Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Capital City Youth Services

on 10/27/2015

CINS/FINS Rating Profile

Standard 1: Management Accountability	
1.01 Background Screening	Satisfactory
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Satisfactory
1.05 Analyzing and Reporting Information	Satisfactory
1.06 Client Transportation	Satisfactory
1.07 Outreach Services	No rating

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	Limited
3.07 Special Populations	Satisfactory

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

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

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

Overall Rating Summary

Percent of indicators rated Satisfactory:96.00%
Percent of indicators rated Limited:4.00%
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

Keith Carr, Lead Reviewer FOREFRONT LLC/Florida Network of Youth and Family Services

Sherri Swan, LMHC, Clinical Director, Lutheran Services Florida - Northwest

Sylvester Jones, Assistant Shelter Manager, Anchorage Children's Home of Bay County, Inc.

Ken Phillips, Operations Review Specialist, Florida Department of Juvenile Justice

Jessica Fansler, Contract Management Specialist, Florida Network of Youth and Family Services

Persons Interviewed

- [x] Program Director
- [ ] DJJ Monitor
- [ ] DHA or designee
- [x] DMHA or designee

2 Case Managers
3 Clinical Staff
1 Food Service Personnel
0 Health Care Staff

0 Maintenance Personnel
3 Program Supervisors
8 Other

Documents Reviewed

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

8 Health Records
6 MH/SA Records
18 Personnel Records
0 Training Records/CORE
12 Youth Records (Closed)
14 Youth Records (Open)
0 Other

Surveys

10 Youth
8 Direct Care Staff
0 Other

Observations During Review

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

Comments

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

At the time of this program review, the agency did not have any Case Staffings during the last year. The Policy and Procedure is in place for CINS/FINS Petitions. The agency does have all required operation elements including forms and documents necessary to meet the needs of the CINS/FINS Petition Process.

Strengths and Innovative Approaches

Rating Narrative

The Capital City Youth Services (CCYS) agency reported several program and operational changes and updates since the last on site Quality Improvement (QI) Program Review. The agency reported that there have been several physical changes in the youth shelter. The kitchen remodel/ upgrade were completed. This included the installation of new tile flooring, new cabinets and a new countertop. The kitchen was also repainted.

The agency is also fully staffed with Non-Residential Counselors and servicing nine (9) counties across the 2nd Judicial Circuit in north Florida.

Based partially on feedback from youth, the two (2) relocated common spaces on either side of the staff station were reversed, making the smaller area a space for a new ping pong table and foosball table. This improved the program's ability to provide more diverse indoor recreation activities (such as when needed during inclement weather). The larger area was converted into a different multipurpose area with less tables and a larger area for seating and TV viewing.

Artwork in the resident bedrooms were replaced and the common areas of the shelter were repainted.

The walkway between the shelter and nonresidential/administration building was covered, making movement between the 2 buildings much easier in rainy weather.

Through the agency's Program QI process, the need for a maintenance/facilities coordinator position was identified, recommended and approved. At the time of this on site QI program review, the agency has not yet filled the position.

The CCYS agency continued its fundraising efforts in a variety of ways—most notably its annual signature event, "The Tally Awards". Local businesses are nominated and the favorites are selected in an online voting campaign. The winners are announced at the annual gala. Local TV station ABC WTXL and auto dealership Kraft Nissan were major sponsors of the 2015 event—which led to a profit of approximately $30,000 for the agency.

The agency became the first in the state of local CINS/FINS service providers to receive a Pyxis 4000 Med Station and participated in the piloting of this statewide initiative among the FNYFS agencies. The agency has also recently hired a part-time Registered Nurse with the designated appropriation.

The agency relocated its SOP's Drop-in Center after a plumbing problem at the first site. The agency's Going Places Street Outreach Program has continued to operate strongly in the community, helping both to educate about services and to assist runaway, homeless and otherwise at-risk youth in getting off the streets and into shelter as appropriate.

The CCYS agency has actively sought a new therapeutic/behavior support model that includes trauma-informed care practices. After initial consideration of the Sanctuary Model, the agency is sponsoring an introductory training on Collaborative Problem Solving with the intent to possibly implement this as the new approach. The FNYFS has partnered with CCYS to help sponsor the training which will be attended by other Network agencies and will feature an expert presenter from Boston (Massachusetts General Hospital).

The agency is in the planning stages of implementing the Stop Now and Plan (SNAP) program as one of four (4) FNYFS agencies that will utilize this program that has been piloted by the DJJ.

The CCYS Leadership reports that its management staff is more stable with all major supervisors having now been in their current positions (current structure) for a full year.

The CCYS agency reports that its management planning is placing emphasis on training and specifically the professionalization of the direct care staff. In 2015, the agency began the monthly day of training to help provide more opportunities for staff to obtain the needed hours and topics. We also had the youth shelter's Program Manager certified in the Managing Aggressive Behavior curriculum and their Residential Supervisor was trained as a "Trainer" to train in a Youth Care Worker certification program. The CCYS agency continues, also, to have a robust internship program with the local colleges and universities (including FSU and FAMU). In addition to providing practical education for students, the agency believes that supporting and building a solid program for internships creates training grounds and potential staffing resources for future employees.

The agency reports that its partnership with the Leon County Sheriff's Office strengthened in a couple ways over the past year. In November 2014, an interagency agreement was signed wherein the Sheriff's Office (SO) committed to transporting youth from the Juvenile Assessment Center to the youth shelter as appropriate when they were arrested and then referred to the agency for Domestic Violence Respite. Additionally, the SO included CCYS in the initial trial of an online referral system known as SPIRIT project. The agency has mainly received referrals from local School Resource Deputies for non-residential services and the platform continues to grow.

The Needs Assessment Summary is generally a well written and thorough document. The Chronologicals are very useful in tracking client contacts and efforts to engage families in staffings.

The agency's Personnel records and documentation are well organized and complete. The facility and furnishings appear very clean. CCYS staff are knowledgeable of the youth and day to day operations, and helpful with the quality assurance process.

Standard 1: Management Accountability

Overview

Narrative

Capital City Youth Services, Inc. is responsible for administering and coordinating the delivery of residential and non-residential services for Jefferson, Madison, Leon, Wakulla, Franklin, and Taylor Counties to Children in Need of Services and Families in Need of Services (CINS/FINS) as outlined in Florida Statutes through local service providers.

Capital City Youth Services (CCYS) is led by Kevin Priest, Chief Executive Officer. Mr. Priest oversees a team of educated professionals that includes Gina Dozier, Chief Operating Officer; Crystal Griffin, Human Resources Manager; and Patrick Minzie, Shelter Program Manager.

The agency has a Human Resources (HR) Director that oversees all HR functions including background screening and training. The agency trains all new and on-going staff as required. The agency utilizes a combination of live instructor and online web-based training. In addition, the agency uses a training format that captures all training dates, topics, hours that is maintained on each staff member.

1.01 Background Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policy and procedure which outlines compliance with regulations and protocols as defined by Florida Department of Juvenile Justice (DJJ) and Department of Children and Families (DCF). Employees and volunteers must be screened prior to hire. Nine (9) staff files reviewed for compliance with background screening requirements and procedures outlined in DJJ policy. All nine records contain evidence of background screening have been completed prior to the staffs' hire/start date. None of the nine files reviewed had a rating of in-eligible. A sample of three staff files were utilized to show program compliance with five-year re-screening procedures as well. All three (3) contained evidence of being rescreened prior to the five-year mark.

The agency provided evidence that the Affidavit of Good Moral Character form was submitted to the DJJ Office of Background Screening prior to the end of January 31, 2015.

No exceptions were noted for this indicator.

1.02 Provision of an Abuse Free Environment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policy and procedure in place that outlines staff requirements for reporting any known or suspected cases of child abuse or neglect immediately. A sample of six (6) staff personnel records were also obtained to document staff acknowledgement of this procedure and abuse reporting requirements. This procedure is completed during New Employee Orientation. All 6 files contained an Acknowledgement of Abuse Reporting Requirement form signed by each staff. All 6 files also included documentation and signatures for reviewing the program's Abuse Reporting policy and procedure. Position descriptions also reflect that staff members maintain a professional and respectful demeanor when interacting with youth.

A sample of youth case files were reviewed which included documentation of youth signature for receipt of the youth handbook, program's grievance procedure, and abuse hotline numbers, including statement of youth having twenty-four hour unimpeded access to the abuse registry. Emergency and abuse hotline numbers are posted clearly in youth living areas.

The program has a written policy which outlines procedures for completion of grievances for residential and non-residential youth. Grievance boxes are located in the residential day room area and the administrative building, and are accessible to all residents. Grievances are maintained in a locked box and are only accessed by a supervisor, manager or administrator. The program's written policy states that upon receipt of a written grievance, a Residential Supervisor or Program Manager will review the information presented and respond within seventy-two (72) hours. The response is to be given directly to the resident, advocate, or the Transitional Living Program Mentor for relay to the resident. The youth will be informed of any action to be taken. Six (6) of eight (8) youth surveyed reported that they are familiar with the program's grievance process. A sample of twenty-seven (27) youth grievances were utilized for the scope of this review.

Nine of 9 staff surveyed reported they have never observed a co-worker using profanity when speaking with a youth. Nine of 9 staff also reported they have never observed a co-worker refusing a youth the opportunity to contact the Abuse hotline. Eight (8) of 8 youth surveyed at the program were able to recite the number for the Abuse Registry or identify where the number is posted.

There are exceptions documented for this indicator. In regard to the response to Grievances, there is no area to indicate if youth are satisfied with outcome or any comments for youth after resolution narrative. Nine of 27 youth grievances included youth signature and date that was dated prior to the resolution date signed by the staff member receiving and completing the grievance. Six (6) of 8 youth report that they have heard adults use curse words when speaking with them or other youth. Two (2) of nine (9) staff members surveyed report they have observed a co-worker using threats, intimidation, or humiliation when interacting with the youth.

1.03 Incident Reporting

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a written policy in place specific to incident reporting procedures applicable for residential and non-residential youth served by the agency. The policy includes internal incident reporting procedures and notification procedures for the DJJ Central Communications Center (CCC).

An interview with the facility program manager discovered when staff witnesses or has initial knowledge of an incident occurring, they will complete the facility incident report and notify the supervisor on duty or on-call administrator of the incident. The staff will then be given direction to notify the CCC and follow reporting procedures if the incident meets criteria outlined within policy.

Ten (10) reportable incidents requiring notification to the CCC were reviewed for a period from April 2015 to September 2015. Nine (9) of 10 incidents had evidence of the program notifying the Department's CCC within two hours of the incident occurring. One (1) of 10 incidents was outside of the two hour requirement for CCC notification. An interview with the program manager found that staff failed to properly report after becoming aware of the incident. The program manager further reported that the staff received corrective action as a result.

The program provided evidence of follow-up communication and special instructions required by the DJJ Central Communications Center in order to further investigation of reported incidents. Two (2) specific reportable incidents were reviewed to support this process taking place. Evidence of electronic notifications and requests for follow up from the Department personnel conducting management review of the incident were maintained.

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1.04 Training Requirements

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a detailed policy that addresses the requirements for Training indicator 1.04. The agency has a consistent process for ensuring that staff members meet either the eighty (80) hour annual requirement for first year staff members or the forty (40) hour annual requirement for on-going staff members.

All staff members received the required amount of training (80 hours for new hires and 40 hours for on-going staff) per the annual standard. The sample of files selected on site included various topics and courses. Of the files reviewed, all staff members took all of the required training topics. As well as all of the recommended trainings. The training files are easy to read with a spreadsheet on the left with a list of trainings, hours and a cumulative total completed on a quarterly basis. On the right is the corresponding certificates and/or sign-in sheets in ascending order. The CCYS agency offers a training day every month in order to offer mostly in-service trainings. They also have several staff members certified to train in Managing Aggressive Behavior (MAB), Residential Child and Youth Care Professional (RCYCP) and First Aid/CPR.

An exception is noted for this indicator. The only exception is one employee is overdue for their CPR/First aid. Last done on 5/14/13—it is valid for two years.

1.05 Analyzing and Reporting Information

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy specific to the requirements of the Analyzing and Reporting indicator. Documentation of reports were provided to identify patterns and trends within the program. The program provided sample documentation of multiple meetings which are conducted to review residential life such as incidents, grievances, internal program quality improvement, review of customer satisfaction, and monthly reviews of NetMIS data reports.

Client satisfaction surveys are reviewed by staff for each youth during the youth's stay in the program. Findings are reviewed by program administrators. A sample was provided for this review for the month of August 2015. The sample included six youth that participated.

Residential Operations meetings are conducted weekly. Samples were provided which included participation from clinical and director and residential counselors, along with other supervisors, to discuss various residential issues and concerns. The meeting is facilitated by the Program Manager. Agenda topics also include medication and medication administration for youth.

The program completes a monthly review of NetMIS data report information. The program's Chief Operations Officer completes and tracks the information monthly. Information is disseminated and discussed in multiple staff and management team meetings. A sample of this information and electronic documentation of the dissemination of the information to program stakeholders was obtained to assist in verification of the practice.

The program has not begun the process of utilizing the Knowledge Portal or Pyxis Med-Station Reports. The Program manager reports the quarterly review of medication management practice is completed weekly during staffings for each resident receiving medication.

1.06 Client Transportation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policy and procedure which outlines the use of vehicles and transportation of clients. The program's policy discourages staff members from transporting a youth unless accompanied by a third party such as an approved volunteer, staff, or another youth. When a third party is unavailable to assist, the program's policy includes exceptions which include notification to a supervisor or on-call professional staff who may authorize the transport.

Prior to a new staff hire, the program's Human Resource Manager obtains and validates the individual's driver license, then forwards the information to the program's insurance provider who will then give final confirmation for clearance. A sample of six (6) staff personnel files were reviewed to verify this process was being completed. An example of one potential hire, who was determined to be 'not eligible' by the insurance carrier, was also provided for this review. The staff was determined as unable to hire based on this information and is thus not on the current staff roster for the program.

A sample of six (6) staff personnel records included verification of a valid Florida Driver License, as well as electronic confirmation by the program's insurance carrier, approving coverage. Vehicle logs are maintained which include documentation of driver name or initials, date and time, mileage, number of passengers, and intended destination.

While on site, the review team observed the agency's adherence to the new youth transportation by staff members working to address this performance indicator. An on-site observation was completed for this review of a youth transportation. Staff observed utilizing another youth as a third party for the purpose of picking up a youth from school and returning the youth to the program. Staff observed giving youth clear directions. Both youth and staff observed wearing seatbelts. Staff members documented completed vehicle log as required.

When a single driver is transporting a single youth, the program does not routinely document approval given by a program supervisor for the transport. An interview with the Program Manager revealed that in situations when a youth will be a single transport to court hearings, supervisors are made aware through youth team meetings.

1.07 Outreach Services

☐ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency's Program administration reports involvement in circuit meetings. However, the local 2nd Judicial Circuit area is currently making changes to improve overall participation by community partners. The program provided documentation of participation in council meetings to ensure CINS/FINS services are represented in an effort to increase public safety by reducing juvenile delinquency through prevention, intervention and treatment services.

The program has developed the Capital City Youth Services (CCYS) Outreach Plan which mission states CCYS plan to be a well-known and highly respected community agency that provides quality services to youth and families in crisis. Documentation provided details the goals and objectives of the plan. Staff members that are designated to attend local and circuit level meetings convened by the Department include the program's Chief Executive Officer, Chief Operations Officer, as well as non-residential and residential clinical directors.

Samples of quarterly Circuit Advisory Board agenda meeting minutes as well as JAC Steering Committee Meeting minutes were provided as evident of outreach services being implemented by the program.

The program provided documentation and written agreements between CCYS, Inc. and local law enforcement agencies and schools as examples of written agreement with community partners that include services provided and a comprehensive referral process.

No exceptions are noted for this indicator.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

The Capital City Youth Services (CCYS) agency provides residential and non-residential services to youth ages 6 - 17. The Some Place Else Youth Shelter residential facility is located in Tallahassee. The non-residential services provide services to four counties: Franklin, Gadsden, Jefferson, Leon, Liberty, Madison, Taylor and Wakulla. The Non-Residential program is under the direct supervision of a Licensed Mental Health Counselor (LMHC). The agency LMHC supervises the counseling team comprised of 10 Counselors. The Residential program is under the direct supervision of a Licensed Clinical Social Worker (LCSW). The agency's LCSW supervises the counseling team comprised of 4 Counselors. The Non-Residential program services client need across several counties. Several of these counties are in rural and outer-lying areas. The agency provides several services. The referrals for services are received from parents, school, counselors, the court system, the youth themselves and other sources. The services provided by CCYS include individual, family and group counseling along with case management services. Case management services include life skills, social skills and referrals for services upon the youth's return to the home/community. Youth also receive referrals for substance abuse and mental health services.

A CINS/FINS screening is conducted on each youth prior to their entry into the facility to determine if they are appropriate for the program. Trained staff are available to determine the needs of the family and youth. A needs assessment is then conducted on each youth to ascertain what services they will need to be provided. The youth and family participate in a face-to-face session in order for the staff to assess their individual needs and develop an individualized plan of services to accomplish specified goals. After completion of the needs assessment a case/service plan is created to address these issues. Residential counseling services including individual, family, and group therapy are provided. In addition, case management and substance abuse prevention services are also offered in non-residential settings. Referral and aftercare services begin when the youth are admitted for services. Aftercare planning includes referring youth to community resources, ongoing counseling, peer support, advocacy, financial assistance, housing assistance, and educational assistance.

CCYS leads and 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 may include representatives from the school district, DJJ or CINS/FINS provider, State Attorney's Office, Mental Health and Substance Abuse organizations, law enforcement and DCF. The Case Staffing Committee meets monthly and can also recommend a CINS Petition be filed to court-order participation with treatment services.

The Residential and Non-residential Programs are meeting the requirements of this standard. The Chronologicals in the files are accurate and do a great job of consistently tracking client contacts, efforts to engage parents/guardians and staffings. While the 7 day practice of completing the Needs Assessment is an acceptable practice, it delays the focus and documentation of the counseling sessions.

The supervision process seems consistent and appreciated among staff, as they report feeling a sense of family with their supervisors and co-workers. The clinical staff, including the newer ones, are well informed of their responsibilities and agency practices and seem genuinely moved to help their community.

2.01 Screening and Intake

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Policy and Procedure is in place indicating that screenings are conducted 24/7, in person or by phone. The policy and procedure contains required elements including explaining available service options, rights and responsibilities, need for referrals beyond the scope of services and grievance procedures.

All ten (10) files reviewed contained screening forms (completed at various times) that properly documented client eligibility information. Additionally, the SPE Youth Contract and the Program Overview & Guidelines for Parents/Guardians include the required elements of the standard. The Parent form includes acknowledgment that parents have received the CINS/FINS Brochure that documents available service options. All 10 files reviewed contain evidence that all requirements were met.

The Residential and Non-residential programs have done an excellent job including the required standard elements into the intake documentation. All 10 of the files reviewed contained the completed intake documents with the required signatures (youth, parent and staff) indicating complete compliance with this indicator. Additionally, the screenings were completed at various times supporting the 24/7 service provision practice and policy.

No exceptions noted for this indicator.

2.02 Needs Assessment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The Policy and Procedure is in place that indicates the Needs Assessment (NA) is initiated when the SPE Intake and Assessment Form is completed. The needs assessment is initiated in the initial session and is completed within two-three sessions, in accordance with Network requirements. The agency policy and procedure also indicates that a YFA "**initiates**" the Needs Assessment within 72 hours of a youth's intake. Youth records support this confusing practice. According to the first definition of initiating the needs assessment, all five (5) residential files reviewed met the 72 hour requirement because the forms are completed during the youth intake. Because the YFA practice a seven (7) day timeframe to complete the needs assessment, only two (2) of the 5 files reviewed contained a completed Needs Assessment.

The policy and procedure does not indicate that Needs Assessment must be completed by a Bachelor's or Master's level staff; however, all files reviewed contained documentation of staff known to be Master level clinicians or Master student clinicians under supervision.

Only one (1) of the five (5) reviewed scored with an elevated risk of suicide was determined at intake. This youth was assessed for suicide by a Master's level clinician and supervised by a licensed clinician.

Interviews with four (4) clinicians support the practices noted in the P&P and documented in the files. Interviews with counseling staff and review of the files support documentation of both of these practices (documented on the Chronological notes). In addition, the notes also document all the efforts made to engage parents in the Needs Assessment and Plan of Service provision process.

Over all, the Needs Assessments, when completed, are very well written and thoroughly document the youth's situation including past and present information and input from the parents when possible. Further, the Plans of Service are individualized according to needs identified during the Needs Assessment.

Five (5) non-residential files were reviewed and all but one contained a completed needs assessment. The one incomplete needs assessment was due to the family's early withdrawal from services.

2.03 Case/Service Plan

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The CCYS policy and procedure is in place for this standard and includes all the required elements with the exception of the date the plan was initiated. The Plan of Service (POS) form has all the required elements including space for all required signatures and a space for date of initial service plan. Three of the five residential files reviewed contain completed POS. Two (2) of the three (3) files contain supervisor signature. The 1 file not signed did not have a completed needs assessment and had not been reviewed by supervision yet. Only one (1) of three (3) files contained a parent signature, however all files documented numerous efforts to engage parents with services.

The non-residential policy and procedure also includes all the required elements, with the exception of the date the plan was initiated. The non-residential plan of service includes all the required elements including the date of initiation and appropriate signatures. Four of the five Non-res files reviewed contain completed POS--all completed within the 7 day timeframe because they were completed the same day the NA is completed. One file did not contain a POS but this was due to the family's failure to continue services. Numerous efforts to re-engage the family were documented in the file.

None of the files reviewed contain a 30-day review of plan of service. The residential files were not open long enough to warrant such a review. Three of the Non-res files were not reviewed due to the families' failure to continue services. In these cases, numerous efforts were made and documented to re-engage the family. One case was due for review at the next session and the final family stopped services prior to review date.

Interviews with Residential and Non-residential clinical staff supported the procedures for creating the POS at the final session designated to complete the Needs Assessment. Because of this practice, all files with completed plans of service met the 72 hour requirement.

2.04 Case Management and Service Delivery

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The CCYS policy and procedure is in place under the title of "Services Modalities and Interventions" and includes reference to specific types of interventions including Case Management. While the program has a policy regarding "Services Modalities and Interventions" that includes the variety of services provided, including Case Management, the only specific reference to the required standard elements is the "Referral to additional services".

Three (3) out of the 3 residential files that contained completed plans of service met all the required elements when indicated. Documentation on the "Chronologicals" supports the numerous efforts of staff members to engage families in the service provision process. Additionally, those files with completed Needs Assessments included input from parents. Regular staffings are held to support this process.

A total of four (4) of the five (5) non-residential files reviewed contained completed plans of service, need assessments and chronological notes that documented coordinated efforts to deliver services.

The policy and procedure does not specifically include all of the other required elements. They are somewhat implied throughout different policies, however, are not specifically stated.

2.05 Counseling Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The CCYS policy and procedure for this indicator is captured under three (3) separate policies: Services Modalities and Interventions, Chronological Records & Case Notes, and Confidentiality of Client Information.

Due to the short length of stay and the program's process to allow seven days to complete the Needs Assessment, none of the five (5) residential files included documentation of counseling services aside from entries on the Chronological regarding sessions to gather information for the needs assessment and plan of service. The chronological notes documented incidences of the counselors meeting with the youth but the program practices consider these meetings as information gathering to complete the needs assessments. This process doesn't give the program credit for counseling work that is undoubtedly going on during these "information gathering" sessions.

In the 3 files that had partially completed needs assessments and plans of service, it was noted that the youth's presenting problems were addressed in both documents.

Client participation in group sessions was noted for all five (5) clients, in the Client Activity Logs. These groups are conducted by Youth Care Specialists or Student Interns.

Four (4) out of the 4 non-residential files reviewed that contained completed needs assessments and plans of service, all contained documentation of counseling sessions and the youth's

presenting problems in the NA and POS. The remaining file reviewed did not contain a completed needs assessment or plans of service because the family did not return for services despite numerous efforts to re-engage them.

The Non-residential program files included all the required documents to show counseling services are being provided and supervision is monitoring client progress. Interviews with clinicians support the routine supervision process.

2.06 Adjudication/Petitiion Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The Program has Policy and Procedure in place that meets the indicator requirements as well as forms created to meet the needs of the CINS petition process.

Not Applicable as the program hasn't had any cases go to petition.

The policy and procedure forms designed to support the Staffing Committee and Petition Process are in place. However, the program hasn't had any cases go to petition in the last year.

2.07 Youth Records

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The CCYS Policy and Procedure is in place to meet the standard under two (2) policies: Confidentiality of Client Information and Record Retention. All ten (10) files reviewed were marked confidential and were maintained in a neat and orderly manner for ease of access. The file room was locked and marked confidential. According to interviews with several of the clinical staff, it was noted that only the Clinical Directors and Chief Operations Officer have access to the keys.

Two (2) Non-residential clinicians were interviewed and showed the file containers they use to transport their files. They were opaque, lockable and marked confidential.

Interviews with clinicians as well as review of the CCYS policy and procedure, client files, the file room and lock boxes showed everything to be in place for this standard.

Standard 3: Shelter Care

Overview

Rating Narrative

The Some Place Else (SPE) Shelter is licensed by the Department of Children and Families (DCF) an eighteen (18) bed Child Caring Agency through March 31, 2016.

The SPE shelter provides short-term respite residential services to youth ages 6-17 in the Department of Juvenile Justice (DJJ) CINS/FINS program as well as for youth from the Department of Children and Families DCF. The SPE youth shelter is designated by the Florida Network of Youth and Family Services to provide staff secure services and other special populations. Specifically, this shelter is designated by the Florida Network to provide staff secure services, Domestic Violence (DV) respite, Probation Respite, and Domestic Minor Sex Trafficking.

The shelter program management team is comprised of a Residential Shelter Manager and two (2) Residential Supervisors. Each shift also has YCS that is the designated team leader. An organization chart dated 09/04/2015 shows a total of fourteen (14) Youth Care Specialist positions in the shelter program. There are also four (4) residential counseling positions.

The CCYS SPE youth shelter building includes a large day room, individual girls' and boys' sleeping rooms, individual bath rooms, kitchen, laundry, residential and counseling staff offices. The exterior of the office includes a large outside basketball and recreation area. During the Quality Improvement review, the shelter was found to be in clean and good condition. The furnishings are in adequate condition and the rooms and common areas were clean. The bathroom floors are tiled and the plumbing appeared functional. The bathrooms are scheduled to be remodeled in the near future. The sleeping rooms houses two - three (3) youth each. The sleeping room is equipped with individual beds, bed coverings and pillows. The windows are equipped for privacy for the youth.

The program has policies and procedures in place for its Shelter Care programming. The Direct Care workers are responsible for completing all applicable admission paperwork conducting youth orientation to the shelter, and providing necessary supervision. Health and medication related activities are the responsibility of the staff. The facility has recently hired a part-time Registered Nurse (RN) as required by the 2015 CINS/FINS contract. Oversight of clinical services is provided by both the residential and non-residential Licensed Clinicians.

3.01 Shelter Envonment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The reviewer of this indicator reviewed several documents. The agency has a general policy to address this indicator. Writer reviewed four (4) of the youth's rooms and the walls were clean and odor free. Several beds have paint chipping and scratches on them. Walls are free of graffiti. The SPE common area has been painted and is well lit. The agency has also completed other renovations such as a new kitchen and new kitchen flooring and stove.

Health inspection sheets and fire inspection sheets are up to date and show passing in all areas. The facility has conducted 1 fire drill per month—none are out of the time line of 2 minutes. Mock drills are completed according to standards. Facility is equipped with knife for life, first aid kits, wire cutters.

All staff have a key card (fob) to gain entry into the building and non-staff members have to buzz a buzzer and wait for staff to assist them into the building. The grounds are clear of debris. Dumpster area is cleaned and covered.

Writer inspected the vehicles on site all are equipped with fire extinguishers, seat belt cutter and window breaker. All vehicles have insurance.

The CCYS agency has a DCF License are posted at the front entrance of the shelter.

3.02 Program Orientation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has in place a policy and procedure that support the Program Orientation Disaster preparedness. The reviewer assessed a total of six (6) files (3 open and 3 closed). There is a checklist for the youth and staff to sign off on after they have reviewed and explained all orientation documentation. Each youth is given a handbook upon entrance to the program which goes over in detail their rights and expectation of them while in the program and what they should expect from the program.

Each resident is given a tour of the shelter and a map of the facility. The DJJ and the Abuse hotline numbers are posted clearly for the youth to see. The residents' daily schedule is posted in every area that the youth are in (classroom, dining room, common area and staff desk). There is a place for the youth and the youth's parent to sign on the consent form.

3.03 Youth Room Assignment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has Policy and Procedures in place that supports the process of classification and room assignments of residents admitted to the SPE youth shelter. The CCYS uses standardized forms that include the Intake & Assessment form. The CCYS Screening & Eligibility Form includes screening components that include the identification of the race, gender, gender identification, gang affiliation and others.

The program has a clear Alert system in place and is noted on the Intake Assessment form and on the outside portion of the binder and med sheet. Writer reviewed 6 files (3 open and 3 closed). All of the files had the areas in question filled in or needs assessment in place. The progress notes also keep track of the youth's interaction in the shelter.

No exceptions noted for this indicator.

3.04 Log Books

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a Policy and Procedure in place for log book documentation. At the front of the book it has color codes for the entries that reflects the policy. The reviewer assessed log books dated back from March 2015 to September 2015. Entries are brief and legible. Each staff are identified after writing shift change that they have read the log book. There is indication in the logbook that the Shelter Manager has reviewed the logbook on a weekly basis. Safety concerns were noted in the book and highlighted. Head counts are noted at the beginning of each shift and any important information to the shift is highlighted (e.g. sight and sound and medication of youths).

The reviewer assessed the logbook and of the nine (9) incidents reviewed, seven (7) were in the logbook and two (2) were not found. This reviewer interviewed staff. Staff members reported and explained that after a youth is discharged they do not list anything in the book about them. Those that were in the book gave clear detail of the event and the actions steps taken.

Exceptions are noted for this indicator. A couple of intakes are not highlighted in the program log book. The Residential Supervisor does not note in the logbook that they have reviewed the book as well. The CCYS policy (Supervision of youth policy) states that a head count will be noted after fire drills and or emergency situations but it is not noted in the log book. Several voids weren't dated or had no initials and several had no notations only the line through.

3.05 Behavior Management Strategies

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policy in place for the Behavior Management performance indicator. Upon a youth's admission into the program they're given a youth contract which list the Target skills that youth select from a list of target skills. Additionally, those selected target skills are used on the youth's point card which is kept with them. It does protect the rights of the youth and promote fairness, respect and social skill growth.

The program has in place a level system that clearly states what it takes to advance to the next level and what the do's and don'ts for each level. It clearly states the consequences and rewards. This information was posted on the wall in the hall, but the program is currently making changes to the level requirements and in the process of changing the BMS.

The reviewer interviewed the SPE Shelter Manager Patrick Minzie. The Shelter Manager reported that following a new hire, the program requires new staff to complete a full week of shadow training and on the job training until the next orientation training. The Residential Supervisors are not directly involved in the supervision of the youth, so they are on the floor to offer feedback to the staff while on shift daily. The staff at the Town Hall meeting have an opportunity to offer feedback to management about the failure or success of the BMS. These meetings are held at least three (3) times a month.

3.06 Staffing and Youth Supervision

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

The program has a policy in place and it clearly states how the scheduling of youth by direct care workers are to be addressed. Writer reviewed the schedules for the past six months (not including the current one). Every shift has at least three staff on duty, with the exception of overnight which has two. Each shift does have staff gender rationed well. Staff schedule is posted at the staff desk and they receive one via email. All of the staff contact numbers are posted on the schedule if one is needed to be called in.

The reviewer did a camera check and their sixteen (16) cameras are in working video condition. When looking at the cameras live you cannot hear sound unless it is saved to the flash drive. Any events that may need to saved are saved to a flash drive for later purpose.

If a youth is not in their bed there is a code used to state the status of the resident. They conduct bed checks every ten (10) minutes which is above the fifteen (15) minute bed check minimum set by the Network.

Exceptions are noted for this indicator. Bed checks are kept on a ledger paper with all of the youths' name and the time of the bed check. The reviewer noted that all of the overnight bed checks are the same. No consistent real-time capture of bed check time is being documented. In addition, a couple of the sheets had pre-written bed check in times documented, but no bed checks conducted. Agency had no reviews by supervisors to documenting their detection and or corrective action to detect this issue.

3.07 Special Populations

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program does have a written policy in place to support Staff Secured youth. However, they have not had one in the past six (6) months in question. The policy does lay out who will be

involved in the treatment of the youth, groups and how the parent is involved in the process. The staff schedule will have a male/female staff identified to work with the youth per shift and if it was a youth in shelter they would identify that staff assigned to the youth in the shift change logbook. At the end of the youth's stay information concerning the youth is shared with the courts.

The agency does not have a policy in place to reflect youth that are referred to DV Respite. However, according to Ms. Regina (COO) they will be treated in compliance as any other CINS/FINS youth. Writer reviewed 5 files. Of the files reviewed two were given approval the next business day (one was a 1:00am intake). No youth stayed past the 14 day allowed, but one youth did transfer to CIN/FINS status after her 14 days (noted in the youth chrono. to note the transfer in NetMis). One of the youth was not here in DV care to create a plan due to being Baker Acted on the second day in shelter by mother.

The agency does not have a policy in place for Probation Respite or Domestic Minor Sex Trafficking and have had youth in the shelter for those area.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The CCYS agency has detailed policies and procedures related to the screening, health admission screening, classification, assessment and room assignment of youth to ensure the safety and appropriate supervision of youth admitted in the program. All youth receive an initial assessment to determine the youth's risks, needs and issues. Based on this information, the youth is assigned a room which can change after further assessment.

All staff members are trained on risk screening methods that immediately identifies youth who are admitted with special needs and risks—such as risk of suicide, mental health, substance abuse, physical health (acute and chronic), or security risk factors. Once risks are identified through the screening and assessment process all staff and management are notified. The youth are placed on alert status. The agency takes steps to ensure that measures are taken to maintain a safe and secure placement; and supervision is provided by direct care staff during the resident's shelter stay. The agency maintains a program log, general alert system, pass down/shift exchange forms, and other notification systems. Youth admitted to the shelter with prescribed medications are also provided their medications during their shelter stay.

Staff members participate in routine mock emergency drills and receive orientation and annual training courses that include Universal Precautions, Safety and General Program Risk Management training. In addition, the agency's Shelter Manager is a certified Managing Aggressive Behavior (MAB) Trainer.

4.01 Healthcare Admission Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a detailed policy last updated on December 2014. The policy is called Health Screening Admission. The policy contains Procedures for health information screening for the residential program, DCF program and Transitional Living program. The agency's health info is primarily captured on the Screening and Eligibility form. Some follow up general health information screening information is captured on Intake and Assessment form. General health-related issues are screened for on Health and Mental Health history. In this section, the agency captures current, food and other allergies, mental health diagnoses, prescribed medications, SIPP or Psychiatric facility History and Baker Act History. The Intake and Assessment form captures general physical health issues that include observable injury, illness or health related issues, medical, dental or health conditions or concerns, medical problems in the last year, allergies, dietary restrictions, nutritional concerns, and several other possible health conditions.

A total of 8 client files were reviewed on site with the agency's Registered Nurse. All client files contain and meet the general requirements of this Health Screening indicator. The file review revealed that all client cases contained the required health screening form and documentation required for completion. All form reviewed during this sample of 8 residential files were accurate and complete.

No exceptions were noted for this indicator.

4.02 Suicide Prevention

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The CCYS agency has a detailed policy called Suicide Prevention. The policy includes all suicide prevention procedures and methods that meet the current requirements of the indicator. The plan indicated each youth admitted to the shelter will be screened for suicidal risk by the six (6) suicide risk questions on the CINS/FINS Intake form. The agency has two (2) levels of suicide risk supervision. The agency maintains a 1 to 1 Supervision Level where staff members are required to be within an arm's length at all times. This is usually a youth that has responded yes to questions 2 and 3 on the Suicide Risk. The agency also utilizes a Sight and Sound Supervision Level. This status required that the agency ensure that a staff member can see and hear the youth on this level of supervision at all times. In the event that the resident answers "yes" to any of the 6 questions, the trained youth care worker will immediately place the youth on the appropriate level of suicide risk supervision. The resident is placed on Constant Sight and Sound Supervision until a full suicide assessment can be completed by a qualified mental health professional. The Master's Level counselor on duty or On-Call then completes the full Suicide Risk Assessment and determines the level of risk. The agency has 2 residential counselors that are required to have completed 15 hours or 5 suicide risk assessments. These assessments are done under the supervision of the designated Licensed Clinicians. At the time of this on site program review, the agency has a total of three (3) licensed clinicians. Clinical credentials of all 3 licensed clinicians are in effect. The counselor consults with the available licensed clinical professional to determine if the youth will remain on the current level of suicide risk or be stepped down and removed from this level and placed in the general population.

A total of six (6) client files were reviewed on site during this QI program review. All 6 files reviewed (6 closed files) contained documentation that indicated a suicide risk screening was completed during the initial screening and intake process. All 6 files contained documentation that indicated the suicide screening results were completed by the Masters level counselor. All 6 files had evidence that the youth met the criteria and were applicable for sight and sound supervision requirements. All 6 client files were placed on the appropriate level of supervision based on the suicide risk assessment results. All applicable youth were placed on sight and sound supervision until assessed by a licensed professional or non-licensed staff under the direct supervision of the licensed professional. All 6 cases had evidence that each suicide assessment was reviewed and signed by the clinician. The supervision level was not changed or reduced until approved by a licensed professional. Supportive documentation was reviewed to include precautionary observation logs and 15 or less minute checks across the entire period that the youth was under suicide elevated supervision. Five (5) out of 6 cases had evidence of when the youth was placed on and taken off their current suicide risk level. All 6 files contained the required documentation to be in general compliance with the requirements of this indicator.

The agency added the 2 residential supervisors to the ON-Call schedule. This allows the agency to reduce the number of staff required to be on call and reduces the amount of time people to be on-call. The agency now has a single point of contact instead of having 2 persons being on-call.

A total of five (5) out six (6) cases documented date and time of consultation sessions to confirm removal of the resident from sight and sound to being placed in the general population. One out of 6 did not document date and time the counselor consulted with the licensed clinical to remove the youth from their current suicide risk level to the general population. One (1) out of 6 cases did not have consistent evidence of when the youth was placed, identified on each shift and taken off their current suicide risk level.

4.03 Medications

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The Capital City Youth Services agency has a current medication policy that was recently updated on August 2015. The current policy ensures client safety—all medications will be kept secure and dispensed in a responsible and confidential manner by all staff members authorized to distribute medication.

The current medication policy addresses Receiving Medications, Storage, Prescription Drug information, Verification, Assisting a Youth with self-administration of medication(s), Prescription Medication, Prescription Asthma/Allergy Medication, Non-Prescription Medication, Record Keeping and Documentation, Non-Prescription, Inventory, Disposal, School Issues, Big Bend CBC/DCF Youth and Staff Responsibility. The agency utilizes the Medication Oversight and Inventory Record. One staff member initials that the form has been completed on the document and another area that includes a person that completes secondary review of this document for accuracy and completion.

The agency also has a process that documents the completion of the Verification of Medication of all youth admitted to the program. Medication is verified upon admission to the program and documented on the bottom of page one of the Medication Oversight and Inventory Record. Medication verification documentation was also found in the progress notes section of some client files. Medication verification is completed by staff members and by the Registered Nurse. Of the files reviewed on site, five (5) out of five contained evidence that the agency had completed the steps necessary to confirm verification of each youth's medication in order to meet this requirement.

At the time of this on site QI program review, there are a total of five (5) residents on medication in the youth shelter. Of those 5 client files, 4 out of 5 have the proper medication alerts affixed on the outside of the client file. One (1) out of 5 is missing the blue dot affixed on the spine of the 3-ring binder and on the Contact Authorization and Medication Schedule Overview Forms. Other forms in Section D of the Chart include Informed Consent, Medication Oversight and Inventory Record, Pharmacy Drug Information Sheet and Drug.com Information.

The agency provided a list of a total of twenty-one (21) staff members that have been trained on medication distribution and are authorized to assist in the delivery of medication. These staff members have access to secured medications, Over the Counter medications and Controlled Substances.

All medications in the shelter are stored in a designated medication-specific room that is a separate and secure room. The medication room is used solely to house a double locking medication cabinet. The medication room now houses a Carefusion Pyxis Med-Station 4000 Medication Cabinet. The Pyxis MedStation is stored in this locked room that is inaccessible to residents. CCYS was the first CINS/FINS local service provider to utilize the automated medication cart. The cart was installed in April 2015. The agency was trained by Carefusion trainers and they have a minimum of 2 Super Users and 4 or more Regular Users. The monitor observed that the agency is utilizing the MedStation to store all medications (prescribed and over the counter), count and distribute medication. The MedStation cannot be accessed by residents. The MedStation can only be accessed via a Personal Identification Number (PIN) and second biometric finger print scan.

The agency has a pill counting tray and pill counter. All controlled and prescribed medication are stored in small cubes on 1 of 6 drawers in the Pyxis MedStation. Each cube is electronically assigned to the resident on prescribed medication. The MedStation has different sized cubes based on the size and scale of the prescribed medication. All medication whether oral, topical or liquid medications are stored separately. There were no injectable medications on site or identified as needed for any youth during the time of the QI program review. The agency has a system in place for refrigeration of medication if needed. Following the installation of the Pyxis MedStation, the agency refrigerator was moved out of the current medication room due to lack of space. As of the date of this review, the agency reported that there was no medication that required refrigeration during the time of review.

A review of the DJJ CCC data base indicates a total of one (1) Complaint Against Staff incident that involved a youth not received medication. The agency report to the DJJ CCC indicates that the agency informed the DJJ CCC that staff involved in this incident received follow-up administrative action and re-training at the next agency-wide medication specific training.

Agency sharps are maintained in the medication room. Sharps are counted once per day on the overnight work shift on a designated sharps form. Sharps counts were reviewed from March 12, 2015 through the onsite review date September 16-17, 2015. Sharps counts are consistent and well documented. The agency disposes of razors in a dedicated wasted bio hazard wasted bin. The agency has three (3) plastic bio-hazard waste disposal bins to collect all discarded razors and needles. The bio hazard bin was not full at this time.

The agency provided over the counter (OTC) medication to clients on an as needed basis. The agency provides general OTC medication to residents during their shelter stay on an as needed basis. The agency requires that counts be conducted once per day on the overnight work shift. A review of the OTC medication inventory counts and distribution records from April 2015 to September 2015 were conducted. Over the Counter medication counts and distribution documentation is generally consistent. However, the reviewer found discrepancies in the daily documentation of these counts in the last 90 days between June 2015 and September 2015. Some exceptions were noted.

There are exceptions noted for this indicator. There are a total of five (5) residents on medication in the youth shelter. Of those 5 client files, 4 out of 5 have the proper medication alerts affixed on the outside of the client file. One (1) out of 5 is missing the blue dot affixed on the spine of the 3-ring binder, the Contact Authorization and Medication Schedule Overview Forms.

A review of the agency's policy requires daily counts of Over the Counter (OTC) Medication on the overnight work shift. Daily counting of OTC medications on certain days or weeks is inconsistent on certain weeks. Daily OTC Medication Counts documented on the agency's OTC Medication Oversight and Inventory Record did not show consistent documentation of daily counts for certain medication that includes Nite-Time, Day Time, Pepto, Jr. Tylenol.

A review of the Central Communication Center (CCC) reports indicated a total of one (1) medication error within the last six (6) months. This single incident that was reported to the CCC on April 13, 2015 related to a staff member failing to give a youth their medication on April 7, 2015.

Agency reports generated by the Pyxis Med-Station indicate that there are discrepancies that required assessment of issue and clearance from the system.

4.04 Medical/Mental Health Alert Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The CCYS agency has a section in their policy and procedure manual that addresses indicator 4.04- medical/mental health alert process. Any critical information concerning a client's medical condition, mental health status, and/or other pertinent information can be found by a color coded dot on the outside of the client's file and on the clients picture called the Hot Dot system. The corresponding Hot Dot is placed on a large white board that acts as general alert board on the wall directly across from the YCS work Station. The colored dot alert system is also documented in the logbook at shift change. The entries are reviewed and signed by the on-coming staff to indicate that they read and were provided sufficient information and instructions, as necessary, regarding the youth's medical conditions, allergies. In addition, the information would allow them to recognize and respond to the need for emergency care and treatment.

The dot classifications are as follows:

Red Dot- Major Health Issues

Blue Dot- Non-Controlled Medications

Yellow Dot- Allergies

Orange Dot- Sexual Behavior Concerns

Pink Dot- Controlled Medications

Green Dot- Mental Health and Behavioral Concerns

White Dot- Single Room Only

Suicide risk alerts and mental health alerts are in place to inform the staff of any immediate issues which may require emergency care, assessment and treatment via the log book, the shift manager and the youth care advocate on shift. A total of 4 charts (2 open and 2 closed) were reviewed. Both open files contained the appropriate hot dot stickers that were in the correct locations—on the spine of the binder and next the youth's picture. Both closed files had the hot dots next to the child's picture. Logbooks were also reviewed. At the end of the shift, staff will log all youth with color codes and current situation. The oncoming staff will read and review the logbook prior to shift and sign.

There are a total of five (5) residents on medication in the youth shelter. Of those 5 client files, 4 out of 5 have the proper medication alerts affixed on the outside of the client file. One (1) out of 5 is missing the blue dot affixed on the spine of the 3-ring binder, the Contact Authorization and Medication Schedule Overview Forms.

4.05 Episodic/Emergency Care

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The CCYS agency has a policy that includes all of the mandatory requirements for indicator 4.05-Episodic/Emergency Care—obtaining off-site emergency services, parental notification requirements, incident reporting to the CCC, development and implementation of daily log and verification of receipt of medical clearance, discharge instructions and follow-up care if needed.

All staff, with the exception of one, is trained in First Aid/CPR. The knife for life and wire cutters were located in the staff station in the safety cabinet with the first aid kit. There was also a first aid kit in the van. The keychain for the van has a seatbelt cutter and a window breaker. The logbooks are easy to read, color-coded and detailed describing the events of the shift.

The past 6 months of CCC reports were reviewed, and of the 12 reports one was a medical incident. All protocols were followed in regards to this incident with the exception of the parents being notified (Incident 4/13/15). Several internal incidents were reviewed dated back for the past six months and all coincided with the logbooks and chronological report in the youth's file. Also noted—all parents were notified in the required incidents.

Exceptions are noted for this indicator. Documentation was not found for the Parent of 1 resident that was not notified in a medication error incident.