what they wanted to do while they were there and all three stated "YES". The next question asked three (3) youth what goals, if any, are they currently working on. All three stated that they wanted to go back to school while one (1) youth additionally added that they wanted to also get out of the shelter. The last question asked three (3) youth if the counseling sessions were helping them meet their goals. Two (2) youth stated "YES" While one (1) stated "NO.

Exception:

No exceptions are documented for this indicator.

2.06 Adjudication / Petition Process

☒Satisfactory ☐ Limited ☐Failed ☐Not Applicable

Rating Narrative

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

A case staffing committee meeting is scheduled to review a case of any youth or family that the program determines is in need of services or treatment if: (1) the youth/family is not in agreement with the services or treatment; (2) youth/family will not participate in the services selected; or (3) the program receives a written request from the parent/guardian or any member of the committee. A case staffing committee is convened within seven (7) working days from receipt of the written request from the parent/guardian. Youth and family are provided with a new or revised plan for services within seven (7) working days of the case staffing committee providing family with outlining the committee's recommendations and the reasons behind the recommendations.

The program will work with the circuit court for judicial intervention for the youth or family, as recommended by the case staffing committee, in accordance with the procedures outlined in Florida Statute and the Florida Networks Policy and Procedure Manual for CINS/FINS. Program will provide complete review summary prior to the reviewing hearing, informing the court of the youth's behavior and compliance with court orders and providing recommendations for further dispositions.

Ten (10) files were reviewed. All files met the applicable standards set forth by the Adjudication/Petition Process. The following criteria were meet in compliance to this policy: Person initiating the case staffing, if parent/guardian initiates, staffing is held within 7 days, Notification to family and committee no less than 5 working days prior to the staffing. All the applicable staffing included local school district, DJJ Provider, Mental Health, Substance Abuse, Law Enforcement, and DCF Representatives. Because of the case staffing committee meeting, the youth and family are provided a new or revised plan for services. Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations. The program works with the circuit court for judicial intervention for the youth/family. These were all the applicable findings for the 10 reviewed files. The program files also established case staffing committee and has regular communicati8on with committee members. The program has an internal procedure for the case staffing process, including a schedule for committee meetings.

Exception:

No exceptions are documented for this indicator.

2.07 Youth Records

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

The policy of Youth and Family Alternatives Inc. that the program maintains confidential records for each youth that contains pertinent information involving the youth and his/her treatment at the program.

The agency maintains a youth record policy and procedure, last reviewed and signed by authorized officials of YFA on 2/15/17. The policy matches the Florida Network Standard. The facility provided a location for the file box and large opaque envelopes in addition the reviewer also reviewed the items within.

Ten (10) files were reviewed and all were applicable meeting the standards set forth having all records marked “confidential”, being kept in a secure room or locked in a file cabinet that is marked “confidential”. When in transport, all records are locked in an opaque container marked “confidential”. Of the ten (10) files two (2) files were not maintained in a neat and orderly manner. Program was made aware of the situation.

Exception:

No exceptions are documented for this indicator.

2.08 Sexual Orientation, Gender Identity, Gender Expression

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

The agency's policy on this indicator is forth coming.

The provider doesn’t have a written procedure in place however their practice which is supported by their paperwork is to ask the youth how they identify and then based on the information gathered allow the youth to determine where they are most comfortable sleeping and who they are most comfortable socializing with.

During the review period, the program had one biological female that identified as gender fluid. The youth was asked where they felt most comfortable sleeping and they preferred the female quarters but preferred to socialize with the boys. There was one youth that showed up in the system as Trans-gender female however it was a data entry error as the youth did not identify as transgender in her paperwork.

Exception:

At the time of the review, the agency has not yet an established policy for this indicator. The agency is currently working on updating and reviewing all policies and states this is one of the policies being developed currently.

Standard 3: Shelter Care and Special Populations

Overview

Rating Narrative

The RAP House is an eighteen (18) bed crisis shelter facility located on Plathe Road approximately 2 miles West of Little Road in Port Richey. The program is operated by Youth and Family Alternatives which also operates two other CINS/FINS shelter facilities in (Brooksville and Bartow). This residential shelter operates twenty-four hours a day, 365 days a year and is licensed by DCF to serve up to twenty residents for runaway and emergency shelter services. The youth shelter is contracted to serve both CINS/FINS youth and children placed by the Department of Children and Families (DCF).

3.01 Screening and Intake

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

The agency has a written policy SH 3.01 that addresses key elements of the shelter environment being clean, neat and well maintained at all times. The policy which was reviewed by the Chief Operating Officer and the Vice President of Prevention Services on 2/15/17 states the facilities shall be safe to the extent possible and reflect a home like environment.

The provider's written procedures require weekly safety inspections of all internal and external areas and equipment including but not limited to equipment for emergency situations and documentation of those inspections in the Weekly Inspection Log. Any corrective action will be communicated to the Program Director and any maintenance request will be forwarded to a maintenance technician via FMX. Random checks are to be conducted by the Program Director, Residential Supervisor, Shift Leader or designee to conduct a formal daily inspection of each of the wings at the shelter three times a day.

A tour of the facility was conducted and the facility is well maintained, nicely decorated with client artwork, nice decals and pictures. The youth have access to a lovely backyard space complete with a screened in pavilion, basketball court, and volleyball net. The agency had satisfactory health and fire inspections as well as required mock and fire drills. The agency was able to produce MSDS sheets for all of the chemicals used by the program. The agency has their DCF License displayed as well proof of their accreditation. The program does have the youth's daily schedule posted in kid accessible areas which reflects youth's study time, outside time and activity time.

Exception:

During the tour it was observed that while the outside dumpster does have a cover on it, the trash cans in the kitchen have no lids for them.

3.02 Program Orientation

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

The program has a policy to ensure all youth are orientated to the program upon intake.

The shelter completes the orientation process within 24 hours of admission. The youth and youth development staff are to sign and date the Client Orientation Checklist confirming all provisions of the orientation. All youth are provided with a comprehensive Youth Handbook. Youth are provided with Client Rights and Youth Grievance Process and sign acknowledging receiving both.

Six (6) youth records were reviewed, three open and three closed, of which four documented the practice of the program was followed and orientation was completed within 24 hours of admission. Two of the youth records did not documents the youth's signature on the orientation checklist. Of the two who did not have a signed orientation checklist, one youth did sign the form which is signed by both the parent and the youth indicating they did receive their orientation handbook; however was three days late. The additional youth did not sign the orientation checklist, nor did he sign acknowledging he received the youth handbook and orientation. All six youth were assigned a room during orientation and a Youth Room Assignment form was located in each youth record. The orientation process does include obtaining the signature of the youth and parent, reviewing the disciplinary actions, grievance procedures, emergency/disaster procedures, contraband rules, physical facility layout map, daily activity schedule and providing the Florida Abuse Hotline. Through review of the orientation process for each youth, it was documented the program follows their procedures pertaining to suicide prevention.

Exception:

Two of the youth records did not documents the youth's signature on the orientation checklist.

Of the two who did not have a signed orientation checklist, one youth did sign the form which is signed by both the parent and the youth indicating they did receive their orientation handbook; however this was three days late.

The additional youth did not sign the orientation checklist, nor did he sign acknowledging he received the youth handbook and orientation.

3.03 Room Assignment

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

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

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

Six (6) intake files were also reviewed and each file had accurate documentation of youth's referral behaviors and what problems they presented. All six intakes youth room assignments were asked and answered questions on youth's history status & exposure to trauma, age, gender, history of violence, disabilities, physical size/strength, gang affiliation, suicide risk, sexual aggression, gender identification, collateral contacts, entering alerts for documentation, and initial interactions and observation reviews.

Exception:

No exceptions are documented for this indicator.

3.04 Log Books

☐Satisfactory ☒ Limited ☐Failed

Rating Narrative

The agency has a written policy SH 3.04 that addresses the documentation of daily activities. The policy which was reviewed by the Chief Operating Officer and the Vice President of Prevention Services on 2/28/17 states the program will maintain logbooks 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 providers written procedure require that all entries that could impact the security of the program are highlighted; additionally, all entries should be written in ink, be legible and include date & time of event and name of all youth and staff involved. A brief statement of the pertinent information of the incident should be included as well. The procedure states that if there is an error, it should be corrected with a single line strike through and the word “void” written by the error as well as the staff’s name. All direct care staff should review the log book for the previous two shifts and make a signed and dated entry in the log book. The supervisor is to review the log book weekly and make an entry in the chronological notes with follow-up and or recommendations.

A review of randomly selected Program Log Books revealed that Supervisors are consistently reviewing the log book and giving pertinent feedback and follow-up to staff. The log book consistently captures the youth counts as well as pertinent numbers and agency codes. The logbook has an explanation of the color coded system used to highlight youth on sight and sound, intakes/discharges, important information, open line and outreach.

Exception:

Program staff consistently didn’t review and or document their review of the last two shifts in the logbook. Furthermore, staff consistently wrote over errors or scribbled over their errors versus using the one line strike through as outline in the agency’s procedure. Finally, as previously stated, the program does have a color-coded system in place to highlight important information in the logbook however it doesn’t seem to be a consistent practice to highlight all identified “important” information as defined by the program in the front of their log books.

3.05 Behavior Management Strategies

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

The agency has a written policy RM780 that addresses the use of proactive behavior management techniques. The policy which was reviewed by the Chief Executive Officer and the Board Chair on 3/19/18 states the behavior management techniques emphasize positive and preventative measures in the management of youth behavior. Restrictive behavior management in the form of physical restraint may be used only in an emergency. Seclusion, mechanical and chemical restraints is strictly prohibited.

The provider’s written procedure requires that all youth admitted to the shelter and their parents or legal guardian shall be informed of the behavior management program at intake, including the use of physical restraints in an emergency situation and as a

means to protect the youth from self, other youth and/ or staff. The Youth Development System (YDS) is used in working with youth and is comprised of a philosophy and approach that includes Advancing Youth Development, Character Counts and Managing Aggressive Behavior. Staff is to integrate the behavior management system so that youth are recognized and rewarded for positive participation with their peers, staff, family members, school and community. Consequences for violation of program rules, disrespect for others and destruction of property shall be provided according to the seriousness of the offense.

A review of the Behavior Management system showed there are positive reinforcements for seeking positive attention. The shelter uses a wide variety of rewards and incentives in order to motivate the youth with RAP Bucks which they can spend at “the store” to purchase items such as sneakers, fingernail polish and other various items. The BMS has four levels; Orientation, Education, Graduation and Collegiate. As the youth moves up the system they gain more privileges. The program recently added “Reflection” as part of their BMS. If a youth is placed on Reflection due to noncompliance they will lose their privileges for 24hrs but they must also complete specific task that entails them reflecting on their behavior, identifying which “Pillars of Character” they failed to use during the incident and then communicate how they could have used to the “pillars” for a better outcome prior to the youth coming off Refection. The youth and parent does receive a copy of the BMS in their orientation packet however there is no written description of Reflection or any other consequence as outlined on postings around the facility in their orientation packet. Staff are trained on the system and there continues to be ongoing training on the system during the first thirty minutes of staff meeting.

Exception:

No exceptions are documented for this indicator.

3.06 Staffing and Youth Supervision

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

The agency has a written policy SH 3.06 that addresses staffing and youth supervision. The policy which was reviewed by the Chief Operating Officer and the Vice President of Prevention Services on 2/28/17 states the agency shelter programs are appropriately staffed to ensure adequate supervision of youth and safety and security of youth and staff.

The provider's written procedure requires that the program strive to maintain one male and one female member on duty at all times; additionally, a staff to client ratio of 1:6 will be maintained pursuant to regulations and the program maintains 24-hour awake supervision of youth. Moreover, staff shall observe youth every 15 minutes while they are in the bedroom sleeping area regardless of time of day and document an entry in the log book with staff observations.

The program maintains a schedule that includes the names of staff and shifts that are working and meets minimum staffing ratios. The overnight shift is always staffed with a minimum of two staff. The program attempts to maintain both genders on shift but the program has had periods where they were unable to employ male staff on a consistent basis; as a result, they hold weekly open interviews every Friday looking to hire with an focus on males. There is no formal holdover roster; however, the staff has an informal system in place where they fill their on shifts if they require time off after the schedule is completed, posted and emailed to staff. If staff is unable to secure coverage for their shift, the Residential Supervisor will attempt to fill the shift with available staff; however, if she is unable to cover the shift with staff she will work the shift. There is documentation in the house log that bed checks of all youth are made on average of every fifteen minutes. There were times documented outside of the fifteen minute window (i.e. 16-20 minutes) but there were also times documented sooner than the required fifteen minutes. Overall, bed checks are consistently done and documented throughout the log books.

Exception:

No exceptions are documented for this indicator.

3.07 Special Populations

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

The agency has a formulated policy that addresses vital components of the IQ indicators for Special Populations. The policy was effective on 04/01/2016 and was signed by the Chief Operating Officer and Vice President of Prevention Services. No review date thus far however, program manager provided draft documents of the policy. There is an inscribed policy that states all agency shelters shall provide services designated to deliver a safe substitute to secure detention for youth with pending or adjudicated charges for domestic violence to special population including: domestic violence respite, domestic minor sex trafficking, probation respite, and staff secure for youth 10-17. These services will be provided primarily to youth who reside in Citrus,

Hernando, Sumter, Pasco, Hardee, Highlands and Polk counties—unless approved by Florida Network.

Procedures for each special population (i.e. Domestic minor sex trafficking, probation respite & staff secure referrals) includes an overall description of services as it related to youth eligibility, youth referrals/determination, limits on youth to be served, and services to be provided. Each section details criteria and process.

Two (2) files were reviewed, one (1) Domestic Violence Respite and one (1) Probation Respite. No files were provided for Staff Secure (i.e. No cases in the last 6 months), Domestic Minor Sex Trafficking (i.e. No CINS/FINS cases in the last 6 months. Clients are DCF not CINS/FINS, per Program Supervisor), Intensive Case Management (i.e. Agency does not receive referrals at this location. Referrals are forwarded to agency's provider George W. Harris, Jr. Runaway and Youth Crisis Shelter, per Program Manager) and FYRAC (i.e. No cases in the last 6 months). All two (2) files contained accurate referral source documentation from JAC/Detention. Two (2) out of two (2) files case plans were not completed. Program manager was interviewed in which she reported if the discharge date is before the seven (7) day period, no case plan is required. All files reviewed contained progress notes articulating case progress.

Exception:

No exceptions are documented for this indicator.

3.08 Video Surveillance System

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

The agency has a written policy RM660 that address YFA will utilize video surveillance technology at each of the three shelters. The policy which was reviewed by the Chief Executive Officer and the Board Chair on 4/7/17 states YFA will utilize video surveillance technology as a means to provide a secure environment, protect its facilities and enhance the safety of youth, staff and visitors.

The agency's written procedure requires the agency to keep a list of designated personnel approved to access the system for review purposes; additionally, a Video Review Log must be maintained documenting review of random footage and bed checks every fourteen days by management or a designee. The agency's procedure also requires signage posted at the entrance advising that the program is under video

surveillance. Cameras are to be placed in the general work areas however camera placement in bathrooms and bedrooms are strictly prohibited.

The program utilizes nineteen visible cameras, 7 external and 12 internal. The external cameras cover the parking lot and the youth's recreational area. The remaining 12 cameras are strategically located inside the facility to cover the male and female dormitory hallways and remaining youth areas including but not limited to the kitchen, dining area and living room areas. No cameras are placed in the youth's bedrooms or bathroom. The system records date, time, location and stores up to 30 days of information; furthermore, it will continue to be operational in the event of a power outage. The program has signage posted at the entrance alerting that the facility is under video surveillance. The supervisor's review is consistently conducted every fourteen days to review bed checks and random video footage.

Exception:

No exceptions are documented for this indicator.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

Youth and Family Alternatives (YFA) utilizes a process that requires that all prospective clients that meet CINS/FINS eligibility requirements be screened by staff members for the existence of potential health and mental health issues. All YFA direct care are trained to administer the screening process on all resident. Youth and Family Alternative staff residential and non-residential staff members utilize agency screening forms that include the general screening form, CINS Intake form, Psycho-Social Assessment and the Evaluation of Imminent Danger for Suicide (EIDS). The agency also uses the CINS intake form that includes a health screening section that is required to be completed on all residents.

4.01 Healthcare Admission Screening

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

The policy requires each youth be screened for health-related conditions at the time of admission to ensure the youth has no health or medical conditions requiring immediate

attention. During shelter stay, all youth shall receive basic monitoring of and appropriate health care.

The program has a procedure in place requiring all prospective youth, their parents, and service providers inquiries are documented using the Central Intake Screening Form. Upon determining admission appropriateness, staff shall inquire about any issues related to medications, any medical or health problems, allergies, substance abuse and/or intoxication. Upon admission to the shelter, the youth care worker will utilize the CINS/FINS Intake Assessment form and Health Screening Form to screen each youth. If necessary, first aid treatment can be administered, or emergency medical personnel contacted. Ongoing monitoring of each youth is required. Any issues/needs assessed during the admission process are to be addressed in the Service/Treatment Plan. Whenever possible, the parent/guardian are involved in the coordination of medical appointments. All follow-up appointments and emergency care are to be documented in the youth's case record and the Communication Logbook. The program utilizes a Medical Alert/Allergy Board to document and ensure staff are aware of each youth's medical conditions and allergies. Each youth record is documented with a Medical Alert and Allergy Label if applicable.

Three youth records were reviewed for healthcare admission screening verification. Of the three, one record contained a Healthcare Admission Screening Form documenting all of the required elements. The second youth record reviewed contained a Healthcare Admission Screening Form documenting all of the required elements with the exception of documenting two requirements. The two requirements not documented were the youth's distinguishing features and whether the youth had a recent head injury; both were left blank. The third record reviewed contained a Healthcare Admission Screening Form documenting all of the required elements with the exception of the youth's medical needs. The form documented the youth indicated there were medical needs; however, the specific medical needs were not documented as required. Each youth record documented the known allergies and medical alerts on the front of the file. Of the three youth's Healthcare Admission Screening Forms, two documented the nurse reviewed/singed the form within 24 hours; the requirement is within five days. The other youth record was reviewed by the nurse twelve days after the screening was completed. It was verified by the reviewer; the RN was on vacation during this week and the shelter does not have an additional nurse on staff.

Exception:

Youth M. Morales record was reviewed and contained a Healthcare Admission Screening Form documenting all the required elements with the exception of the youth's medical needs. The form documented the youth indicated there were medical needs; however, the specific medical needs were not documented as required. Of the three

youth's Healthcare Admission Screening Forms, youth H. Bunnell's record was reviewed by the nurse twelve days after the screening was completed.

4.02 Suicide Prevention

☐Satisfactory ☒ Limited ☐Failed

Rating Narrative

The program's policy indicates they have a comprehensive system for assessing potential risk with clients if indicated.

The program has a screening process in place which indicates a comprehensive screening will take place on all referrals to determine appropriateness of services. In addition, a suicide screening is included as part of the initial intake process. When the screening identifies a youth as being at risk for suicide, staff will ensure a suicide risk assessment is completed for that youth within 24 hours after the screening, unless it is between the hours of Friday at 5:00pm and Monday at 9:00am, and in this case, the assessment must occur within 72 hours. The youth is placed on constant sight and sound awaiting the assessment. If immediate concerns are observed and the youth requires a Baker Act, the youth is placed on one-to-one supervision until the youth is Baker Acted. Upon return from a Baker Act, the youth is placed on constant sight and sound until an assessment of suicide is completed.

Five youth records were reviewed for suicide prevention. A CINS/FINS Intake Form was completed for each youth upon admission; in addition, an Evaluation of Suicide Risk Among Adolescents was completed for each youth during the intake process. Each youth was placed on the appropriate level of sight and sound after the results of the evaluation was reviewed and determined each youth were at risk. Sight and Sound Supervision logs were completed for each of the youth and documented interval of 5 minutes apart for supervision. There were two exceptions. For one youth, it was difficult to follow the sight and sound form and validate the required time intervals. For the second youth (unknown date – date not documented on sight and sound form), between the hours of 7:25pm and 8:30pm, there were no checks documented. Of the five youth records reviewed, three youth's sight and sound forms were not reviewed/signed by supervisory staff for a total of 9 forms. Within 24 hours, a Suicide Assessment Form was completed for each youth by their clinical staff, with the exception of two; however one was still within the required timeframe. The one Suicide Assessment Form which was not completed within 24 hours, was completed on Monday after the youth was admitted on Saturday. The second youth did not have a Suicide Assessment Form in the file. Of the five youth records reviewed, there were multiple sight and sound forms

which were not reviewed/signed by supervisory staff. A review of the logbook and shift summaries validated the youth placed on sight and sound is documented in both, documenting their status and sight and sound checks.

Survey information: Five staff were surveyed and indicated they would notify a mental health authority, provide constant sight and sound, document the supervision, and searching the youth and room.

Exception:

There were two exceptions on sight and sound logs when documenting sight and sound at intervals of 5 minutes:

For youth D. Stacy, it was difficult to follow the sight and sound form and validate the required time intervals.

For the youth B. Garced (unknown date – date not documented on sight and sound form), between the hours of 7:25pm and 8:30pm, there were no checks documented.

Of the five youth records reviewed, three youth's sight and sound forms were not reviewed/signed by supervisory staff for a total of 9 forms:

Youth M. Morales had four sight and sound forms and two of the four were not reviewed/signed by a supervisor.

Youth D. Stacy had four sight and sound forms and three of the four were not reviewed/signed by a supervisor.

Youth B. Garced had seven sight and sound forms and four of the seven were not reviewed/signed by a supervisor.

Youth D. Thomas did not have a Suicide Assessment Form in the file.

4.03 Medications

☐Satisfactory ☒ Limited ☐Failed

Rating Narrative

The program has a policy indicating the agency ensures safe, uniform medication control and management.

The program's procedures indicate upon admission; the youth's medication is accepted in the original labeled bottle. Once the medication is verified with the pharmacracy, it is

entered into the Pyxis Med-Station 4000 Medication Cabinet, which is utilized for all medications at the shelter. All medications are stored in the Pyxis Med-Station, including controlled medication, in the medication room. Oral medication and topical medication is stored in its own locked compartment within the Pyxis Med-Cart. The medication room and medicine cabinet are locked at all times and inaccessible to youth. The medication requiring refrigeration is kept in a refrigerator, only used for medication. A Medical Distribution Log is used for each medication, every time a youth is provided medication.

Syringes and sharps are secured in the medicine cabinet and a perpetual inventory is maintained. A perpetual inventor is maintained for all medications in the youth's individual Medication Log sheet. Shift to shift inventories will occur for controlled medications only. Discrepancies are tracked in the Pyxis System and are reviewed and cleared each shift

All medications for the youth in shelter are kept in the Pyxis System Med-Cart. There are three Super Users, the RN, program supervisor and program manager. The shelter does not accept any injectable medications, except for epi-pens, nor do they accept any over-the-counter medications. All oral medications and topical mediations are securely stored separately in the Pyxis System Med-Cart. Any medication requiring refrigeration is stored in a medication-only refrigerator, which had a temperature of 37 degrees at the time of review. A verification of shift to shift counts validated the staff and RN, depending who is on site, completes this each shift. The shelter conducts a perpetual inventory of all controlled substances and it was verified for the last six months. All users, who have access, to the Pyxis System Med-Cart are trained by the RN prior to user permissions. The only sharps the RN maintains is the lice comb, which is kept in the Pyxis System Med-Cart and inventoried on a weekly basis, at minimum. The RN or staff who administer medication is documented on a medication distribution log, documenting all required elements. The RN conducts a monthly review of medication management utilizing the Knowledge Portal and was verified for the last six months. The RN utilizes a Medication Verification Form to verify all medication for youth. Through review of medical records and interview with the RN, it was determined the delivery process of medication is consistent with the FNYFS Medication Management and Distribution Policy. It was documented the shelter does not always clear discrepancies after each shift, but often times within 24 hours. The RN has discussed this concern with staff at multiple staff meetings and discusses the importance of this process when conducting training. The Pyxis System Med-Cart is able to report any discrepancy and this report is reviewed by the RN when she is on-site.

Five staff were surveyed and four indicated they provide medication to youth.

Five staff were survey and indicated they are informed of youth's medical and mental health alerts and medication side effects through the medical alert log, alert form in the file, and shift transition. Two of the staff indicated this process is very good, two indicated it is good and one felt it was fair.

Three youth were surveyed and two indicated they take medication and it is administered by the nurse and staff. The youth were also asked if they received medical care while at the shelter, one youth indicated they did. These youth, all three females, also indicated they are provided with female hygiene/sanitary products when needed.

Exception:

There is inconsistency in the documentation medication discrepancies being cleared by the agency at the end of each shift. It was documented that the shelter does not always clear discrepancies at the close of each shift, but often times it is within 24 hours.

In reviewing the DJJ CCC reportable incident reports, it was noted that a total of eight (8) incidents involved medication errors. Of these 8 incidents, 7 involved clients not receiving their prescribed medication on time or the agency not distributing the prescribed medication to the youth at all as required. Further, one (1) incident involved the youth receiving an incorrect prescribed medication. Of the eight (8) reportable DJJ CCC medication incidents, only three (3) incidents had documented evidence of the agency reporting that it had facilitated corrective action measures on the staff involved in the medication incident.

4.04 Medical/Mental Health Alert Process

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

The program has a policy indicating they shall have an effective system in place to ensure information concerning youth's medical and mental health conditions, including allergies. It further states staff shall be provided with sufficient information and instructions which allows them to recognize and respond to emergency care and treatment as a result of these medical and mental health conditions.

During the intake process, staff are able to determine the youth's medical and mental health conditions through the completion of the CINS/FINS Intake Assessment. Once the intake assessment has been completed the known medical alerts and allergies are placed on a label on the front of the youth's record. In addition, staff shall place this

information on the medical alert board in the medication room. Youth Development Staff are to check the boards each time they come on shift. Any special dietary needs or allergies are to be placed on the alert board in the kitchen. All alert information should be documented in the communication logbook. If any youth requires emergency medical care, upon return to the program, the shelter will file a verification of receipt of medical clearance and discharge instructions. If a new medical alert or allergy is identified, while the youth is in the program, the medical log and alert boards shall be updated.

Five youth records were reviewed for validation of the program's medical and mental health alert process. All records documented each youth was placed on the appropriate alert board and each had documentation for each alert on the front of the youth's file. The nurse on staff, who is a registered nurse, indicated she conducts training for staff for first aid, CPR, and emergency care procedures to ensure staff recognize and know how to respond to the need for emergency care for medical and mental health concerns.

Exception:

No exceptions are documented for this indicator.

4.05 Episodic/Emergency Care

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

The program has a policy in place indicating there shall be a comprehensive process in place for the provision of emergency and non-emergency care, ensuring staff respond appropriately and timely to youth.

The staff are provided training in CPR, first aid and the use for Knife for life. Healthcare simulations are conducted on at least a quarterly basis, on each shift. All instances of first aid and emergency care are documented as required. The assigned counselor/therapist is to contact the parent/legal guardian. Parents/guardians are to provide transportation for general care, and if they are unable to do so, the youth development staff will provide the transportation. In the event of an emergency, the shelter will call 911. If the youth is transported to an off-site facility for medical attention, the shelter is to record the youth's monitoring note to reflect the hospital to which the youth is taken. At that time, the shift leader or designee will contact the parent/guardian and document all attempts and contact in the Communication Logbook. Upon the youth's return to the program, the shelter will keep in the youth's file, a verification of

receipt of medical clearance, any discharge documentation and follow-up care, if required.

Reviewed the CCC reports for the last six months, which documented nine off-site emergency care episodes. Of the nine, all documented the parent was contacted and an incident report was called into the CCC. Of the nine records, the verification receipt of medical clearance/discharge instructions was located in seven. One youth returned to the shelter; however, the verification of medical clearance was not in the youth record. The other youth did not return to the shelter and was discharged by the parent and not returned to the shelter after the emergency room visit; this was documented in the logbook. The RN provided evidence of compliance for staff receiving training in CPR, first aid, medication administration, and medication orientation. All users of the Pyxis Med-Cart are trained on medical prior to being entered as a user. The shelter has three first aid kits on site and one in each vehicle, for a total of five. All five first aid kits are inventoried and checked, by the RN, for expired items at minimum on a monthly basis. This practice was verified for the last six months. The shelter maintains two suicide response kits which contains a knife-for-life and wire cutters. The RN does not maintain an episodic care log/daily log documenting episodic care. The information is captured in the shelter logbook and a Incident/Complaint Report Form is completed and documented for each of the nine incidents.

Exception:

Youth P. Nesbitt returned to the shelter; however, the verification of medical clearance was not in the youth record.

The RN does not maintain an episodic care log/daily log documenting episodic care.