Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Anchorage

on 11/08/2017

CINS/FINS Rating Profile

Standard 1: Management Accountability	
1.01 Background Screening of Employees/Volunteers	Satisfactory
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Satisfactory
1.05 Analyzing and Reporting Information	Satisfactory
1.06 Client Transportation	Satisfactory
1.07 Outreach Services	Satisfactory

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

Standard 2: Intervention and Case Management	
2.01 Screening and Intake	Satisfactory
2.02 Needs Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management and Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petitiion Process	Satisfactory
2.07 Youth Records	Satisfactory

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

Standard 3: Shelter Care	
3.01 Shelter Environment	Satisfactory
3.02 Program Orientation	Satisfactory
3.03 Youth Room Assignment	Satisfactory
3.04 Log Books	Satisfactory
3.05 Behavior Management Strategies	Satisfactory
3.06 Staffing and Youth Supervision	Satisfactory
3.07 Special Populations	Satisfactory
3.08 Video Surveillance System	Satisfactory

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

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

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

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

Rating Definitions

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

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

Review Team

Members

Ashley Davies, Lead Reviewer and Consultant, Forefront LLC Jason Ishley, Clinical Director of Non-Residential Services, Capital City Youth Services Travis Scott, Residential Supervisor, CDS Family and Behavioral Health Services Central Lea Herring, Regional Monitor, Department of Juvenile Justice

Persons Interviewed

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

5 Case Managers
3 Program Supervisors
1 Health Care Staff
1 Maintenance Personnel
2 Food Service Personnel
6 Clinical Staff
3 Other

Documents Reviewed

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

5 # Health Records
3 # MH/SA Records
14 # Personnel Records
8 # Training Records
5 # Youth Records (Closed)
5 # Youth Records (Open)
0 # Other

Surveys

5 Youth
5 Direct Care Staff

Observations During Review

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

Comments

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

Strengths and Innovative Approaches

Rating Narrative

Hidle House moved from a Shelter Manager and Assistant Shelter Manager management structure to a Shelter Manager and three Lead Youth Specialist system; providing one lead for each shift. Within the Residential Case Manager unit they also established a Lead. These changes were done to help provide increased support to direct care staff; help improve communication and the flow of information from one shift to the next as well as from the Residential Case Manager to the Youth Specialist. These changes were also done to improve the overall continuity of care across the entire program.

Hidle House has been using the electronic logbook full-time and as the only source of documentation regarding the daily activity within the shelter since April 2017. Staff quickly adapted to the change and have been fully supportive of the improved method of tracking the shelter's daily activities.

Hidle House replaced all twenty old wooden beds with new metal frame beds. The closet areas in each room were also renovated to provide additional storage areas to make up for the loss of storage which had been provided by the wooden frame beds which also had drawers.

Hidle House has also been the recipient of two new dishwashers for the kitchen, as well as two new washers for the laundry room.

Hidle House was able to purchase a new fifteen passenger van from donations gathered through a collective effort by multiple community partners.

The Hidle House dining room area, which is made up of multiple windows, was treated with special reflective tint to help make the area more energy efficient during the summer months. This upgrade was donated to the shelter through a volunteer group project by a local business.

Hidle House put in a small garden area which also included the planting of three fruit trees. This was done in coordination with a local Permaculture Project.

Hidle House has been provided a grant from a local foundation in order to replace the carpet in the shelter with laminate wood planks; this is tentatively scheduled to be completed mid-December. An additional shelter facility upgrade currently being pursued is the remodeling of all nine of the bathrooms.

The agency's training and meeting room which is also used by the shelter for groups has been upgraded.

Standard 1: Management Accountability

Overview

Narrative

Anchorage Children's Home of Bay County operates the Hidle House Youth Shelter. The agency is a well-established, not-for-profit organization located in Panama City, Florida. The agency is led by Mr. Joel Booth, Executive Director. The agency provides both Residential and Non-Residential CINS/FINS services for youth and their families in Bay, Gulf, Calhoun, Holmes, Jackson and Washington Counties. The residential program and main non-residential offices are located at 2121 Lisenby Avenue in Panama City, Florida.

The agency has a total of thirteen Youth Care Specialist (YCS), three Lead YCS, one Program Administrator, one Executive Director, one Shelter Manager, one Registered Nurse, three Residential Case Managers, six Counselors, one Lead Counselor, one Clinical Supervisor, and one PQI/Training Director. The agency provides residential and non-residential services through its direct care and residential and non-residential counseling staff. The agency maintains several on-going community partnerships, conducts outreach activities and hosts local community-based organizations to provide services to the youth and families it serves.

The program requires new hires and on-going staff members to complete first year and annual trainings. The agency has an individual training file for each employee, with training provided through a broad array of local service provider options and other industry specific resources. Annual training is tracked according to the employee's date of hire. The agency does utilize the Florida Network, computer-based trainings.

1.01 Background Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a written policy and procedure; "Background Screening" (ACH-ADM-HR-009), which addresses all the key elements for this indicator. This policy and procedure was last reviewed and signed by the Executive Director and Board of Directors on July 10, 2017.

The program's procedure requires all potential employees; interns and volunteers, who provide direct service to children or who oversee direct service personnel are screened in accordance with Chapters 409, 435, and 985 of the Florida Statues.

Fourteen staff personnel files were reviewed for initial background screening prior to being hired by the program. All fourteen staff had an initial background screening completed prior to the staff's date of hire. Three staff personnel files were eligible and reviewed for five year rescreening. Two of the three staff had a background rescreening completed prior to their anniversary date of hire. One staff record was completed on May 16, 2017, and the anniversary date of hire is April 30th. Each of the seventeen background screenings were completed through the Department of Juvenile Justice Background Screening Unit (BSU). The program did not have any volunteers or interns hired during the six month period being reviewed. A review of the Annual Affidavit of Compliance with Level 2 Screening found it was completed on January 5, 2017.

Exception:

One staff record was completed on May 16, 2017, and the anniversary date of hire is April 30th.

1.02 Provision of an Abuse Free Environment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a written policy and procedure; "Code of Ethics" (ACH-HH-PM-002), which addresses the key elements for this indicator. This policy and procedure was last reviewed and signed by the Executive Director and Board of Directors on March 6, 2017. The program also has a written policy and procedure; "Abuse/Neglect Reporting" (ACH-CS-SD-018), which addresses the key elements for this indicator. This policy and procedure was last revised, reviewed, and signed by the Executive Director and Board of Directors on May 1, 2017. In addition, the program outlines the code of conduct, professionalism, and ethical practices to be modeled by staff within the employee handbook, which each employee receives upon date of hire.

The program's procedure requires all employees to work together in an effort to accomplish the program's mission. This procedure requires professional, respectful, and ethical interaction with all youth, coworkers, and supervisors. Employees must ensure they demonstrate compassion to the youth they serve and maintain appropriate professional relationships with them. In addition, each employee of the program is a mandatory reporter for any suspected abuse or neglect of any child, disabled adult, or elderly person under Florida Statute 415.504.

Review of three randomly selected personnel files showed a signed employee code of ethics. Review of staff training records show that staff receive training in mandatory child abuse reporting. There were no abuse allegations made toward staff within the six-month review time. Calls made to the Florida Abuse Hotline on behalf of a youth's allegation are recorded in the individual youth record. The program maintains a binder specifically for those calls which meet reporting requirements under Florida Administrative Code 63F-11 Central Communications Center (CCC). This binder captures all other incidents pertaining to daily operations.

There were six CCC reports for the six-month review period, which none of the reports were regarding abuse allegations. The program has a written policy and procedure; "Youth/Family Grievances" (ACH-HH-PM-017), which addresses the key elements for this indicator. This policy and procedure was last reviewed and signed by the Executive Director and Board of Directors on March 6, 2017. The program has a grievance box located in the living unit of the program. Youth have unimpeded access to complete and submit a grievance as needed. The grievance box is checked daily and efforts are made to address youth grievances timely.

There were no exceptions to this indicator.

1.03 Incident Reporting

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Hidle House does have an incident reporting policy. In fact, there are two policies that cover the instructions for when an incident occurs. They are titled "Unusual Incidents" and "DJJ/Families First District One Incident Reporting." (ARC-HH-PM-006 and ARC-HH-SS-009). They were both last reviewed on March 6, 2017, by the Executive Director and Board of Directors.

The procedures for incident reporting include the involved staff member notifying the appropriate supervisor of the actual event as soon as possible. Every staff member with direct knowledge of the incident must then complete an Unusual Incident Report (individually) as quickly as possible after the incident is resolved and prior to leaving work for the day. Each report is to be completed individually without any input from any other person. Once the report is completed, it is immediately submitted to the appropriate manager for review and any further action if necessary. In the case of a reportable incident to DJJ, the program supervisor will contact the on-site case manager or on-call case manager/counselor to contact the Department for the Central Communications Center (CCC) call and complete the DJJ Incident/Complaint Report Form. The CCC is to be notified as soon as possible but no later than two hours after the incident, or within two hours of the affected facility, office or program learning of the incident. Documented on the back of the DJJ Incident/Compliant Report Form is any pertinent information received

from the Hotline operator. The policy and procedures do meet the required mandates of this indicator.

After reviewing the last six months of incidents through the DJJ report, six CCC reports were documented. The Hidle House Unusual Incident Report Log Book, it is noted that the program does notify the CCC within two hours of the incident or two hours of becoming aware of the incident. After reviewing the program's Unusual Incident Report Log, there is evidence that the program clearly identifies the people involved, the actual incident and supervisory review/follow-up. All incidents are signed by the Program Administrator.

There were no exceptions to this indicator.

1.04 Training Requirements

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Hidle House does have a policy "Professional Development" (ARC-ADM-HR-029) to ensure the professional development of all hired personnel. The policy was last reviewed by the Executive Director and a member of the Board of Directors on July 10, 2017.

The program has a training plan that serves as policy as well. The procedure is for each team member within the first year of employment must have 80 hours of training for the first 120 days and at least 40 hours every following year. The agency provides training opportunities through on-site orientation, training sessions in conjunction with staff meetings, formal in-service trainings, and off-site training.

There were eight employee files-- four pre-service which includes certain training classes completed within 120 days with all training required in the first year and four in-service training records were reviewed. The program maintains an individual training file for each staff which includes: an annual employee training hours tracking form, and related documentation such as certificates. Of the four pre-service training, three staff completed a training class outside of the 120 days. One staff did not complete two classes of pre-services training as well. Four staff records were reviewed for in-service training and were in compliance.

Exception:

Three staff completed a training class outside of the 120 days. Additionally, one staff did not complete two classes of pre-service training.

1.05 Analyzing and Reporting Information

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has policies such as "Internal Review" and "Records Review" which corresponds to Analyzing and Reporting Information (that meets the general requirements of this indicator).

Interview with the Hidle House Performance Quality Improvement/Training Director and observations of documents found evidence of quarterly case records reports and peer reviews, quarterly incident, accidents, and grievances reports, monthly NetMIS data reports, and annual reports that contain documentation on non-residential and residential (shelter) outcome data. There are Performance and Quality Improvement reports (II & III) that documents activities at both the Anchorage Children's Home and Hidle House to include all outcome data generated from both programs. This included both residential and non-residential programs that is also used in the monthly Senior Management Report. There was documentation of CINS/FINS Client Satisfaction Surveys for both non-res and all Anchorage Children's Home that are compiled into a single annual report. There are quarterly and monthly staff meetings among the administrative and direct care staff to present findings from the previous monthly activities at the program.

There were no exceptions to this indicator.

1.06 Client Transportation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The Hidle House program has a transportation policy (ARC-HH-PM-005), which addresses the key elements for this indicator. This policy and procedure was last reviewed and signed by the Executive Director and Board of Directors on March 6, 2017.

Written program procedures include - The staff provides transportation for: group and individual outings, emergency needs, off-site appointments, routine medical/mental health/dental care, and other needs. All staff have to meet the driving criteria at the time of hire.

Approved agency drivers are checked by way of approval through the Department and driver’s license check. Approved agency drivers are documented as having a valid Florida driver’s license. A third party is an approved volunteer, intern, agency staff, or other youth. Documentation of use of a vehicle notes destination, approximate mileage, and anticipated arrival. As per the program administrator, the program allows only approved drivers to drive the Hidle House vehicles.

Review of the program’s transportation log showed documentation of the use of vehicle, name or initials of driver, date and time, mileage, number of passengers, purpose of travel, location, and approval of single client transports. The documentation of the transportation log had been improved greatly from the first of the calendar year. However, there were still inconsistencies with the number of passengers and purpose of travel. All single travel transports were all noted and included the name of the approving supervisor.

Exception:

There were inconsistencies with the number of passengers and purpose of travel.

1.07 Outreach Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program does have a policy in reference to outreach services in the layout of an outreach plan. The plan is entitled “Public/Community Involvement” (ARC-ADM-PQI-003), which addresses the key elements for this indicator. This policy and procedure was last reviewed and signed by the Executive Director and Board of Directors on July 10, 2017.

The program’s effort into reaching the community and at-risk youth and families’ population is by: participating in the Juvenile Justice Council Meeting for each county; contacting and explaining services to all middle schools and high schools in the service area, and contacting and explaining services to local law enforcement agencies, state attorneys, DCF, DJJ, or other agencies. Documentation of this involvement was reviewed in the form of meeting agendas, emails with participants, and meeting minutes. The program has memorandum of understandings and written agreements with Safe Place, Community Activity, Cooperative Service, and many other organizations and entities in the community. Anchorage participate in the Circuit 14 Advisory Board meetings. A program representative attends the Bay Regional Juvenile Detention Center weekly detention reviews.

There were no exceptions to this indicator.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

Anchorage Children's Home Residential and Non-Residential programs offer CINS/FINS services to youth and their families in Bay, Gulf, Calhoun, Jackson, and Washington County. Currently, the agency has a Licensed Mental Health Counselor who serves as the Clinical Supervisor and provides oversight for both Residential and Non-Residential services. The agency also has six Non-Residential ("AFC") counselors and three Residential Case Managers ("RCM").

Three Nonresidential Counselors have offices off site while the other three, as well as, the three Residential Case Managers have offices on-site, or within the primary agency location. All three Residential Case Managers have Bachelors degrees as well as four of the Non-Residential Counselors. Two of the Non-Residential Counselor's have a Master's degree. Both the Residential Shelter Manager and Program Administrator have MSWs, while the Clinical Supervisor is a Licensed Mental Health Counselor.

The residential cases are reviewed as a team, with the Residential Shelter Manager and RCMs, twice a week. During this meeting staff discuss youth behavior, youth progress and discharge planning. The Program Administrator and Clinical Supervisor occasionally join the weekly meetings depending on the census and risk level of youth in the program. Clinical staffing meetings are held once a month with the Program Administrator, Clinical Supervisor, RCMs, and Youth Specialists.

The Non-Residential cases are also staffed as a team once a week and include the Clinical Supervisor and all four Non-Residential Counselors. During staffing meetings, youth progress and case plans are reviewed as well as any relevant clinical concerns including mental health needs and suicide assessments.

The ACH non-residential program also conducts Case Staffing meetings to address identified problems and non-productive outcomes for both youth and their family. The Case Staffing Committee can also recommend CINS Petitions to be filed in court to order chronic status offenders to participate in additional treatment services to assist and resolve serious non-delinquent issues.

2.01 Screening and Intake

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Anchorage Children's Home has a policy in place to address centralized screening and intake. The policy is located within the agency's "Client Services and Outreach Policy and Procedure" manual. It was last reviewed on 3/06/17 and signed by the Executive Director.

Referrals for services are accepted twenty-four hours a day, seven days a week. Screenings for eligibility are attempted with all youth and families referred for services. Centralized intake services are also available to youth and their families twenty-four hours a day, seven days a week.

During normal business hours, referrals are received by support staff who then direct the referral to a counselor. The counselor then attempts to reach the family referred to complete a screening and determine eligibility for services. If a counselor is not available at the time of the referral, then the on-call counselor/case manager will attempt to complete the screening. "Walk-ins", or any youth or family that arrives on site without an appointment are met by a counselor/case manager who completes eligibility screening with the family. An on-call schedule is in place to ensure youth and families have access to 24/7 intake services. If an intake occurs within regular business hours the intake is completed by a counselor or case manager on site. After-hour intakes are completed by the on-call staff or a trained youth specialist.

There were four residential case files (two closed and two open) reviewed for this indicator. All reviewed files met the minimum requirements for this indicator with the exception of one open file not containing the CINS Voluntary Placement Agreement which contains documentation of the parent/guardian receiving the Parent/Guardian Brochure and CINS/FINS brochure. Reviewer was informed by a counselor that youth was brought in by DCF and legal guardians are currently in another country.

There were four non-residential case files (two open and two closed) also reviewed for this indicator. All reviewed files met the minimum requirements for this indicator. In two of the non-residential files (one open and one closed), the eligibility screening time of the referral was expired due to inconsistencies of the guardians. The inconsistencies were well documented.

Exception:

One open file did not contain the CINS Voluntary Placement Agreement which contains documentation of the parent/guardian receiving the Parent/Guardian Brochure and CINS/FINS brochure. Reviewer was informed by counselor that youth was brought in by DCF and legal guardians are currently in another country.

2.02 Needs Assessment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Anchorage Children's Home has general policies and procedures for both residential and non-residential services and additional policies and procedures for each component (residential and non-residential program) separately. They were all last reviewed on 03/06/17 and signed by the Executive Director.

Needs assessment policies and procedures are covered in both the general policies and procedures and the individual policies and procedures. General policies and procedures require needs assessment for all youth. For residential services, a Needs Assessment must be initiated within 24 hours of admission. The Needs Assessment is typically completed at the time of intake by the residential case manager (RCM). However, if a youth specialist completes the intake, then the Needs Assessment will be completed within 72 hours by an RCM. For non-residential services, the assigned counselor completes the Needs Assessment with the youth and family within 72 hours of admission into services. Most often this occurs during the intake process.

There were four residential files reviewed (two open and two closed). All files reviewed met the minimum requirements for this indicator.

There were four non-residential case files (two open closed and two closed) also reviewed for this indicator. All files reviewed met the minimum requirements for this indicator.

In addition, one residential counselor was interviewed and articulated the process of initiating and completing a Needs Assessment.

There were no exceptions to this indicator.

2.03 Case/Service Plan

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Anchorage Children's Home has a policy in place to address the case/service plan. The policy is located within the agency's "Client Services and Outreach Policy and Procedure" manual. It was last reviewed on 03/06/17 and signed by the Executive Director.

The policy states that the case plan is initiated at the start of services and updated as necessary based on progress made by the youth and family. The case plan provides a summary of the presenting issues, goals to be addressed as well as strategies/objectives for meeting those goals. In addition the case plan is created with input from the youth as well as the parent/guardian.

For non-residential and residential services the case plan is initiated at intake. The case plan is completed by the assigned counselor within 72 hours of completing the Needs Assessment. It is reviewed every 14 days and updated to note progress or new goals needed.

There were four residential case files (two open and two closed) reviewed for this indicator. All reviewed files met the minimum requirements for this indicator, except one open file. In that file the service plan expired with no completion dates noted. However, on-going services are still being rendered to the

youth/family—per documentation.

There were four non-residential case files (two open and two closed) also reviewed for this indicator. All reviewed files met the minimum requirements for this indicator.

Exception:

In one file the service plan expired with no completion dates noted. However, on-going services were still being rendered to the youth/family—per documentation.

2.04 Case Management and Service Delivery

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Anchorage Children's Home has multiple, separate policies outlining case management and service delivery. The policies are located within the agency's "Client Services and Outreach Policy and Procedure" manual. They were all reviewed on 03/06/17 and signed by the Executive Director.

The case management policy states that through advocacy and case management, staff will assist families and youth who have a variety of needs. It references external referrals will be made to address needs that are not provided by Anchorage. In procedure, case management services are provided to every referred client. At intake, a case manager is assigned to the client.

For non-residential cases, the counselor also provides case management services. These services are documented in progress notes in individual client files.

There were four residential case files (two open and two closed) reviewed for this indicator. All reviewed files met the minimum requirements for this indicator.

There were four non-residential case files (two open and two closed) also reviewed for this indicator. All reviewed files met the minimum requirements for this indicator.

In addition, two residential staff (counselor and case manager) and one non-residential counselor were interviewed and informed reviewer of case management services including referrals and case assignment.

There were no exceptions to this indicator.

2.05 Counseling Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Anchorage Children's Home has a policy in place to address counseling services. The policy is located within the agency's "Client Services and Outreach Policy and Procedure" manual. It was last reviewed on 03/06/17 and signed by the Executive Director.

Residential Case Managers/counselors provides the following service modalities: individual and family sessions (at least 1x weekly), facilitate group sessions (5x weekly), and assess in crisis intervention as needed. All counseling services are warranted according to the youth's service plan.

Non-Residential Counselors meet weekly with their assigned youth and offer family sessions as needed.

There were four residential case files (two open and two closed) reviewed for this indicator. All reviewed files met the minimum requirements for this indicator.

There were four non-residential case files (two open and two closed) also reviewed for this indicator. All reviewed files met the minimum requirements for this indicator.

There were no exceptions to this indicator.

2.06 Adjudication/Petitiion Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Anchorage Children's Home has a policy in place to address adjudication/petition process. The policy is located within the agency's "Client Services and Outreach Policy and Procedure" manual. It was last reviewed on 01/09/17 and signed by the Executive Director.

The process is in place for youth who have previously demonstrated behavioral symptoms which meet criteria for chronic running away, habitual truancy, and persistent disobedience of the reasonable and lawful commands of a parent that are not specifically the result of a developmental disability or a psychiatric disorder.

The procedure in place outlines that if the case staffing committee recommends a CINS petition for a youth, a case manager will be assigned to the case and is expected to prepare the documents necessary for the DJJ attorney to file a CINS petition in court. The documents will be completed within 21 days of the case staffing and forwarded to the Clinical Supervisor. The case manager attends court hearing and serves as the Anchorage representative. The case is reviewed every 30 days with a staffing team and at least quarterly with the entire case staffing committee.

There were three CINS files reviewed. All files met the requirements of the indicator.

There were no exceptions to this indicator.

2.07 Youth Records

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Anchorage Children's Home has a policy in place to address youth records. The policy is located within the agency's "Client Services and Outreach Policy and Procedure" manual. It was last reviewed on 07/10/17 and signed by the Executive Director.

All client records are stamped confidential and kept within a locked filing cabinet inside a locked office. No file or portion thereof is taken off of property at any time without the knowledge and prior consent of the Program Manager, supervisor or designee from the specific program. When it is necessary to transport a file(s), the file(s) will be secured in a locked, opaque container that is marked confidential.

There were eleven files reviewed for this indicator and all files met the minimum standards for this indicator. File room locations were directly observed and found to meet the standards of this indicator.

In addition, a residential counselor was interviewed regarding the process for transporting youth files. The counselor was able to articulate the process of transporting files and showed reviewer locked, opaque box.

There were no exceptions to this indicator.

Standard 3: Shelter Care

Overview

Rating Narrative

The ACH program provides residential CINS/FINS services at its Hidle House youth shelter that is located in city limits area of Panama City, Florida. The shelter facility is located in the rear of the property. The shelter contains two side entries for shelter and for counseling services respectively. The ACH residential program has adequate staffing and maintains a licensed residential shelter with a maximum of twenty beds in the shelter.

The facility is equipped with a large day room with split level sleeping rooms on each side. In addition, there are additional day or activity rooms with more split level rooms. The agency has excellent community support and hosts several local groups to visit and spend time with the residents during their shelter stay.

Hidle House is adequately staffed, maintains a license for operation from DCF, is COA accredited, and is licensed for twenty beds.

3.01 Shelter Envonment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

All policies and procedures for this indicator are current and signed by the Executive Director as of 03/06/17.

The program has written policies and procedures on facility maintenance, shelter operations, daily youth schedules/programming, fire safety, key control, and vehicle maintenance and repair.

The shelter environment was observed to be clean, organized, and all furniture appeared well maintained. The agency recently obtained funding for new beds in all rooms, and are working towards obtaining new flooring and hopefully renovating the bathrooms. This writer did not observe any apparent insect infestation, and a youth and staff also reported not seeing any insects. An inspection of the bathrooms revealed that all faucets, showers, and toilets were in working order. The exterior grounds appeared well maintained and no debris was observed on the property.

External doors, offices, and vehicles were all locked properly; key control appeared to be in compliance. Inspection of two agency vehicles revealed them to be locked, and all required safety equipment (first aid kit, fire extinguishers, glass breaker, seat belt cutter) were present.

Maps of the facility are posted throughout and emergency exits are clearly labeled. Grievance forms, abuse hotline information, general client rules/expectations, COA certification, and the DCF Child Care License are all posted in easily viewed areas. Each youth has their own bed with clean linens, covered mattress, and pillow(s).

Chemicals are stored in two locked cabinets in a locked room. MSDS sheets are maintained for each item. Sign-in/sign-out sheets for all chemicals are posted and are consistently dated and signed by staff. The washers and dryers were in working order, lint traps clean, and maintenance schedules were posted and up-to-date.

An annual facility fire inspection was last completed on 6/20/17 and the agency is in compliance with all local codes and regulations. An inspection of fire extinguishers was completed on 2/17/17 and all were found to be in working order. An inspection of the sprinkler system was completed on 2/24/17 and is up to code. The alarm system was last inspected on 4/20/17. Two smoke detectors failed their test and were replaced on the same day. The overhead hood in the kitchen passed inspection on 10/31/17. The agency has a current Residential Group Care Inspection report as of 1/12/17.

The agency routinely completes three fire drills per month (one per shift) dating back to January 2017. It should be noted only one drill was completed in February 2017. Drills are regularly completed between one and two minutes.

Food was observed to be stored properly based on temperature, and opened items were in correct containers and dated. The kitchen area appeared clean and well maintained. A weekly menu was also posted.

The daily youth schedule is posted in the common area and includes an array of activities including enhanced learning, exercise, field trips, and study time. A two-hour block of time is devoted to physical activity. The agency has a well-stocked library of books at various reading levels to accommodate different age ranges. Faith-based activities are offered to the youth on a regular basis. The shelter manager reported the usage of activities will vary on the demographics of the youth at the time.

There were no exceptions to this indicator.

3.02 Program Orientation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy titled "Intake/Orientation Process" (ACH-HH-AD-002) that is current and reviewed by the Executive Director on 03/6/17. The intent of the policy is to ensure youth make a successful transition into the program by understanding the expectations of the program.

When the youth arrives at Hidle House it is the staff's responsibility to ensure this transition is smooth. An admission checklist is completed and a site specific handbook is provided that outlines youth expectations and program orientation. During intake youth are made aware of their rights & responsibilities, grievance procedure, means of contacting the abuse registry. All youth are made aware of services available, sick policy, and how to access medical care if needed.

There were four youth files reviewed for program orientation. Two of the four files clearly had an orientation to the program within twenty-four hours of admission. One file reviewed was of a youth recently admitted less than twenty-four hours prior to the review, so some documents had not been completed yet. In another file it appears there was a delay in the orientation process due to a language barrier that required a translator.

Each youth was provided with a client handbook, disciplinary action, grievance procedures, emergency procedures, daily activity, abuse hotline, and contraband rules were explained or provided. There are emergency/egress facility layout diagrams posted throughout the program. One file had a suicide alert and the youth was placed on elevated supervision and an EIDS was completed.

There were no exceptions to this indicator.

3.03 Youth Room Assignment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy titled "Room Assignment" (ACH-HH-PM-09) that is current and reviewed by the Executive Director on 3/6/17. It states room assignments are made according to information about the youth being placed and information related to the potential roommate in order to increase the potential for positive adjustment to the program.

The Residential Case Manager (RCM)/designee assigns each incoming youth to a specific bed and storage

area in an assigned room. Information gathered during the intake process is considered when the room/bed assignment is made to assist the youth in adjusting to the program. This room/bed assignment is documented in the daily log. Male and female bedrooms are on separate sides of the house. Room assignments are changed as the need arises.

Four open files were reviewed for this indicator. All four files reviewed had a room assignment form completed upon admission to the program. Each youth's room assignment was made based upon the following criteria: age, gender, history of violence, disabilities, gang affiliation, suicide risk, sexual behavior history, and gender identification. Of the four files reviewed, three had alerts placed on the outside of the file.

There were no exceptions to this indicator.

3.04 Log Books

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy for Log Documentation that was revised and reviewed on May 1, 2017 by the Executive Director.

The agency has procedures in place for the use of an Electronic Log. The Electronic Log is maintained in the Staff Office in a locked cabinet or on the person of one of the Youth Specialists. The log is not left unattended. The Electronic Log will be used by staff for official use only. Clients will not be permitted to use the device. Specific highlighting shall be used on entries requiring it, all events relating to the operation of the shelter or safety and security of the youth or shelter shall be documented.

The log is to be read early on each shift by all Youth Specialists. The Lead Residential Case Manager and Lead Youth Specialists review the Electronic Log each workday, or previous 48 hours if they have been off work, and take note of any unusual incidents or significant concerns that need immediate attention. Upon review, staff will make an entry in the Electronic Log when they have reviewed it. In the event the Electronic Log is unable to be used, then a paper log book will be put in place until the Electronic Log is usable.

The agency started using the Electronic Logbook solely in April 2017. The shelter has three tablets which are rotated to ensure there is always one charged and ready to use. Staff are still learning new things about the log and how to appropriately use it. Staff quickly adapted to the change and have been supportive of it and willing to learn.

A review of the Log was conducted with the Shelter Manager. Random days and time frames were reviewed over the last six months. Incidents were found to be documented and highlighted appropriately. Youth supervision and counts were documented. There were reviews of the Log conducted, for the most part, by staff coming on shift. Although it was not always documented they reviewed the previous two shifts. There were weekly reviews documented by a supervisor. The Shelter Manager reported staff had very little errors or mistakes now with the Electronic Log, so there were no errors observed during the time frame viewed. All entries were signed electronically by the staff member making the entry.

There were no exceptions to this indicator.

3.05 Behavior Management Strategies

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a core area of policies and procedures titled "Behavior Management". Within this section there are policies covering Behavioral Intervention, Discipline, Room Restriction/Timeout, and Rewards/Privileges. All policies are current and were reviewed by the Executive Director on 3/6/17.

All team members provide behavioral intervention with youth as needed. It is the Youth Specialists' responsibility to work with youth within the context of these guidelines, but Lead Youth Specialists and Shelter Managers/Supervisors teach/model these skills as well. A key aspect of working with the youth is identifying strengths and utilizing them to bring about positive changes in their lives. The agency operates from a trauma informed care model and training is provided in Managing Aggressive Behavior and Quality Parenting. Rapport building, positive reinforcement, verbal praise, and encouragement are means by which staff work to bring about positive youth behavior.

Discipline is utilized by the staff as a restorative and educational process, not a punitive one. Staff work to identify the needs motivating the behavior and assist youth in getting them met in more positive ways. When a behavior occurs requiring consequences staff make all reasonable efforts to discuss/explain/explore possible consequences. Natural and logical consequences are used based on age and developmental level. These may include loss of privileges, restitution, program restriction, and room restriction for a "time out" only.

The focus of the program is not to externally gain control over the youth; rather it is to assist youth in gaining control over their own behavior. This is done by addressing core underlying issues motivating their behavior and/or attitudes.

At intake, the youth are issued a point card and explained the point system. All new youth receive the same four target skills: disagreeing appropriately, accepting no, following instructions, and accepting criticism/consequences. Points are earned for displaying these social skills and also completing activities such as getting up in the morning, going to school, completing chores, and participating in activities on-site. Youth are responsible for maintaining their point cards but staff do encourage them at every opportunity to fill them out. The program provides an allowance and has 'Resident of the Day' and 'Resident of the Week' incentives. These youth appear to act as 'leaders' for other youth in shelter as they model positive, pro-social behaviors.

This writer observed the target skills posted clearly above the staff office. A discussion with a youth revealed that she likes the point card because it helps her be accountable, and enjoys being rewarded for positive behavior. A staff member noted the point cards are useful for reinforcing positive behavior while also providing opportunities for teaching moments.

There were no exceptions to this indicator.

3.06 Staffing and Youth Supervision

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy and procedure to address this indicator titled "Staffing Requirements and Scheduling" (ACH-HH-PM-10). It is current and was reviewed by the Executive Director on 3/6/17.

Hidle House Youth Specialists provide awake supervision 24 hours per day, 7 days per week. Staff ratios are maintained at a minimum of 1:6 during wake hours and 1:12 during sleeping hours.

The shelter manager's staff schedule identifies adequate coverage for all shifts while minimizing overtime and the over-utilization of youth specialists. The care of the youth and needs of the program are of primary concern and therefore determinants of the program schedule. There is a female and male staff member scheduled on duty when possible.

The monthly schedule is ideally created by the 20th of every month. The schedule is posted in a visible location for staff. In addition to days/shifts scheduled to work it also includes training, meetings, days off, and Holidays.

The current, and previous, schedules were reviewed. It was observed that staff were in appropriate ratios

on shifts, and there was at least one male and one female on each shift including overnight.

The staff and program manager both reported use of the log book on a regular basis for documenting 10-minute bed checks. This writer observed entries in the log book dating back to September 2017. Surveillance footage was reviewed from 10/9/17, 10/24/17, and 11/9/17. The footage was compared against printouts from the logbook noting when bed checks were being completed. Staff was consistent and diligent in noting not only the bed checks, but youth behaviors as well.

There were no exceptions to this indicator.

3.07 Special Populations

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has policies and procedures in place for Staff Secure, Domestic Violence Respite, Probation Respite, and Domestic Minor Sex Trafficking youth. As was noted in last year's review, Anchorage Children's Home is not a contracted provider for staff secure youth with the Florida Network of Youth and Family Services.

Domestic Violence Respite (DV) services are designed to assist youth that have been arrested on a domestic violence charge. They are screened at local detention centers where they do not meet detention criteria and cannot immediately return home. DV respite is short term and designed to facilitate services and supports for safe return of the youth to his or her home and minimize the risk to re-offend.

Probation Respite services are designed to serve youth that are currently on probation with adjudication withheld and referred by the Department's Juvenile Probation Officer. Probation respite is designed to facilitate services and supports to reduce or eliminate the youth's risk to re-offend and for the safe return of the youth to his or her home.

Domestic Minor Sex Trafficking services are designed to serve domestic minor sex trafficking youth approved by the Florida Network who may exhibit behaviors which require additional supervision for the safety of the youth or the program. DMST services provide a more intensive staffing and individualized service than the short-term shelter services, but provided in the same unlocked, living environment and facility as temporary and voluntary shelter services.

For staff secure youth the assigned case manager will coordinate placement of all court ordered youth with the appropriate provider agency as provided by the Florida Network of Youth & Family Services. Coordination of placement will include, but not be limited to, transportation of youth, transfer of documentation related to service history and custody; and communication regarding mental health, substance abuse, medical and other pertinent needs. The assigned Case Manager will ensure that the youth has necessary items such as prescribed medications, adequate clothing, and personal items permitted by the receiving agency.

Anchorage Children's Home will provide services to youth who are identified special populations including DV Respite, Probation Respite, and DMST in accordance with the guidelines established through the Florida Network of Youth and Family Services policy and procedure manual.

The agency has not had any staff secure, DV respite, Probation Respite, or Domestic Minor Sex Trafficking cases in the past six months.

There were no exceptions to this indicator.

3.08 Video Surveillance System

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy and procedure in place titled "Video Surveillance System" (ACH-HH-DO-18). It is current and was reviewed by the Executive Director on 3/6/17. Hidle House has video surveillance that operates 24 hours a day, 7 days a week to monitor and capture activity to ensure the safety of all youth, staff, and visitors. The system is meant to proactively deter any misconduct, and ensure any incidents are recorded for review.

The agency ensures video and images are secured on a secured network and access to the video surveillance system and recordings is limited to personnel designated by the Program Administrator. Staff are authorized to view recordings and trained to do so in professional, ethical, and legal manner.

Supervisory review of video is done bi-weekly and documented in the Video Surveillance Log. Review is conducted by the Program Manager or designee. Each review includes a random sample of two day shifts and three overnights shifts. The Video Surveillance Review form includes dates, times, and shifts reviewed; as well as any significant findings. The Program Manager will notify the Program Administrator of any concerns/findings that require further review.

Anchorage ensures video is stored for a minimum of 30 days unless the video is associated with a specific incident that is requested for review. If a video is being used in an investigation it is kept until said investigation is complete. In the case of video being used as evidence in a criminal/civil proceeding it is kept indefinitely, or until otherwise directed by DJJ.

This writer observed cameras in exterior and interior locations of the shelter, hallways for sleeping rooms, common areas, recreation area, and where visitors enter/exit the buildings. Cameras were observed to be in working order on a screen at the staff station, as well as upon review individually via an agency desktop. No cameras were observed in youth bedrooms or bathrooms. This writer observed notices posted throughout the agency making it clear that cameras were in use for security purposes.

The staff and program manager both reported use of the log book on a regular basis for documenting 10-minute bed checks. This writer observed entries in the log book dating back to September 2017. Surveillance footage was reviewed from 10/9/17, 10/24/17, and 11/9/17. The footage was compared against printouts from the logbook noting when bed checks were being completed. Staff was consistent and diligent in noting not only the bed checks, but youth behaviors as well.

This writer also reviewed the Video Surveillance Log. The Program Manager reviewed the log book on a bi-weekly basis, and chose random sample of day and night shifts. No issues or concerns were noted.

There were no exceptions to this indicator.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The ACH program provides screening, counseling and mental health assessment services to eligible clients in the service region. The agency has a Program Administrator, Residential Shelter Manager and Assistant Shelter Manager that oversee the daily operations and responsibilities of the program. The direct care staff members are trained to conduct screenings, assessments and notify all staff members of conditions and risks of all youth admitted to both residential and non-residential CINS/FINS programs. The agency provides risk screening and identification methods to detect youth referred to their programs with behavior, mental health conditions and risks. The agency also screens for the presence of acute health issues and the agency's ability to address these existing health issues. The residential program uses a general alert board to inform all staff members on each shift of the health and mental health status of all youth in the shelter.

The agency provides assistance to all youth admitted to the program that require medication. The agency provides medication distribution training to select direct care staff members. The agency has a Registered Nurse on the agency schedule for a total of twenty (20) hours per week. The RN provides all medication distribution training. All medications are stored in an automated medication cart called the CareFusion Pyxis MedStation 4000. The Pyxis machine is stored inside a secured closet in the residential service area.

The agency does provide all staff with first aid response, CPR, fire safety, emergency drills and exercises and training on suicide prevention, observation and intervention techniques. At the time of this onsite Quality Improvement review, the agency has an active and functional suicide risk screening process. In addition, the agency has a LMHC Clinical Supervisor and senior counselors that are the key members in conducting the assessment phase of the suicide assessment process.

4.01 Healthcare Admission Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place for Medical Care for Routine, Acute, and Chronic Medical Conditions that was last reviewed on March 6, 2017 by the Executive Director.

A Health Screening Form is completed upon each youth's admission to the program to determine any dental, medical, or mental health needs or acute or chronic medical conditions a youth may have. Documentation at intake is required for youth diagnosed with chronic medical conditions that identify: Qualified professionals making the evaluation, specific diagnosis, current evaluation and/or follow-up information, individual functional limitations identified with the condition, and any adverse effects to the general public from exposure or possible contaminates associated with the illness. During clinical staffings any youth identified with medical concerns will be staffed to ensure all required documentation has been received and all required medical services and/or follow-up is provided in a timely manner.

There were four youth files reviewed for Healthcare Admission Screening. All four files documented the CINS Intake Assessment form was completed on the day of admission. All four files also documented a Health Screening Form was completed that included additional health screening information. All four files documented the Registered Nurse (RN) did review the Health Screening Form and completed all vital signs within seventy-two hours.

None of the youth had any type of medical condition requiring a follow-up; however, procedures are in place if needed.

There were no exceptions to this indicator.

4.02 Suicide Prevention

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place for Suicide Prevention and Intervention that was last reviewed on November 6, 2017 by the Executive Director.

At intake, a full suicide risk screening must be completed by the Residential Case Manager or Counselor on each youth entering the shelter. The full risk screening is completed using the Evaluation of Imminent Danger for Suicide (EIDS) tool. In cases when the youth is admitted to the shelter and a Counselor or Case Manager is not present, a Youth Specialist will complete an intake screening using the six suicide risk screening questions on the Shelter Intake Assessment Form. If the youth answers "yes" to any of the questions they will be placed on constant sight and sound supervision until a full Suicide Risk Assessment is completed within twenty-four hours.

The agency has three levels of supervision. One-to-one supervision is used for those youth whose behavior has escalated to making suicidal or homicidal statements or gestures, and/or stating a specific plan to carry out a suicide/homicide. It is also used for youth waiting for transportation to a Baker Act facility. The second level supervision is constant sight and sound. This is used for youth who are identified as being at risk of suicide but are not expressing current suicidal thoughts or threats. The last level of supervision is elevated supervision and this is for youth who are not at significant risk of self harm and can remain in the shelter without further evaluation off-site. This level of supervision is a step down from constant sight and sound.

The shelter employs three Residential Case Managers who are supervised by the Clinical Supervisor who is a Licensed Mental Health Counselor (LMHC). One of the case managers is a supervisor and had previously completed the suicide risk assessment training with the LMHC. The other case manager was new and was in the process of completing the five supervised suicide risk assessments with the LMHC. The third case manager was new since the last on-site review and documentation was provided to show the case manager had completed the five supervised suicide risk assessments with the LMHC and all suicide risk training required.

There were three youth files available for review of youth who had been placed on suicide precautions, one open and two closed. All three files documented the youth were placed on suicide precautions at intake due to issues identified during the screening process. All three youth remained on constant sight and sound supervision until assessed by a qualified professional. All youth were seen and assessed using a suicide risk assessment within twenty-four hours. All suicide risk assessments were completed by a counselor and reviewed by the LMHC. The supervision level was not changed or reduced until approved by the LMHC. One youth was placed on standard supervision after this first suicide risk assessment was completed. The other two youth were placed on an elevated supervision level upon completion of the suicide risk assessment and then one of those two youth were placed on standard supervision after another suicide risk assessment had been completed. The other youth remained on elevated supervision until discharged from the shelter, which was for approximately twenty days. There was no documentation of the youth being re-assessed at any point during those twenty days to see if the youth could return to normal supervision. The Residential Case Manager reported it was an oversight and the youth should have been assessed again and returned to normal supervision levels. All three youth had ten minute observations documented the entire time they were on sight and sound supervision and thirty minute observations maintained for the two youth while on elevated supervision. Any youth on suicide precautions sleep in their bedrooms with a staff member positioned outside the door or sleep on the couch in the dayroom and ten-minute checks are maintained.

Exception:

One youth was left on elevated supervision status until discharged from the shelter, approximately twenty days, without being re-assessed during that time to see if the youth could return to normal supervision levels.

4.03 Medications

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy on Medication Management that was last reviewed on March 6, 2017 by the Executive Director.

The agency has procedures in place for the use of the Pyxis Med-Station 4000 Medication Cabinet. There are procedures for the verification of medication. There are procedures for documentation relating to medication administration and refusal of medication. There are also inventory and disposal procedures. All procedures comply with the Florida Network's Policy and Procedure Manual for CINS/FINS.

The agency provided a list of sixteen staff who are trained to supervise the self-administration of medications. The Registered Nurse (RN) is listed as the Super User of the Pyxis Med-Station, as well as, a Shift Leader from each of the three shifts.

The shelter has an RN on-site Monday thru Friday from approximately 7:30am till 1:00pm. The RN will distribute any needed medications when on-site. Direct care staff distribute medications in the mornings before the RN arrives, in the evenings, and on the weekends.

The RN trains all staff on the use of the Pyxis Med-Station and the medication administration process at hire. This training is conducted on two separate days, one day to review policies and paperwork and one day to review the Pyxis Med-Station. The RN also conducts an additional refresher training for current staff members during the year.

All medication is stored in the Pyxis Med-Station, including over-the-counter (OTC) medications which are stored in the top and bottom bins of the Med-Station. Prescription medications are stored in the second and third drawers of the Med-Station. Medications are verified at admission using one of the four approved methods by the Florida Network.

The RN reported there have been no major discrepancies with the Pyxis Med-Station. There have been minor discrepancies, mainly involving staff entering the wrong number when inventorying medications. However, there have been very few of these discrepancies and they were easily fixed and cleared out by the end of the staff members shift. There have been no discrepancies at all in the last thirty days. The shelter has never had a discrepancy involving a controlled substance.

The RN completes a weekly inventory of all medications on-site. Trained direct care staff complete an inventory every shift of all the controlled substances. This inventory is documented on the youth's Medication Oversight and Inventory form. An inventory of the medication is completed every time it is given and a perpetual inventory is maintained.

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 is also a separate locked cabinet where sharps are stored. All sharps are also inventoried weekly and as used. The youth must use disposable razors which are discarded on the red sharps box after use.

The RN prints-out four different reports from the Knowledge Portal each month: a Discrepancy Report, a Summary by Transaction Report, a User Summary Report, and a Profile Overrides Report. These reports are printed out on the first of every month. The RN also goes into the Knowledge Portal at least once a week to view different reports.

There was currently one youth in the shelter currently on medications. This file as well as two additional closed files were reviewed to verify the medication administration process. The agency changed the medication form used to make it easier and more user friendly for staff. The new form is called Medication Oversight and Inventory. This form documents the youth's name, medication, strength, date of birth, prescription, pharmacy, physicians name, expiration date, beginning count, reason for the medication, instructions for use, distribution, inventory, signatures of staff and youth. A picture of the youth is located in front of this form in the Medication Log Book and side effect information is located behind this form. All

Medication Oversight and Inventory forms reviewed for the youth documented that all medications were given at prescribed times.

There are procedures in place for medication refills when needed. The Pyxis Med-Station keeps a list of medications that are running low. Staff will review this list in the Med-Station and notify the youth's parent that a refill is needed. This is also documented in the program log book.

The shelter has had one CCC report in the last six months relating to a medication error. The error occurred on June 18, 2017 and was due to two youth not receiving a scheduled dose of medication. The pharmacy was contacted and reported there would be no side effects from the error. The youth were given their medication; however, received it ten minutes outside of the hour time frame to be given.

Exception:

There was one CCC report in the past six months for missed medication.

4.04 Medical/Mental Health Alert Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place for Medical/Mental Health Issues Alert that was last reviewed on March 6, 2017 by the Executive Director.

All "Medical Alert" conditions are communicated through documentation in the youth file in progress notes, Health Screening Form, Psychosocial Assessment, and Daily Log and are communicated verbally at clinical staffing/team member meetings by the Program Administrator or designee. All team members are informed of any "Medical Alert" or "Mental Health Alert" conditions pertaining to each youth that might result in the need for team members to recognize and respond to the need for emergency care and treatment because of these medical problems. A youth's file will be marked with a colored dot placed on the outside of the binder for easy identification. There are three different colored dots used: Red dot = Mental Health Diagnosis or history of mental health concerns, Yellow dot = Medical Alert and/or on medication, Green dot = History of running.

There were four youth currently in the shelter. These four open files were reviewed for the Medical/Mental Health Alert process. The agency uses colored dots on the spine of the youth's file to indicate applicable alerts. The alerts documented on the spine of the file corresponded with information documented on screening forms inside the file, for all four open files reviewed. There is also an alert board located inside the staff work area in the shelter that documents all youth in the shelter and any alerts or allergies they may have. All alerts documented on the youth files reviewed also corresponded with the alerts documented on the alert board.

There were no exceptions to this indicator.

4.05 Episodic/Emergency Care

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place for Emergency Medical Care that was last reviewed on March 6, 2017 by the Executive Director.

Protocol states all team members are to be trained in CPR, first aid, and crisis intervention training and are to respond immediately and calmly to emergency situations. In the event a youth needs emergency medical, dental, or mental health care, team members initiate all necessary immediate response techniques and services available to provide life-sustaining care.

The shelter has had two instance of off-site episodic emergency care incidents since the last Quality Improvement Review. In both incidents, the youth's parent was notified, and the youth was transported to the local emergency room. In one case the youth was transported by EMS and the other case the youth were transported by their mother. The shelter maintains an Episodic Log for Emergency Medical Care that documents the incident, youth involved, and follow-up care.

The shelter has multiple first aid kits located in the residential shelter and the transportation vans. The RN re-stocks the kits when they are used and inventories them every couple of months for expired items. The knife-for-life and wire cutters are maintained in a locked cabinet in the staff work area.

During a recent staff meeting a training was conducted using the knife-for-life and each staff member was required to use the knife-for-life to cut through clothing, sheets, and belts. This mock drill/training was completed on October 26, 2017.

A review of a sample of training files revealed staff are certified in CPR and first aid and have received training in crisis intervention.

There were no exceptions to this indicator.