



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of CHS Treasure Coast, WaveCREST

on 11/18/2014

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

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

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/Petition 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 4: Mental Health/Health Services

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

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

Overall Rating Summary

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

Review Team

Members

Marcia Tavares, Lead Reviewer, Forefront LLC

Keith Carr, Principal, Forefront LLC

Ashley Davies, Consultant, Forefront LLC



Rosby Glover, Executive Director, Mount Bethel Human Services Corporation

Persons Interviewed

- | | | |
|--|--------------------------|-------------------------|
| <input checked="" type="checkbox"/> Program Director | 0 Case Managers | 0 Maintenance Personnel |
| <input type="checkbox"/> DJJ Monitor | 1 Clinical Staff | 2 Program Supervisors |
| <input checked="" type="checkbox"/> DHA or designee | 0 Food Service Personnel | 0 Other |
| <input type="checkbox"/> DMHA or designee | 0 Health Care Staff | |

Documents Reviewed

- | | | |
|---|--|---|
| <input type="checkbox"/> Accreditation Reports | <input checked="" type="checkbox"/> Fire Prevention Plan | <input type="checkbox"/> Vehicle Inspection Reports |
| <input checked="" type="checkbox"/> Affidavit of Good Moral Character | <input checked="" type="checkbox"/> Grievance Process/Records | <input type="checkbox"/> Visitation Logs |
| <input checked="" type="checkbox"/> CCC Reports | <input type="checkbox"/> Key Control Log | <input checked="" type="checkbox"/> Youth Handbook |
| <input type="checkbox"/> Confinement Reports | <input checked="" type="checkbox"/> Logbooks | 3 Health Records |
| <input checked="" type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 3 MH/SA Records |
| <input checked="" type="checkbox"/> Contract Monitoring Reports | <input type="checkbox"/> PAR Reports | 14 Personnel Records |
| <input type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 8 Training Records/CORE |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 4 Youth Records (Closed) |
| <input type="checkbox"/> Escape Notification/Logs | <input type="checkbox"/> Sick Call Logs | 6 Youth Records (Open) |
| <input checked="" type="checkbox"/> Exposure Control Plan | <input checked="" type="checkbox"/> Supplemental Contracts | 0 Other |
| <input checked="" type="checkbox"/> Fire Drill Log | <input checked="" type="checkbox"/> Table of Organization | |
| <input checked="" type="checkbox"/> Fire Inspection Report | <input type="checkbox"/> Telephone Logs | |

Surveys

- | | | |
|---------|---------------------|---------|
| 3 Youth | 3 Direct Care Staff | 0 Other |
|---------|---------------------|---------|

Observations During Review

- | | | |
|--|---|--|
| <input type="checkbox"/> Admissions | <input checked="" type="checkbox"/> Posting of Abuse Hotline | <input checked="" type="checkbox"/> Staff Supervision of Youth |
| <input type="checkbox"/> Confinement | <input type="checkbox"/> Program Activities | <input checked="" type="checkbox"/> Tool Inventory and Storage |
| <input checked="" type="checkbox"/> Facility and Grounds | <input checked="" type="checkbox"/> Recreation | <input checked="" type="checkbox"/> Toxic Item Inventory and Storage |
| <input checked="" type="checkbox"/> First Aid Kit(s) | <input checked="" type="checkbox"/> Searches | <input type="checkbox"/> Transition/Exit Conferences |
| <input type="checkbox"/> Group | <input type="checkbox"/> Security Video Tapes | <input type="checkbox"/> Treatment Team Meetings |
| <input type="checkbox"/> Meals | <input type="checkbox"/> Sick Call | <input type="checkbox"/> Use of Mechanical Restraints |
| <input type="checkbox"/> Medical Clinic | <input type="checkbox"/> Social Skill Modeling by Staff | <input type="checkbox"/> Youth Movement and Counts |
| <input type="checkbox"/> Medication Administration | <input checked="" type="checkbox"/> 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

The CHS Treasure Coast Division is committed to providing the most effective services to youth and families it serves. The agency has been continuously accredited since 1982 by the Council of Accreditation, demonstrating its commitment to the highest quality of care and service while adhering to the toughest administration standards. Each year, CHS Florida Treasure Coast Division helps more than 11,000 kids and families in the Okeechobee/Treasure Coast area. The programs in the Division operate a myriad of services in their local communities including:

- Adoptions
- Child In Need of Services /Family In Need of Services (CINS/FINS)
- Child Protection Team
- Child Safety/Dependency Case Management
- Teen Life Choices
- Transitional Living Program
- Safe Place

Since the last onsite QI review in September 2013, Children's Home Society WaveCREST has achieved significant accomplishments in terms of facility improvements, programming, and community involvement. These accomplishments are summarized as follows:

Facility Improvements: The program transformed a storage space into an Intake Office, creating privacy, and a quiet space free from interruptions for intakes to be conducted. This initiative was as a result of observations made during the last QI Review as well as the tour of another CINS/FINS facility during a QIC Meeting. The new space has a one way glass window overlooking the living and dining room; it will be equipped with a camera, computer, and telephone. As a result of converting the storage room into an intake office, the program added a new storage shed to its exterior.

As a result of funding received from the Choice Program Award, the Program Manager renovated staff offices including the Residential Counselor's office, making it more conducive for family sessions, and added a computer to the Youth Care Staff office to increase access from one to two computers.

The pavilion on the grounds behind the shelter was damaged during Hurricane Francis. The pavilion now boasts a new roof and Lowes Home Improvement Store donated supplies for its repainting.

In addition, the back porch of the shelter facility was transformed into an exercise area complete with insulation, installation of an AC unit, and state of the art exercise equipment purchased with grant funding from the City of Fort Pierce.

Programming: The program purchased a new evidence-based curriculum with grant funds called Staying Connected with your Teen by the Channing Bete Company. Partnership with a community agency will enable the program to offer parenting support groups offsite as part of aftercare service, utilizing the community space as a venue for parents. So far, 15 parents have benefitted from the incentive driven 8 week curriculum.

The program has also made improvements in the delivery of services to youth and families with the addition of the following:

- New 52 inch TV for youth through a donation
- Newer van for transporting youth
- Addition of two new counselors to target more rural areas with new offices for Non-residential services in Martin County and in the Okeechobee Achievement Academy
- Trained 2 staff to facilitate completion of the Florida Kid Care Insurance applications for youth with no current healthcare coverage.

Finally, the agency has redeveloped its Board of Directors for the Treasure Coast area. The new Board consists of seven (7) active members. A recently approved initiative includes the authorization for an annual fundraiser to specifically benefit the needs of the WaveCREST shelter.

Standard 1: Management Accountability

Overview

Narrative

WaveCREST provides shelter and non-residential services for youth and their families in Martin, St. Lucie, Okeechobee, and Indian River Counties. Under the leadership of a Program Director, the program located at 4520 Selvitz Road in Ft. Pierce, Florida, is managed by a team consisting of a Program Manager, a Residential Supervisor, and a Non-Residential Program Supervisor. Shelter staff includes: a Secretary, Group Living Manager, six fulltime Youth Care Staff (YCS), and five part time/relief Youth Care Staff. The counseling/case-management component has five counseling positions. At the time of the quality improvement review, the shelter had one (1) vacant fulltime YCS and two (2) vacant Relief YCS positions.

The program provides orientation training to all personnel through the agency's Learning Management System (LMS). Each employee has a separate training file containing a training plan and corroborating documentation for training received. Annual training is tracked from the Employees' date of hire initially then transitioned over to the calendar year thereafter. The program provides training through a combination of web-based and instructor-led courses.

Children's Home Society is the only facility serving runaway and homeless youth in its circuit. CHS has designated an Outreach staff to conduct outreach to inform youth of the dangers of living on the streets and services available in the shelter and non-residential programs. Program staff also conducts presentations to middle and high schools as well as community agencies in the circuit. There are currently over 100 Safe Place Sites located in the four counties served by CHS WaveCREST.

The provider has a revised Emergency Response Plan showing a current revision of September 22, 2014. A Universal Agreement for Emergency Disaster Shelter is also in force and was signed by the Executive Director.

In order to ensure management accountability, the program has a Continuous Quality Improvement program and a designated Quality Management Specialist (QMS) who is responsible for the implementation and oversight of its CQI program. In practice, the program's CQI program includes many activities that are conducted by various staff to ensure all aspects of analyzing and reporting data are consistently implemented and documented.

1.01 Background Screening

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy and procedures in place that address the background screening of all employees and volunteers. The program met all the requirements of this indicator. The provider's policy reviewed onsite requires all potential employees, volunteers who work alone with youth, and interns to successfully complete a background check prior to an offer of employment or provision of service within the program. The program's policy requires these individuals to undergo a Level 2 Employment Screening pursuant to Rule 65C-14.023, Florida Administrative Code. Additionally, the provider conducts a background check with the Division of Motor Vehicles prior to hiring staff.

The program maintains personnel records of employee background screenings in the agency's HR database. The reviewer interviewed the program's HR Associate and viewed electronic copies of each completed background screening requested.

A total of thirteen background screening files were reviewed for three new hires, six interns, and four employees who were eligible for a 5-year background screening during the review period. The three new personnel had timely background screenings completed prior to their hire dates. Similarly, the six interns received eligible screening results prior to their volunteer service start dates.

Two of the four employees who were eligible for a 5-year background screening did not have a completed five-year re-screening conducted during the required timeframe. One of the employee's rescreening (DOH 6/1/99) was completed four months (10/14/14) after the due date. The second employee's 5-year rescreening (DOH 10/29/03) was completed five months past the due date on 3/5/14.

The program provided a copy of its Annual Affidavit of Compliance with Level 2 Screening Standards and evidence that it was submitted to the BSU on November 8, 2013.

Exception:

Two of the four employees who were eligible for a 5-year background screening did not have a completed five-year re-screening conducted during the required timeframe. One of the employee's rescreening (DOH 6/1/99) was completed four months (10/14/14) after the due date. The second employee's 5-year rescreening (DOH 10/29/03) was completed five months past the due date on 3/5/14.

1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

Rating Narrative

The program has a comprehensive policy established to ensure the provision of an abuse free environment. The policy requires the prominent posting of the Abuse Registry phone number. Postings of the Abuse Hotline number were evident in numerous locations during the tour. The telephone numbers are displayed in the dorm hallways, in each youth's bedroom, on the wall in the front office, and on the wall across from the Intake Office. The program's policy specifically complies with DCF and DJJ policies related to incident reporting, and require program employees and volunteers to report all known or suspected cases of abuse and or neglect to the Florida Abuse Hotline. Both paid staff and volunteers are expected to abide by the agency's rules of conduct that foster an abuse free environment and prohibit intimidation, physical abuse or force. During orientation, staff is issued a copy of the agency's Code of Conduct that outline its policy and staff's responsibility to ensure the care, safety, and well-being of youth in their care.

The program also has a grievance policy in place that requires families and youth to be informed of their right to grieve and youth acknowledge their understanding of the process by their signature at intake. The program maintains blank grievance forms next to the grievance box on a wall in the dining area. When touring the facility, this reviewer observed that youth rights and responsibilities concerning the grievance process were posted in each youth's bedroom and in common areas accessible to, and in plain view of, youth.

The program provided a notebook of all compiled grievance forms filed in the facility. Since the last QI Review in September 2013, the program has had only one (1) grievance form filed. The grievance was resolved and acknowledged as such by the youth at the informal phase as outlined in the program's grievance policy. There were no personnel actions taken against staff as a result of grievances filed, abuse, intimidation, or excessive use of force.

Three youth were surveyed for this review and all indicated that they knew the Abuse Hotline was available to them and where the number was located in the facility. One of the youth surveyed indicated s/he was stopped or delayed from making the call to the hotline. All three youth indicated that staff is respectful to them and no adult had ever used threats towards youth; however, one youth has heard staff use profanity. The grievance process was known to all three youth surveyed. The facility was observed to be free of graffiti and all of the youth surveyed indicated that they feel safe at the facility.

Three staff members were surveyed for this review. Two of the three indicated that the working conditions were good at the facility, while the third stated condition is fair. All three described appropriate procedures to facilitate youth calls to the Abuse Hotline. None of the three staff surveyed have observed a co-worker telling a youth they could not call the Abuse Hotline. None of the three staff have observed a co-worker using profanity when speaking with a youth or using threats of intimidation, or humiliation when interacting with a youth.

No exceptions as of the date of this QI visit.

1.03 Incident Reporting

Satisfactory

Limited

Failed

Rating Narrative

The program has an established written policy and procedure for Incident Reporting that requires compliance with the Florida Department of Juvenile Justice (DJJ), Department of Children and Families/Identified Community Based Care Agency, and Children's Home Society. Specifically, the policy requires incidents to be reported to the DJJ Central Communication Center (CCC) as soon as possible, and no later than two hours of the incident/gaining knowledge of the incident.

The program maintains information about incident reports via a paperless computer database system called AirsWeb. A log of all incidents which occurred and recorded in the AirsWeb system during the past 6 months was printed and provided to the Reviewer. The program had 36 incidents included in their system log for the review period. Eight of the incidents were called in to the CCC and only three of the eight were accepted. The three incidents accepted were: program disruption, medication error, and runaway/missing youth.

All three reportable incidents were called into the CCC within the two hour time frame per the program's policy and procedures. A review of the remaining 28 incidents on the database log for the preceding six month time period indicated that none of these incidents were CCC reportable incidents.

Minimal information about the incident details are provided as they are printed out from the database system in a log form. However, if needed, the provider can print a more detailed report. The database system is the sole means of recoding incidents and no handwritten logs are maintained any longer. Incident types are described in the report only by use of a numerical code for each type. A copy of the legend for the codes was provided by the residential program supervisor.

No exceptions as of the date of this QI visit.

1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

The program has a comprehensive training policy and procedures to ensure the provision training in necessary and essential skills required for staff to perform specific job functions. In addition to its policy and procedures, the provider has an annual Training Plan for FY 2014-2015 that describes its protocol for complying with the training requirements.

Training is provided through various means including online using the agency's Learning Management System (LMS), the Florida Network, and external professional trainers. The program director develops a training plan with each staff annually and monitors training on a monthly basis to ensure staff receives the required training throughout the year. Monthly training calendars are maintained in a binder along with sign-in sheets and curriculums for trainings conducted each month.

The program maintains an individual training file for each staff member that contains a log of training courses/hours completed and certificates. The program exceeds the requirements of the indicator and has an established procedure requiring certain trainings to be completed by new hires within the first 90 days of employment and a total of 80 hours of training within the first year of employment which must include the courses named as both required and recommended by the indicator.

The training files of five new hire employees, including one who just completed their first year at the program, were reviewed. Two of the five new hires have exceeded the 80 hours of training required and the remaining three are on target for meeting completing the 80 hours during their first year. The majority of training topics required were also completed by the five staff with the exception Crisis Intervention (3 staff), CINS/FINS Core (4 staff), Personal Safety (2 staff), Adolescent Development (2 staff), Professionalism (2 staff), and PREA (4 staff); however, there is still time to complete these topics during the training year. After an employees' first year, the training scheduled uniformly based on the calendar year from January to December, instead of individual employees' hire date.

Three in-service employee files reviewed had until December to complete the annual training requirements of the indicator. Two of the three staff exceeded the 40 hours required annually and all three had completed the required refresher CPR/First Aid and Fire Safety Training required for in-service staff annually. In addition, as of the date of the QI review, two of the three staff had also completed all of the recommended trainings.

The provider's Licensed Clinical Staff is the only staff used to conduct an Assessment of Suicide Risk (ASR). Since non-licensed staff do not complete the ASR, the training requirements associated with this indicator are not applicable for the provider. The provider's training policy and procedure was updated during the QI visit to reflect the aforementioned policy.

Overall, the provider does an excellent job in ensuring staff receives the training required as well as those necessary to serve its at-risk youth population. Training records are well maintained and consistently documented with certifications, sign-in sheets, handouts, etc. The annual training plans developed between the staff and the program supervisor ensures accountability and delivery of appropriate training for each staff.

No exceptions as of the date of this QI visit.

1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

The program has a written policy establishing collection of data from several sources to identify patterns and trends for case record reviews,

incidents, accidents, grievances, customer satisfaction, outcome data, and monthly review of Netmis data reports. In addition, the program has a comprehensive CHS Quality Management Plan, FY 2012-2013, that is comprised of three sections: Section 1 describes the agency's philosophy, Quality Management structure, CQI strategies, and stakeholders; Section II includes a description of the agency's long-term strategic goals and objectives, management/operational performance, and program results/outcomes; and Section III provides procedures for data collection, aggregation of review and analysis, communicating results, using data for implementing improvement, and assessment of the effectiveness of the QM process.

The program has a designated Quality Management Specialist (QMS) who is responsible for the implementation and oversight of its CQI program. In practice, the program's CQI program includes many activities that are conducted by various staff to ensure all aspects of analyzing and reporting data are consistently implemented and documented.

Quarterly case record reviews are conducted by the program clinical staff as directed by the program supervisor and are due on the last day of the 3rd month of each quarter. A copy of the program's schedule for records review was provided to this reviewer. Upon completion of each record review, the QMS aggregates the results and provide a copy of the aggregated report is saved on shared drive and shared with program supervisors to discuss themes, trends, and any areas of concern. Program supervisors include review of these data in their monthly staff meetings, as documented by the agendas and minutes of each meeting, which includes training and remediation where appropriate. The QMS also follows-up at a later date to spot check specific files to verify completion of the corrective actions.

The program's Safety Committee is responsible for reviewing incidents and accidents, performing safety checks and fire drills, and making recommendations to management on a monthly basis. Each program site has a representative who sits on the Safety Committee. The safety committee meets on the third Tuesday of each month by phone. Minutes from each meeting are produced and provided to committee members (including the QMS) and the executive Director (ED). The Division Safety Committee Coordinator discusses safety concerns and suggestions with the ED monthly and follows up with the QMS as needed. The QMS will follow up with the ED and program supervisors as needed to ensure division safety.

Consumer grievances are documented in AirsWeb, submitted to program supervisors and reported to the QMS on a monthly basis via the PPR. Consumer surveys are administered twice a year during the second and fourth quarters. The QMS addresses consumer surveying via email and at a management team meeting and notifies the program supervisors of the outcome of the surveys. The surveys are aggregated by the QMS and provided to supervisors, DPO, and ED. A copy of the Consumer Satisfaction Aggregation Tool for FY 2013-2014 was provided for review.

Outcomes data is reviewed monthly, quarterly, and annually. This information is conveyed to staff at monthly staff meetings, where patterns and trends are noted and quality improvement strategies are solicited and discussed for potential implementation. Monthly and quarterly data is entered into the agency's Division Quality Performance Report (DQPR) into the following areas: program performance, program team minutes, safety, record review, consumer satisfaction, and outcomes. The outcomes data is incorporated into the program's Annual Program Performance Report, which compares all of the contract, Netmis, and program benchmarks required by the Florida Network and DJJ QI to the program's actual performance. A copy of the year-to-date Annual Program Performance Report - Florida Network Outcomes, for FY 2014-2015 was provided and reviewed on site.

No exceptions as of the date of this QI visit.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

WaveCREST is contracted with the Florida Network of Youth and Families to provide both shelter and non-residential CINS/FINS services for youth and their families in Martin, Okeechobee, Indian River, and St. Lucie Counties. The program provides centralized intake and screening twenty-four hours per day, seven days per week, every day of the year. Trained staff are available to determine the needs of the family and youth. Residential services, including individual, family, and group services, are provided. Case management and substance abuse prevention education is also offered. Referral and aftercare services begin when the youth are admitted for services. Aftercare planning includes referring youth to community resources, on-going counseling, educational assistance, and a newly implemented 8-week parenting support group. Direct Care staff are responsible for completing all applicable admission paperwork, orientating youth to the shelter/program, and providing necessary supervision.

The program has a very strong, efficient, well run centralized intake process in place. All staff are well trained on the process, display a knowledge of motivational interviewing, crisis counseling, and gathering all pertinent information in a very professional way. Intervention and Case Management is a vital part of the entire shelter and non-residential operation. A review of all areas under this section indicated that the staff and supervisors at this organization understands the importance of the overall process, from the screening and intake to the counseling and family engagement; to the inclusion of school personnel and court involvement where necessary, to successful discharge. The counseling component consists of a total of five (5) counseling positions and a supervisor. The counselors are responsible for completing assessments, developing case plans, providing case management services, and linking youth and families to community services. At the time of the quality improvement review, the program had nine (9) active youth in the shelter and the non-residential component had seventy-one (71) open cases per the most recent invoice dated 11/10/14.

CHS WaveCREST coordinates the Case Staffing Committee, a statutorily-mandated committee that develops a treatment plan for habitual truancy, lockout, ungovernable, and runaway youth when all other services have been exhausted or upon request from the parents/guardians. The Case Staffing Committee can also recommend the filing of a CINS Petition with the court.

2.01 Screening and Intake

Satisfactory Limited Failed

Rating Narrative

The policy reflects that the program conducts centralized screening and intake, twenty-four hours daily, seven days a week. In addition, parents/guardians are notified, in writing, of available service options, rights and responsibilities of youth and parent/guardian and possible actions occurring through CINS/FINS involvement through services that include: case staffing committee, CINS petition, CINS adjudication, and grievance procedure. This information was found in the program's policy for Screening Eligibility for Services and Intake Assessment, Procedures # 9 and #10.

A review of three Residential and four Non-residential files revealed that each file had documentation of an eligibility screening completed within 7 days after the referral. A review of files also indicated that all of the parents/youth were notified, in writing, of available service options, rights and responsibilities of youth and parent/guardian and possible actions occurring through CINS/FINS involvement through services that include: case staffing committee, CINS petition, CINS adjudication, and grievance procedures.

In one of the files, the client had been court ordered to the Non-Residential program since 9/13/14; thus she was CINS adjudicated and monthly status reports were provided to the court indicating any progress or lack thereof. However, a request has been made for discharge as the client is strictly a truancy case with no other behavioral issues noted.

Though clients were aware of the grievance procedures, there were no grievances filed in the cases reviewed.

2.02 Needs Assessment

Satisfactory Limited Failed

Rating Narrative

The agency has a policy and procedures in place to ensure that a Needs Assessment is completed for all youth admitted into the program. Upon review of the program's Needs Assessment, it was determined that all of the elements required by the Florida Network's Policy and Procedure Manual for CINS/FINS were included in the Needs Assessment.

A review of three Residential and four Non-residential files revealed that the Needs Assessment was conducted within the required 72 hour timeframe for the three Residential youth and within 2 to 3 face-to-face visits for the four Non-Residential youth. All of the assessments were completed by a Bachelor or Master's level staff and all but one of the seven assessments was signed off by a supervisor.

Timely review and approval of the Needs Assessment by a Supervisor was not evident in the four Non-Residential cases reviewed. In one of these files, the youth's Needs Assessment was done the same day of admission. However, it was not reviewed by the supervisor until approximately 4 weeks later. In the second file, the youth was initially placed in residential program and the Needs Assessment was done on 7/16/14, within the required 72 hours of admission. However, the client was admitted into the Non-residential program on 8/3/14 and an updated assessment was provided on that date. The supervisor's review did not occur until 8/13/14. Client #3 was referred on 10/28/14, had an assessment done on 10/31/14; the assessment was not reviewed by the supervisor until 11/14/14. Client #4 had a Psychosocial Assessment done on 9/3/13 and a Needs Assessment done on 9/3/14. The Psychosocial was reviewed 9/10/13 and the Needs Assessment was reviewed 9/30/14.

2.03 Case/Service Plan

Satisfactory
 Limited
 Failed

Rating Narrative

The agency has a policy and procedures in place to ensure that a case/service plan is developed with the youth and family within seven working days following completion of the Needs Assessment.

Each of the three Residential and four Non-residential files reviewed had all 7 of the required elements. The identified needs and goals were specific to the client. The type, frequency and location of service were indicated. The file indicated the person responsible along with target dates for completion. In one file, the target date does not exist (11/31/14). In a couple of files, the location of the services was conflicting; as the location was either the agency or CHS; both used interchangeable; however, the recommended service may have been done at school or at home. All signatures were secured (parent/guardian, counselor, and supervisor) and the date the plan was initiated and indicated in all files reviewed. In one file the completion date was crossed out but not initialed.

2.04 Case Management and Service Delivery

Satisfactory
 Limited
 Failed

Rating Narrative

The agency has a policy and procedures in place to ensure that each youth is assigned a counselor/case manager to ensure that a case plan is developed for the youth and family and delivery of services are carried out through direct provision or referral for services.

In reviewing the three Residential and four Non-residential files it was revealed that appropriate referrals were made for those clients needing additional services. Three of the files reviewed needed Mental Health Counseling and they were referred to an appropriate agency or they were receiving private counseling. One of the files reviewed needed substance abuse intervention and the youth was referred to the provider in their county. Follow-ups were made and noted on any referrals.

Referrals to the case staffing committee are made when the client is not making progress on their service/case plan. Three of the four files reviewed were relatively new and the youth were adhering to their case plans. In speaking with the CINS/FINS Supervisor, it was ascertained that the program conducted approximately 3 case staffings within the past 6 months.

One case reviewed was a court ordered CINS client and monthly reviews were provided by the case manager to the court. Additionally, staff accompanies youth and parent/guardian to court hearings and related appointments as needed.

2.05 Counseling Services

Satisfactory
 Limited
 Failed

Rating Narrative

The agency has a policy and procedures in place to ensure that youth and families receive counseling services in accordance with the needs identified during the assessment process.

It appears that all clients are receiving the appropriate counseling as it relates to their presenting problems. As required, the youth's presenting problems are addressed in the Needs Assessment, Case Plan and Case/Service Plan Reviews in all files reviewed. Individual case files are maintained for each youth that includes: coordination between the presenting problems identified, needs assessment, case plan development, case plan reviews, case management, and follow-up; chronological notes of all services provided and progress made; and on-going clinical reviews of the case records by a supervisor. Individual and family counseling is being done as observed in the files reviewed. Group Counseling is held at least 5 days a week as required by the QI standard, but it is exceeded by this agency as it occurs 7 days a week.

2.06 Adjudication/Petition Process

Satisfactory Limited Failed

Rating Narrative

The agency has a policy and procedures in place to ensure that a case staffing committee meeting is convened to review the case of any youth or family that is in need of services.

The adjudication/petition process for this agency is done in accordance with the policy. A case staffing committee is convened within 7 working days from receipt of the written request. The majority of their requests come from the school system. The case staffing committee usually consists of a teacher, an administrator from the school, the attendance clerk, a school counselor, School Resource Officer, CINS representative and the CINS Attorney who usually attends by phone. Two of the files reviewed demonstrated support of the agency's practice. As a result of the case staffing, the youth and family were provided a revised plan for services and a written report of the committee's recommendations were provided to the parent/guardian within 7 days of the case staffing committee meeting.

All new staff members are trained on the process by the CINS/FINS Supervisor and the agency has scheduled training with the CINS Attorney for November 20, 2014, so that they can further understand the process.

The program works closely with the circuit court for judicial intervention with the youth and family as recommended by the case committee and it's in accordance with the procedures outlined in Florida Statute and the Network's policies and procedures. A review summary is completed prior to the hearing, informing the court of the youth's behavior and compliance with any court orders. Recommendations are provided for further disposition.

2.07 Youth Records

Satisfactory Limited Failed

Rating Narrative

The agency has a policy and procedures in place to ensure confidential records are maintained for each youth receiving services in the program.

All records are marked "confidential" and kept in a secure place. Each office (Martin, Okeechobee, St. Lucie and Indian River) has secure file cabinets for all of their non-residential clients. The shelter files for the WaveCREST location are kept in a locked office, in a locked filing cabinet.

All of the files reviewed were clearly labeled by section and the information was easily retrievable. Each file was divided into 9 sections as follows: Intake, Consents, Assessments, Service Plan, Progress Notes, Legal and Correspondence, School Information, Miscellaneous and Discharge/Aftercare. There were no instances of misfiling noted during the visit.

Standard 3: Shelter Care

Overview

Rating Narrative

WaveCREST Shelter is located in central St. Lucie County. The facility is licensed by the Department of Children and Families for 12 beds and the license is current through February 28, 2015. The shelter also admits youth from the Department of Children and Families (DCF) and also for the Basic Center Program. In addition, the provider has a contract to provide residential services for youth referred by DJJ for domestic violence and/or Probation Respite. The shelter is designated by the Florida Network to provide staff secure services for up to ninety days or as court ordered. At the time of the quality improvement review, the shelter was providing services to a total of nine (9) youth.

The building occupied by the shelter program is over forty years old, and is leased by Children's Home Society from St. Lucie County. Despite deficiencies due to the aging of the facility, during the tour, the facility was found to be in good working condition and the furnishings in good repair. The bedrooms, kitchen, and restrooms were clean but the old flooring in the living and dining areas looked scuffed and dirty. There is a consistent appeal to local agencies and construction providers for assistance in renovating the facility.

Each sleeping room is numbered and the beds are identified with letters. Four of the bedrooms house two youth, each with an individual bed, bed coverings and pillows. The other two bedrooms (male and female rooms) are equipped each with a bunk bed and a twin bed which gives the program the flexibility to accommodate more youth of one gender when necessary. Youth have access to a screened porch equipped with an AC unit, insulation, and state of the art exercise equipment. There is a gazebo in the backyard that was renovated in the past year with a new roof and fresh painting.

3.01 Shelter Environment

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy on Shelter Environment that was last reviewed and updated on September 12, 2014. The physical layout of the shelter includes a living and dining area centrally located with the male and female dormitory on either side. There are a total of six (6) dorm rooms, four house two (2) beds, and two (2) of the dorm rooms have a bunk bed with an additional twin bed, allowing the program to accommodate more youth of a particular gender when needed. The front living room area housed a bed specifically for suicide watch and medication observation. The shelter also recently converted a storage closet into an Intake Office, complete with a window and camera. Also the back porch was transformed into an exercise area. The porch was insulated, an air conditioning unit was installed, and exercise equipment was purchased with grant money.

During the tour the shelter appeared to be clean and well maintained considering the age of the building. Bathrooms were clean and functional. Sleeping quarters and common areas were well maintained and furniture was in good repair with no visible signs of graffiti.

The shelter has a disaster plan in place that was updated 9/22/2014 that includes all components consistent with the Florida Network policy and procedure manual requirements. The shelter documented quarterly inspections of all fire safety equipment on 5/30/2014 and 10/30/2014 by Fire Equipment Services of St. Lucie, Inc. The same company completed an annual fire safety equipment and fire extinguisher inspection on 8/1/2014. An annual fire safety inspection was completed by the local Fire Marshal on 9/23/2014. An annual hood inspection was completed on 6/5/2014 on the overhead hood system in the kitchen. All above inspections were rated as satisfactory. An annual residential group care combined with a food service inspection was completed by the Department of Health on 10/1/2014 also with a satisfactory rating and the only violation noted was a need for test strips for chlorine sanitizer.

The shelter conducted fire drills, one on each shift, every month for the past six months. There was also a mock emergency drill documented on each shift, each quarter. The drills included: a tornado drill, a first aid drill, a baker act drill, a chemical spill drill, a heat exhaustion drill, and an actual event involving the bed bug infestation.

The shelter has a two-week cycle menu posted that is followed and was last reviewed by a licensed dietician in 2012. All first aid kits were fully stocked and are inventoried and re-stocked on a weekly basis by the overnight shift. The overnight shift also inventories all chemicals on a weekly basis; a MSDS is maintained on each chemical and all chemicals are securely stored in the laundry room when not in use. A weekly physical plant/safety inspection/housekeeping and sanitation checklist is completed by the Residential Supervisor.

The shelter has a daily activity schedule in place. Youth are engaged in structured activities seven days a week with minimal idle time. Youth are able to participate in faith based opportunities and are provided down time for reading and homework.

3.02 Program Orientation

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy on Program Orientation that was last reviewed and updated on September 12, 2014. The shelter provides each youth an orientation within twenty-four hours of admission. Each youth is to receive a Resident Handbook and complete the Youth Orientation Checklist. Staff and youth are to initial each item on the checklist and sign the bottom. Each youth is to review and sign a safety agreement stating they will alert staff of any suicidal thoughts. The orientation includes introductions to staff and youth. A re-orientation is to occur weekly with all youth.

There were three youth files reviewed. All three youth were provided an orientation to the shelter within twenty-four hours of admission. An orientation checklist was completed, that documented all required topics were covered, and was initialed and signed by the youth and staff. As part of the orientation process all youth were assigned to a room. None of the youth documented any suicidal issues therefore an alert for suicide was not required. There was also documentation in each file that the youth and guardian received a Resident Handbook. This also covered all topics discussed during the orientation process. Each youth signed a safety agreement, as required per the shelter's policy, stating they will alert staff if they have suicidal thoughts. At the end of the orientation process each youth was given a tour of the facility and introduced to program staff. Staff conducts a weekly re-orientation with all youth. This was confirmed on daily schedules provided for review.

The shelter recently renovated a storage closet and converted it into an intake room. At the time of this on-site review the room had not yet been used. The shelter had recently finished installing a window in the room, a camera in the room, and removing a lock from the door. The Program Manager reported the room is now ready for use.

3.03 Youth Room Assignment

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy on Youth Room Assignment/Classification that was last reviewed and updated September 12, 2014. Staff completes an admission packet including an Admission/Client Orientation Checklist Form, Physical and Health Screening, and a CINS/FINS Intake Assessment Form with the youth and guardian including all factors required in making a determination regarding sleeping arrangements. The room assignment is recorded on the CINS/FINS Intake Assessment Form. Any applicable alerts are entered into the shelter's alert system which is a red form located in the front of the youth's file documenting the appropriate alerts which are also documented in the logbook at admission. It is noted next to the youth's name on the alert board in the shelter that the youth has an alert. Staff then refers to the logbook or youth file to find out more information on the alert.

There were three youth files reviewed and all three files documented the CINS/FINS Intake Assessment was completed at admission and the youth were assigned to a sleeping room. All required factors were addressed when assigning the youth to a room. Any alerts were documented on the red alert form located in the front of the file. Alerts documented on the red form in the files reviewed correspond to information documented throughout the youth's file. The alert board, located in the staff work area, was also observed. The three youth were documented on the board and the two applicable youth had "alert" checked next to their name, as per shelter policy. The logbook was also reviewed and there was an entry made in the logbook, for each youth reviewed, at admission and all applicable alerts were documented.

3.04 Log Books

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place for Logbooks that was last revised September 12, 2014. The shelter uses a permanent bound book to document daily activities, events, and other major occurrences. Any major incidents and anything affecting safety and security of the facility are to be highlighted. Each entry in the logbook is preceded by a code which indicates the type of entry being made, for example, "SR" means Shift Report, "BD" means Bed Check, "SI" means Sign In, "SO" means Sign Out, and so on. There are thirty-three different codes that are used. The Residential Supervisor was able to print out a sheet showing what the different codes mean in the logbook. This system of placing a code before each entry was very effective when trying to locate certain types of entries in the logbook.

Entries in the logbooks were brief, generally legible, and all written in black ink. There were instances observed when documentation in the logbook was not legible. This was occurring with the ten minute room checks being documented on the overnight shift. It appeared to be isolated to one staff member's handwriting and was not a consistent practice throughout the logbook. Safety and security issues, new intakes, daily activities, mental health concerns, room checks, and shift reviews were all documented in the logbooks. A majority of the errors in the logbook were handled correctly; however, there were a few errors observed where the staff would simply cross out the word and not write "void" and initial and there were also a couple instances observed where staff would write-over words instead of crossing out with a single line. All entries made in the logbook were ended with the staff signature. The date was documented at the top of each page. Major incidents and safety and security issues were highlighted in yellow. A shift review is completed at the end of each shift giving the on-coming staff a summary of the previous shift. All staff sign out of the logbook at the end of their shift.

There was documentation in the logbooks that reviews by the supervisors and staff are happening on a consistent basis. All staff working the shift consistently signed in the logbook and documented a review. The Residential Supervisor reviewed the logbook at least once each week. When this review occurred the Residential Supervisor initialed and dated the top of each page reviewed and then made an entry in the logbook that it was reviewed. Any corrections or recommendations were documented in the entry or throughout the logbook, on pages reviewed, in red ink. All entries made by the Residential Supervisor were done so in red ink making them easy to locate. It was also evident by the way the reviews were completed that each page and entry in the logbook had been reviewed by management.

3.05 Behavior Management Strategies

Satisfactory
 Limited
 Failed

Rating Narrative

The agency has a policy on Behavior Management Strategies/Interventions last reviewed and updated September 12, 2014. Youth entering the shelter enter the Behavior Program with "0" points. However, the youth begins to earn points immediately. Points are earned for positive behaviors. A point sheet is used to track the youth's behavior while in the shelter.

At intake, a youth is entered on Orientation Status and remains so for the initial twenty-four hours in the shelter. During Orientation Status a youth will be able to earn a total of 100 points with the display of desirable behaviors. Points will be allotted on a shift-by-shift basis and determined solely by the youth's behavior.

Completion of the Orientation Status will lead the youth to Consumer Status and the youth will begin to earn positive or negative points based strictly on the behaviors exhibited. Throughout the youth's stay in the shelter, a daily point tabulation and behavior check will occur. A youth who scores better than 80 points in a day will not only earn those associated daily privileges but an additional ten bonus points. Bonus points are only used to purchase items from the point store and do not affect daily privilege. A youth scoring 90 points or better will have total privilege and earn the additional twenty bonus points. Any youth having a fully successful day earns thirty-five bonus points. Points in excess of 100 can be "cashed in" at the point store or "banked" for later purchases. Subsequent days will begin following Service Plan Goal Conference. During this nightly period a youth may earn forty points for appropriate bedtime behavior and a quiet night.

There were three youth files reviewed and each file contained a daily Target Skills sheet. Points are earned for different activities throughout the day. The sheet documented how many points were earned for each activity, any negative points accumulated, the total points earned for the day, and the total "banked" points that can be used in the point store. Each file also contained a Behavioral Point Sheet which calculated all points earned for the week and documented all "banked" points. In the three files reviewed it appears that positive rewards and negative consequences are given on a consistent and fair basis.

There were no issues with the behavior management system; it appears to be working well. Three files reviewed indicated rewards and consequences were given on a consistent and fair basis.

3.06 Staffing and Youth Supervision

Satisfactory
 Limited
 Failed

Rating Narrative

The agency has a policy on Staffing and Youth Supervision that was last reviewed on September 12, 2014. Staff schedules were reviewed for the last six months. During the awake hours, the shelter consistently met or exceeded ratio requirements and there was always at least one

male and one female staff on duty. During the sleeping hours there was documentation that ratio requirements were always met; however, there was not consistently two staff on duty or a male and female staff always present. There was gap consistently between 12am and 6am at four to five days each for the past six months in which this was occurring. The Residential Supervisor provided evidence of attempting to cover these shifts to ensure a male and female staff are on duty; however, with the on-going staff vacancies they do not currently have enough staff to cover these shifts. The Residential Supervisor provided documentation of on-going efforts and interviews with potential staff to fill these vacant positions. The position was filled for a short period of time during the month of August; however, this person had to be let go. The Residential Supervisor also provided documentation of a part-time staff who is scheduled to start the week following the on-site review. This will help cover some of the overnight shifts but not all of them.

The shelter completes ten minute checks of the youth during the sleeping hours, exceeding the fifteen minute requirement. The checks are documented in the logbook. The checks reviewed in the logbooks were consistently every ten minutes every night for the past six months. The checks would document the number of youth checked on and then how many of those youth appeared to be asleep and how many appeared to be awake.

Exception:

There has not consistently been two staff on duty between the hours of 12am - 6am for the past six months. Consequently, there has not been a male and female staff on duty during those times. However, ratio requirements were met.

3.07 Special Populations

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy on Special Populations that was last reviewed on September 12, 2014 and meets the requirements of the Florida Network. The shelter has not had any staff secure youth in the last six months.

There were three files reviewed, two for Domestic Violence (DV) respite and one for probation respite. In the two DV files reviewed, there was documentation of prior approval from the Florida Network for placement. There was also evidence in both files that the youth had a pending DV charge. One youth was released from the shelter prior to fourteen days and was not required to be transitioned to a CINS/FINS bed. The second youth was transitioned to a CINS/FINS bed after twelve days. The case plans in both files reviewed documented goals focusing on anger management, family coping skills, and other necessary interventions to reduce violence in the home. All other services for the two DV youth were consistent with all other general CINS/FINS program requirements.

The third file reviewed was a probation respite youth. The youth was originally picked up at a Safe Place location and admitted to the shelter. After admission, the shelter learned of the youth's probation status and transferred the youth to probation respite status. There was documentation the youth was on probation with adjudication withheld and there was approval from the Florida Network to admit the youth as a probation respite. The youth only remained in the shelter three days but there was evidence the youth received services consistent with CINS/FINS program requirements.

Looked at 3 files there were no issues, everything was done as required.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

CHS WaveCREST has specific procedures related to the admission, interviewing and room assignment of youth to ensure the safety and appropriate supervision of youth admitted in the program. Upon admission, program staff will interview youth and complete an initial assessment to determine the most appropriate room assignment given the youth's needs and issues, the current population at the facility, physical space available, and staff's assessment of the youth's ability to function effectively within program rules and expectations. Staff conducting the initial interview and assessment considers the youth's physical characteristics, maturity level, history including gang or criminal involvement, potential for aggression, and apparent emotional or mental health issues. Based on this information, the youth is assigned a room which can change after further assessment. Room assignment is documented on page 2 of the CINS/FINS Intake Assessment.

Staff on duty at the time of admission immediately identifies youth who are admitted with special needs and risks, such as risk of suicide, mental health, substance abuse, physical health, or security risk factors, etc. The Residential Supervisor, on-call Supervisor, or licensed Mental Health Clinician is notified immediately if a suicide risk is identified. Direct care staff follows through with the recommendations regarding placement and appropriate supervision of youth with alerts. Youth alerts are documented in various places such as the census board (check mark), youth alert form, and in the program logbook. The agency also uses the Evaluation of Imminent Danger for Suicide (EIDS) on all youth admitted to the shelter. The qualified mental health professional is the only staff person with the authority to determine the suicide risk status of the youth. The clinician completes a full Assessment of Suicide Risk (ASR) on all youth who scored on the EIDS.

Youth admitted to the shelter with prescribed or over the counter medication will surrender those medication to staff during admission. Medications are stored in a double locked red medication cabinet and topical and/or injectable medications are stored separately from oral medication. Refrigeration is available for medication requiring cool storage. The program has a list of staff who are authorized to distribute medication. An approved staff is scheduled on each shift and their name is highlighted on the staff schedule. Medication records are maintained for each youth and stored in the youth's file on the Medication Log Record (MLR).

4.01 Healthcare Admission Screening

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy contains the general components that meet requirements of the indicator. The agency's policy, Health Care Admission Screenings #7401, addresses the admission protocol that includes an in-depth medical, health, and mental health screening process. The policy was last updated on September 26, 2014 and was reviewed and signed by the agency's Program Director. The written procedures address the referral process and follow-up medical care. All staff members are required to complete medication management, and epi-pen administration, OSHA, blood borne pathogens, universal precautions, first aid and CPR.

The agency's current practice is to use the screening and CINS/FINS Intake Form to identify and document youth admitted to the program with acute health issues and or mental health conditions. The agency also uses a Mental/Medical Healthcare and Follow-Up Notes form to capture real-time health and mental health activity related to the client during their shelter stay. This form specifically tracks, date, time and codes. Further, the form tracks all major events related to medication, medical conditions, and all updates on the status of the youth's health condition.

The CINS/FINS Intake form includes screening for all elements of the indicator: current medications, existing medical conditions, allergies, recent injuries or illnesses, presence of pain or other physical distress, observations for evidence of illness, injury, physical distress, difficulty moving, etc. The agency uses an additional Physical and Health Screening Form to document all general observations that include the presence of hair, teeth, weight, complexion, facial hair, and scars, tattoos, or other skin markings.

A total of seven (7) CINS/FINS client files were reviewed to assess the agency's adherence to the requirements of this indicator. Of these files, three (3) are active client cases and four (4) are closed cases. All 7 client files reviewed included evidence of required health care screening admission forms that include the CINS/FINS Intake Form; Physical and Health Screening Form; and the Mental/Medical Healthcare and Follow-Up Notes form. All aforementioned forms are completed in all the required areas. The agency also documents physical and health screening activity in the client's progress notes.

The agency's procedures indicate residents have unimpeded access to emergency medical care at all times. The procedures indicate if a major medical condition exists the youth will be immediately referred to outside emergency medical care at the emergency room. All medication incidents and accidents are required to be documented and reported to the DJJ CCC. The procedures indicate that staff are to contact the parent/legal guardian to obtain information about pending appointments with medical professionals, current medications and general precautions in the case of an emergency.

All medical referrals were documented on a daily log. All seven (7) files reviewed contained documentation of the CINS/FINS Intake form that was completed the day of the youth's admission. The form addressed all elements of the indicator with the exception of observation of scars, marks or tattoos.

No exceptions are noted for this indicator.

4.02 Suicide Prevention

Satisfactory

Limited

Failed

Rating Narrative

The shelter has a written Suicide Prevention policy CHS-7402. All youth admitted to the shelter will immediately be screened using the EIDS. Then EIDS is completed by YCW staff. If the resident answers a minimum of 5 'yes' responses on the risk factor Criteria area 2 Or 1 yes risk factor response in Criteria area 1 they are immediately placed on the Suicide Precautions Observation status. The agency tracks all youth on observation status every 10 minutes. The staff then informs the licensed clinical social worker (LCSW) of the youth's status. The qualified mental health professional is the only staff person with the authority to determine the suicide risk status of the youth. The clinician completes a full Assessment of Suicide Risk (ASR) on all youth on close observation status. The shelter utilizes two (2) levels of supervision: one to one supervision and constant sight and sound supervision. The plan addresses all elements of the indicator and complies with the procedures outlined in the Florida Network's Policy and Procedure Manual for CINS/FINS.

A review of four (4) cases was conducted onsite. These 4 cases were the only available samples of residents that were placed on precautionary supervision status over the last six months. All 4 files reviewed (four closed files) contained documentation that indicated a suicide risk screening was completed during the initial intake and screening process. Of the four cases, all four files had evidence of a completed CINS/FINS Intake forms, EIDS, and Assessment of Suicide Risk. All applicable youth were placed on sight and sound supervision until assessed by a licensed professional. All 4 cases also had documentation of observation counts being completed in the 10 minute time frame. All 4 files contained documentation that indicated the suicide screening results were reviewed and signed by the supervisor who was also the licensed clinical social worker. The supervision level was not changed or reduced until approved by a licensed professional. The agency also has evidence of a majority of signatures and times required for ten minute counts, and ASR by the clinician and review and signature by the supervisor. All updates on the youth's status are documented on the Mental/Healthcare Follow-Up Notes sheet. In addition, all observation counts are completed as required.

An exception is noted for this indicator. Reviews on 1 out of 4 files do not indicate time and date supervisor review was completed. Notes only indicate review by supervisor by telephone.

4.03 Medications

Satisfactory

Limited

Failed

Rating Narrative

The agency has a Medication policy CHS-7403 that includes a detailed explanation of the agency's policy specific to medication management, including storage, inventories, distribution, documentation and disposal. The agency's policy also requires that medication verification and medication disposal be conducted per its policy. A review of the agency's current policy does require medication activity and other general health activity to be documented. The agency requires staff members to document medication verification on the PINK Sheet, Standing Approval Form, and the Logbook.

The program had a list of eleven (11) staff members posted in the Youth Care Work station that are designated to have access to all prescribed, controlled and over the counter medications. All staff have record of medication training located in their training files.

All medications in the shelter are stored in a separate, secure area, which is inaccessible to residents. The agency houses all prescription medication in a locked four (4) drawer cabinet that requires a key to access the contents of the cabinet. The cabinet has a total of 4 sliding drawers. Drawers store sharps (razors only) on the top drawer; Inhalers on the second drawer; topical medication on the third drawer; and prescribed/controlled medication and sharps on the bottom drawer. Controlled medications are locked in a cabinet behind two locks. The prescribed and controlled medications are stored in a limited access tackle box that is accessible by key.

Client medications are stored in clear plastic bags with the clients name written in pen across the top. All medication assessed on site was stored properly and met the standards of the indicator. A copy of the physical health including photo of the resident on medication is included in the bag. Medication requiring refrigeration is stored in a double-locked refrigerator located in the pantry in the kitchen. However, there was no medication that required refrigeration during the time of review. Additionally, there were no injectable medications on site, or identified as needed for any youth during the time of the review.

All over the counter (OTC) medication is stored in a secure wood cabinet that his located in a locked closet. This cabinet also contains chemicals on the bottom shelf of the cabinet. The agency maintains a total of six (6) pill types of OTC medication (Tylenol, Motrin, Tums, Hall Cough Drops, Pepto-Bismol, and Imodium AD). The agency also maintains a total of seven (7) topical types of OTC medication. All weekly counts are completed by staff members on the overnight work shift. The shelter maintained a weekly count of the OTCs at each shift change for the last six (6) months.

All prescribed and controlled medication is counted shift to shift for a total of three times per day. The monitor witnessed a staff trained on medication distribution conduct a full count all medication of youth in the shelter. The count was executed correctly on site. Over the counter medications that are accessed regularly are inventoried weekly on a perpetual inventory.

The program utilizes the DJJ Medication Log Record (MLR). The MLR contained all the necessary information to include: youth's name (printed and signed), date of birth, allergies, side effects, picture of youth, staff and youth initials on the MLR when medication is distributed and received. A review of medication records found that all MLR contained the majority of the information required of the indicator.

The sharps maintained at the shelter consisted of razors. The shelter maintained a weekly count of the sharps at each shift change for the last six (6) months. All weekly counts are completed by staff members on the overnight work shift.

No exceptions noted for this indicator.

4.04 Medical/Mental Health Alert Process

Satisfactory Limited Failed

Rating Narrative

The agency has a written procedure to address medical and mental health alert process CHS-7404. The policy is designed to ensure that all information concerning a youth is filed and maintained in confidential/limited access information areas of the shelter. The program alert system is designed to help identify the current status of residents in order to respond to appropriate emergency care and treatment. Upon admission Alerts are documented in the CINS/FINS Intake form, log book, Red Alert form, Pink (Mental Health and Medical notes) and White Progress notes up admission.

The shelter maintains a large dry erase board with an Alert section that informs staff to look for various medical/mental health conditions. Each open and closed file is marked with the alert and has confidential printed on the outside. The red Alert sheet section guides the staff to seek out information in each client's file. Each file reviewed contained a red alert form with all medical and mental health alerts. All alerts were also found in the Progress Notes and in the Pink Medical/Mental Health alerts. The agency utilizes a color coded guide for the various conditions to maintain the youth's privacy and confidentiality. Both open files contained the appropriate red sheet and notes in the files with additional information.

The monitor interviewed YCW 2 staff members and the shelter supervisor regarding the Alert process. All staff state and provided sufficient information and instructions regarding their familiarity with the program's medical conditions, allergies and information to allow them to determine the current state of all youth being served in the youth shelter.

No exceptions noted for this indicator.

4.05 Episodic/Emergency Care

Satisfactory Limited Failed

Rating Narrative

The shelter has a written procedure to address episodic/emergency care CHS-7405. The policy requires that the agency have a comprehensive process for the provision of emergency care. The policy was last updated and signed by the program director on September 26, 2014. There were six (4) episodic drill events within the last six (6) months between May 2014 and October 2014. There were a total three (3) official emergency care event documented by the agency over the last six (6) months. All 3 episodic drill events were documented on the episodic log and in the program log book. There was documentation for the parent/guardian notification requirement and obtaining off-site emergency services i.e. EMS or the police for Baker Acts. A review of randomly selected training files of staff members indicates that all staff members receive training that includes All staff members are required to complete medication management, and epi-pen administration, OSHA, blood borne pathogens, universal precautions, first aid and CPR. At the time of this review, the shelter had full stocked first aid kits (2), wire cutters and a knife for life.

No exceptions are noted for this indicator.