Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Crosswinds

on 02/01/2017

CINS/FINS Rating Profile

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

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

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

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

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

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

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

Percent of indicators rated Satisfactory:80.00%
Percent of indicators rated Limited:20.00%
Percent of indicators rated Failed:0.00%

Percent of indicators rated Satisfactory:92.59%
Percent of indicators rated Limited:7.41%
Percent of indicators rated Failed:0.00%

Rating Definitions

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

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

Review Team

Members

Ashley Davies, Lead Reviewer and Consultant, Forefront LLC

Tanesha Strickland, CINS/FINS Service Manager, Stewart Marchman

Keisha Dunn-Pettis, Quality Management Manager, CHS West Palm Beach

Sherri Swann, Clinical Director, LSF Northwest

Toni DelRegno, Regional Monitor, Department of Juvenile Justice

Persons Interviewed

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

1 Case Managers
1 Program Supervisors
0 Health Care Staff

0 Maintenance Personnel
0 Food Service Personnel

2 Clinical Staff
0 Other

Documents Reviewed

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

8 # Health Records
6 # MH/SA Records
15 # Personnel Records
8 # Training Records
4 # Youth Records (Closed)
4 # Youth Records (Open)
0 # Other

Surveys

3 Youth 5 Direct Care Staff

Observations During Review

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

Comments

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

Strengths and Innovative Approaches

Rating Narrative

The agency has reached over their minimum contracted numbers at over 120% utilization. They have implemented a waiting list when needed or used other shelters.

The agency has an extremely supportive Board of Directors. The Board is comprised of numerous different high ranking officials from the local community.

The Board has organized many fundraisers for the shelter throughout the last year including the agency's biggest fundraiser each year-- the annual Duck Race. Last year, the Duck Race raised over $80,000. Outreach activities are involved in preparing for the Duck Race.

Each year in December an email goes out to all Board Members asking for donations for school supplies for the upcoming school year.

The Board also holds a Christmas party complete with gifts, food, and decorations for the kids in the shelter, transitional living, and counseling programs.

The Board has been able to get two ping pong tables donated to the shelter.

A current Board Member has been working on grant funding and secured a grant for a new air conditioning unit for the shelter.

Standard 1: Management Accountability

Overview

Narrative

Crosswinds operates both the Robert E. Lehton Children's Shelter (residential) and non-residential CINS/FINS Program in Brevard County. The CINS/FINS program has a management team that is comprised of a Chief Operating Officer (COO), a Counseling Program Coordinator, and a Shelter Manager. The COO oversees the activities of both the residential and the non-residential CINS/FINS Program. Program staff includes: five Counselors (3 Non-Residential and 2 Residential), one Lead Youth Care worker, and eighteen Youth Care Workers.

Crosswinds Youth Services participates with the National Safe Place Program, a network of voluntary community sites where youth in need of help can go for safe refuge and monitors more than 60 Safe Place sites throughout Brevard County. Outreach services such as making presentations to interested parties or groups, attending community and provider meetings, participating in community events, and distributing informational cards and brochures are conducted by all Crosswinds staff.

The program has an Annual Training Plan for all staff and orientation training is provided to new hires. Employees receive ongoing training from the program's local providers and the Florida Network. Each employee has a separate training file that contains a training plan and supporting documentation for training received.

Crosswinds maintains valuable interagency agreements with several agencies that ensure a continuum of services for the youth and families. The program has a strong outreach component, including a Street Outreach Program, with participation of all program staff and emphasis on designated target areas. The Department of Children and Families has licensed Crosswinds Youth Shelter as a Residential Child Caring Agency for 28 beds.

1.01 Background Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a background screening policy in place that was reviewed in September 2016 and approved October 2016.

The policy states: "All applicants, including subcontractors and volunteers, will be required to undergo background screening. No applicant may be hired, nor may the services of any volunteer, intern, subcontractor staff or service provider will be utilized until the background screening has been completed." A review of the policy indicates the background screening conducted on each potential staff member, volunteer, intern, subcontracted staff or other provider staff, includes screening by the Background Screening Unit of the Inspector General's Office, screening through the Brevard County Sheriff's Department and the Florida Department of Motor Vehicles, as well as an illicit drug urinalysis screening to be rated eligible for an offer of employment. The policy further addresses the eligibility for employment/access to youth based on the results of the background screening and the exemption process, a five-year rescreening process and the annual completion of the Affidavit of Compliance with Good Moral Character Standards by January 31st of each year.

As required by law in Chapter 985.407, Florida Statutes and the Department of Juvenile Justice policies, a Level 2 background screening, which must include a complete criminal history check including fingerprinting is completed on each applicant for hire, volunteerism and/or internship prior to having access to the youth in the programs the agency serves. The agency requires all prospective, new employees, volunteers, and interns to complete several forms in order to conduct the background screening including the Criminal History and Acknowledgement Form, (IG/BSU-003) the Request for Live Scan Screening Form, the Request for Local Law Enforcement Records Check, and the Consent for Motor Vehicle Check. Additionally, the screening requires the provision of a copy of the applicant's driver's

license, social security card, a fingerprint card completed by the Broward County Sheriff's Office and returned to the agency, at least four letters of reference and payment of a fee for the screening. All this information is then submitted to various agencies for the completion of the screening and the results, upon receipt are reviewed.

If an applicant rates eligible subsequent to the screenings and a urinalysis drug test, the applicant may be hired or (in the case of a volunteer or intern) permitted access to the youth served by the agency. If the applicant rates ineligible after the background screening is completed, the applicant is not hired. In specific situations, the applicant does have a process where an exemption can be sought for an applicant rated ineligible due to some criminal offenses.

The program has hired nine new employees since the last compliance review conducted in February 2016. The background screenings were reviewed for each of the nine new employees. Each of the reviewed screenings were completed prior to the date of hire. All nine employees were rated eligible for hire, so no exemptions were required.

The program has recruited three interns. They have provided counseling services during the past year, two of whom were hired since the last annual compliance review. A review of background screenings for these two individuals verifies screening was completed prior to the intern's access to youth in the program. According to the CEO of the agency, volunteer services that would require background screening have not been utilized since the previous compliance review conducted in February 2016.

Three employees were applicable for a five-year background rescreening. A review of the rescreening documentation verified the re-screenings were submitted prior to the five-year anniversary date.

Documentation was reviewed confirming the completion/submission of the Annual Affidavit of Compliance with Level 2 Screening Standards to the Background Screening Unit on January 27, 2017, prior to the deadline date of January 31, 2017 as required by Department of Juvenile Justice Policy.

There were no exceptions noted for this indicator.

1.02 Provision of an Abuse Free Environment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has written policies in place ensuring the youth served by the agency experiences an environment in which they feel safe, secure, and free from threats, harassment, and/or any form of abuse. The policies were reviewed and approved in October 2016.

The policies provide the youth avenues to report any incidents of abuse or denial of basic rights. These polices include a staff Code of Ethics, the accessibility of the Florida Abuse Hotline, to the staff and to the youth, to report any kind of abuse, neglect, or abandonment of a youth, the implementation of a grievance system to ensure youth in the program are able to grieve actions of staff and conditions or circumstances related to the violation or denial of basic rights and the requirement management responds immediately to address any incidents involving any type of abuse, verbal intimidation of youth, the use of profanity by staff in the presence of youth, as well as, any instance of the excessive use of force.

All staff are required as part of the hiring process to review and sign a Code of Ethics form documenting their awareness of the Code and the behavioral expectations of staff during their course of employment. This signed code is maintained in the staff's personnel file.

The program provides staff training regarding the reporting of any suspected abuse, neglect, or abandonment of the youth occurring either outside of the agency property or on-site. The agency ensures all staff have access to the telephone number to the Florida Abuse Hotline with the provision of a training

pamphlet A Professional's Guide to Child Abuse and Neglect in Florida provided upon hiring and via postings on the facility walls. A copy of the reviewed pamphlet is signed by the staff verifying they have reviewed the information and maintained in the staff's personnel file. Additional staff training regarding child abuse is provided to the staff on SkillPro, the Department of Juvenile Justice on-line personnel training site, which all staff are required to complete within the first year of employment.

The program also ensures every youth who accesses their services are aware of their right to contact the Abuse Hotline by reviewing a Client Rights and Responsibilities Form at intake which the youth signs to verify his/her review of the form. The youth are also provided the telephone number of the Florida Abuse Hotline on this form when issued a copy of the completed Client Rights and Responsibilities Form and on the many postings strategically placed in the youth living areas.

The program provides a grievance procedure for the youth to document their perspective of any violation of their basic rights by the shelter staff and to present their concern(s) to management. The procedure involves the completion of grievance form and the submission of the completed form into a locked box ensuring only specific supervisory staff have access to the completed grievance forms. Management staff then meets with the youth to address their grievance. There is an appeal process if the youth is not satisfied with the supervisor's response to the grievance. The youth rights and the client grievance process is clearly outlined on the Client Rights and Responsibilities Form which is reviewed with each youth upon admission and the Resident's Manual is provided to each youth upon admission. All youth grievances and findings are maintained in a specific Grievance Binder for the period of one year.

Procedures are also in place for management to investigate and appropriately address all incidents of abuse, excessive use of force, verbal intimidation, and/or the use of profanity by staff in the presence of the youth. These procedures include internal investigations and contacting of law enforcement, as deemed appropriate, to initiate an external investigation of staff conduct within the workplace.

The program has a Code of Ethics requiring staff to maintain high standards of personal conduct while an employee of the agency. All staff are required to sign an Affidavit of Compliance with the Code of Ethics as evidenced by a review of a random sample of twelve reviewed personnel files, all of which included a signed Code of Ethics form. A review of the Code of Ethics indicated several behavioral expectations of staff are clearly outlined, however, specific language specifying the staff will not engage in physical or sexual abuse of a youth, or use threats or verbal intimidation towards a youth was noted to be absent from the Code of Ethics.

The Chief Operating Officer CEO of Crosswinds Youth Services provided documentation clearly stating these behaviors are in violation of agency policies, however, she conceded they were not specified on the Code of Ethics form signed by all staff at the time of hire. Subsequently, during this annual compliance review, the Code of Ethics form was revised to include the missing language related to physical abuse, threats and intimidation of youth. Sexual abuse was not added to the Code of Ethics as it is addressed in the Sexual Harassment Policy which is also reviewed and signed by the staff at the time of hire. The Chief Operating Officer indicated she will have all staff sign the revised Code of Ethics as soon as possible.

Twelve of twelve reviewed staff personnel records documented staff are trained regarding abuse reporting using a pamphlet entitled Child Abuse and Neglect in Florida, A Guide for Professionals upon hire. Additionally, a review of six pre-service training files indicated each of the new staff had completed additional training regarding child abuse reporting on SkillPro as specified in agency policy.

The Program practice is to document and record all incidents when child abuse was reported and to maintain a log book containing every report. Reviewer reviewed the log book which contained reports dating back to July 2016 to the present day and noted there were eight abuse call reports including one of which was not dated. None of the eight reviewed abuse call reports indicated a staff person was the alleged perpetrator of abuse.

Reviewer observed the program posts the Florida Abuse Hotline number in the several (eight) of the youth living areas to include each dormitory, the kitchen, the game room, the special privilege room, and the common area. Also reviewed a copy of the Resident Manual and one Client Rights and Responsibilities Form signed by a youth to verify the agency seeks to inform/educate the youth regarding their basic rights

and how/when to call the Florida Abuse Hotline.

The program has a process in place for youth to share their concerns with staff. Observed a locked box in the main youth living area readily accessible to youth where youth can submit their grievance/feedback about the program. Just above the box, also readily accessible to the youth are blank grievance forms to be completed when applicable.

Program practice then requires the shelter director to retrieve, review, and address youth grievances. There were nine grievances submitted over the past six months. Five of the grievances were complaints against staff, three were related to youth conflicts with other youth and one related to a youth's perception of unfair practice. Each grievance was addressed in a timely manner and seven of the grievances were resolved satisfactorily after consult with the shelter director or his designee. Two of the grievances were not addressed with the youth due to their discharge before the conference could occur.

During this review, administrative staff advised there have been no incidents related to the abuse of youth by agency staff requiring the attention of management including physical or psychological abuse, or other staff misconduct including threats or intimidation of youth, the use of excessive force, or staff use of profanity in the presence of youth. Congruently, a review of all reports to the Central Communications Center in the past six months indicates no such incidents.

There were no exceptions noted for this indicator.

1.03 Incident Reporting

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There are written policies in place which articulate a reporting process for incidents that may pose a risk or liability to the organization or its clients. The policies were reviewed and approved in October 2016.

The process for completing internal and external incident reports is designed to assist in the identification of problems and to document trends and corrective actions taken to minimize future risk. Additionally, the completion of these incident reports is to assure accurate information is disseminated to appropriate parties and to track and document subsequent actions related to the incidents.

The policy defines an internal incident as "any unusual situation that disrupts or has the potential to disrupt the normal operations of the facility or program and does not meet the Department of Juvenile Justices' criteria for a reportable incident" and outlines the procedure for documenting and submitting an internal incident report. The policy further states the provider complies with the DJJ policy 8000 "Central Communications Center" (CCC) on incident reporting. The CCC policy states the CCC will be notified as soon as possible, but no longer than two hours after reportable incident occurs, or within two hours of the program learning of the incident. This policy also lists all CCC reportable incident types.

All staff who have direct knowledge of an incident that constitutes a risk to the organization and/or clients must complete an Incident Report and, if applicable, must report the incident within two hours to the CCC. Follow-up will be provided to the CCC assigned staff with requested information until they indicate the case is being recommended for closure. All incidents are to be documented in the shelter log book, as well as, on specified incident forms. All incident forms are to be reviewed and signed by the Shelter Director and the Chief Operating Officer or their designee. All incident reports are maintained in binders kept in the Finance Office.

The program maintains binders filled with CCC reportable and non-reportable incident reports for the past year. The program's internal incident report binder was reviewed for the month of October 2016 and select

dates when CCC reports were completed to verify the incident report was documented. A review of incident reports verified the program completed an incident report on each reported CCC incident. Also, reviewed were fifteen randomly selected incident reports, seven of which were non-CCC reportable incidents. Each of the reviewed completed incident reports was signed by three members of the senior staff. Also, this reviewer reviewed the program's form for internal incident reports, critical incidents and reports made to the Central Communications Center (CCC).

Three program logbooks documenting daily events over the past six months were also reviewed. The program documented eight reportable incidents to the Central Communications Center (CCC) during the past six months. Three of these reports were medical incidents, two of which related to youth intoxication and the other, a wrist injury. All three of these youth were taken to a hospital for evaluation. One reported CCC incident documented the battery of a youth on another youth resulting in CINS/FINS youth being charged and transported out of the program by law enforcement and the non-CINS/FINS youth being taken to the hospital for assessment. Another CCC incident documented sexual relations occurred between two youth in the shelter yard. The remaining three of eight CCC reports related to program disruption incidents, two of which involved youth possession of contraband and one of which related to program evacuation due to an approaching hurricane. A review of documentation indicates five of the eight incidents were reported to the CCC within the required time frame.

A review of shelter log books indicates four of the eight CCC reports were documented in the log books per shelter policy. There were no instances when the CCC requested the program complete additional tasks or documentation. However, there was one applicable case were additional tasks were deemed appropriate by the program, specifically, a management review for improper supervision. The program completed task substantiating the improper supervision and then noted failure to report the incident to the CCC within two hours. Subsequently, the report was made to the CCC. The program then complied with the CCC request pursuant to DJJ Policy 2020 to provide a written response to the finalized CCC report regarding the incident.

Exceptions:

Three of eight reportable CCC incidents, (9/19/2016, 9/26/2016, and 10/14/2016) were not reported in the required two-hour time frame. One incident was reported one hour and six minutes late, another incident, one hour and nine minutes late, and the other incident, involving sexual contact between two youth, was not reported until two days later.

Four of eight CCC reportable incidents were not mentioned in the program logbook on the date/time of the incident.

Furthermore, all of the entries in the log books lacked detail stating only, for example, "Youth transported to hospital" without documenting what occurred to cause injury to the youth or why the decision was made to visit the emergency room.

1.04 Training Requirements

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There is a written policy which clearly states the high priority the agency places on staff training and development to ensure staff are properly trained for the duties they perform. The policies were reviewed and approved in October 2016.

The policy outlines a Training Plan developed for each staff which includes documentation of the staff member's training history and tracks the trainings that have taken place. Each individual training plan is to be reviewed by the Chief Operating Office on an annual basis to ensure compliance with the training plan to identify any deficiencies in training before the plan is submitted to the Florida Network Office to facilitate the verification of compliance with training requirements. This policy also lists required trainings and time

frames for completion of trainings for new employees and ongoing in-service requirements for longer term employees consistent with DJJ standards. There is also a policy regarding the maintenance of employee training records placing responsibility for the training records on the Shelter Manager. Specific forms are attached to the policy to be used to document any training not completed in the on-line DJJ SkillPro training system.

Upon hiring, the Shelter Manager develops an initial training plan with the new staff membera and schedules appropriate trainings to ensure designated time frames for the completion of the training are able to be met. The training plans are designed to specify which trainings need to be completed to ensure compliance with the DJJ requirements, as well as, other funding sources. Each staff signs the training plan acknowledging their responsibility for completion of the trainings. Staff participation in all trainings are documented on sign-in sheets for verification and the dates of training completion are documented on the training plan.

All direct care staff are to complete eighty hours of training in their first year of employment including hours that are to be completed within the first 120 days of employment in such areas as suicide prevention, CPR/First Aid, ethics and signs and symptoms of mental health and/or substance abuse disorders/emergencies. Training plans are then updated annually to ensure compliance with required training updates.

Reviewed were the training records of five new staff (hired in the past calendar year) and three established staff. This evaluater observed each file contained a current training plan signed by the staff member and the shelter manager. Each reviewed training record was well-organized, up-to-date, and contained sign-in sheets and other documents verifying a training was attended/completed. There were also certificates of completion for some applicable trainings in the file, in particular, certification in CPR and First Aid. All reviewed training files documented timely completion of most of the required trainings and compliance with the training plans with only the few exceptions stated below.

Each of the new five new staff were on target to complete and/or exceed the required eighty hours of training by their first year anniversary date and all applicable staff (three of the five reviewed records) had completed the trainings required during the initial 120 days of employment. Two reviewed staff still had time to complete the 120 day requirements. All three reviewed records from established staff indicate the three staff had exceeded the required twenty-four hours of annual training in the past year. Furthermore, a review of the training records verifies training opportunities are provided throughout the year for new and established staff.

There were no non-licensed clinical staff trained to complete suicide risk assessments under the supervision of a licensed clinician during this review period.

Exceptions:

The two files reflecting staff who were hired after July 1, 2016 when the updated policy regarding required trainings to be completed within one hundred twenty days of hire were found to be lacking the required training in Understanding Youth/Adolescent Development.

One training file indicates the staff has not completed a refresher training in crisis intervention since her first training in September 2013, failing to meet the requirement of attending refresher training every two years.

Two of three files reviewed for in-service training document failure of the staff member to complete the PREA re-training as required every two years. Both of these files would have needed to have a PREA refresher training in September 2016 to be in compliance. Rather, they are more than four months late.

1.05 Analyzing and Reporting Information

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The provider has policies in place to review and analyze pertinent information regarding program performance and quality of services and to then utilize this information to plan for improvements in service delivery and efficacy. The policies were reviewed and approved in October 2016.

Information is gathered through a variety of ways and from various individuals (including staff, parents, and the youth who are served) and analyzed and put into report form. The reports are then conveyed to the program staff, the management staff, and the Board of Directors for discussion and decision-making.

The program has an articulated process of gathering information and maintaining data including raw data and statistical data. All specific information is maintained as confidential per Florida statute. Data collection is completed through the review of incident reports, data bases (including NetMIS) accumulating demographic information, various program-developed checklists, youth/parent completed Service Satisfaction Questionnaires and 180-Day Follow-up forms. Additionally, staff input obtained during staff meetings is also documented and reviewed. All this information is then analyzed and various monthly, quarterly and the annual report are documented and disbursed, to the management staff and the Board of Directors.

The program has gathers and reports the following information to generate a monthly report of relevant program data including incidents, accidents and grievances. The CEO reviews the report, as well as the NETMIS data reports. On a quarterly basis, the Chief Operating Officer compiles a report of incidents accidents and grievances. Case record peer reviews are also conducted quarterly using a standard form and data is compiled and summarized in a report. These reports, along with NETMIS data reports, funder and licensing reports and reports from Human Resources are all reviewed by the program directors and Supervisors Team at their bi-monthly meeting. An Annual Report is developed for each program aggregating specific data to highlight specific activities, trends, successes and recommendations, achievement of goals, consumer satisfaction data and client outcomes.

The program developed and maintains a Performance and Quality Improvement (PQI) Plan that includes short-term plans, internal quarterly program reviews, incident report reviews, case record reviews, outcome measurements, information regarding consumer satisfaction, plans for correction actions and a focus on organizational planning. Progress on the PQI is assessed semi-annually with the program staff and stakeholders.

The program provided a sample of aggregate data, summarized in detailed graphs for review. Also reviewed was a copy of the last quarterly report and the last annual report. The program also provided a report detailing an internal quality improvement compliance review. A review of this compliance report substantiated the program staff are working to identify program weaknesses and areas of improvement and then developing strategies to enhance performance in these areas. A review of documentation provided by the program verifies the consistent collection and analysis of various data to identify program patterns and trends, program strengths and weaknesses and to enhance decision making to maintain and improve the quality of services provided by the program.

Reviewed documentation indicates reports are completed monthly regarding a variety of data including, but not limited to the daily census, admissions, length of stay, the provision of family counseling services, program incidents, accidents and grievances, as well as, youth and family satisfaction survey results. Monthly review of NetMIS data reports are also completed. Observed quarterly analysis reports are completed regarding case file reviews, logbooks, and other documents as part of the program's comprehensive performance and quality improvement plan. Each quarterly report focuses on identifying where improvement is needed to enhance the provision of services. A review of a CINS annual data analysis report indicated the collection of statistics on almost every aspect of program operations. Additionally, the report documented trends and action items addressed for clarification of issues and goal setting for positive change.

The provider agency has a process in place clearly articulated in the reviewed PQI report to communicate with all staff regarding program operations and performance and to provide feedback to consumers. There is a definitive time schedule documented in the reviewed PQI report and the schedule specifies how the information is distributed (mail, e-mail, personal delivery, and/or agency-wide meetings). Frequent telephone conferences for administrators and supervisors also serve as a forum for information exchange.

Exception:

The few staff meeting minutes available for review (August 10, 2016, November 10, 2016, and December 2, 2016) do not document a formal process whereby administrative staff seeks to inform non-management staff regarding data analysis results addressing program strengths and weaknesses, effectiveness, trends, or quality improvement initiatives that have been implemented to enhance program performance.

1.06 Client Transportation

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

Crosswinds Youth Services has a program policy in regards to client transportation. It was last revised in March 2016 and reviewed in October 2016 by the COO. The policy requires that staff be approved to transport clients by their Program Coordinator, Shelter Manager, Director of Counseling Services, or Chief Operating Officer. There is also language that prohibits transporting a youth without an approved third party. The policy further details the expectations should a third party not be available. The Manager or designee will consider the client's history, evaluations and recent behavior prior to a single transport. Consent is documented in the logbook.

The following guidelines are listed as it relates to transportation of clients:

1. **Have a valid Florida Class E Safe Driver's license**
2. **The vehicle has a valid State of Florida registration**
3. **Have a valid insurance coverage as required by the State of Florida**
4. **Have reliable and properly maintained transportation**
5. **Ensure passengers are utilizing age appropriate vehicle passenger restraint systems**
6. **Are covered under Crosswinds' insurance policy.**

Staff are required to document each trip in the van log. Though not included in the policy, the Shelter Manager advised that the expectation is that staff document in the log book when they have a single client transport as well as obtaining management pre-approval and remaining on the phone until return. This communication was documented in the program's November 10, 2016 meeting. Agenda and minutes were provided by the Shelter Manager during this review.

In reviewing both the van log and log book, it was found that documentation is not occurring if staff are leaving the shelter alone to pick up a youth; including known single client transports. There were fourteen instances that documented a single client transport and there was no documentation of approval or notification. The Shelter Manager advised that the need to seek approval for single client transports has been repeatedly emphasized in supervision and meetings.

The shelter maintains van log that document destination, driver, start time, end time, number of passengers, and ending mileage. A review of the van logs revealed the logs are not always filled out in their entirety and some of the above information is missing.

All staff transporting youth had a valid driver's license.

Exceptions:

The shelter had no process in place for approval or notification of single client transports.

Van logs were not consistently completed in their entirety.

1.07 Outreach Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Crosswinds Public Awareness and Targeted Outreach Services policy was last revised December 2015 and reviewed by the COO in October 2016. The policy details their commitment to providing quality, innovative programs to meet the needs of youth and families. Outreach efforts include but are not limited to interactions with the public, phone calls, written correspondence and email, written and verbal requests for information, representation at community meetings, case management, and attendance at conferences and workshops, as well as formal and/or planned outreach activities.

Crosswinds also has a written Outreach Plan dated March 2014 that includes public awareness and outreach activities targeting youth who are most highly likely to become delinquent or have issues with substance abuse or other negative behaviors.

The COO designates a lead staff member to attend local DJJ board and council meetings and local circuit level meetings. This person advocates for the effective use of CINS/FINS services and updates agency leadership on meeting activities. This individual will also obtain meeting minutes for the file and obtain a copy of attendance at meetings.

The COO provided documentation from January 2016-November 2016. The program uses several means of communicating about the program: newsletters, local paper, agency website, and Facebook. Many fundraisers are also conducted including: Clue at the Zoo which raised $38,000 and their biggest fundraiser the annual Duck Race. This is a major fundraiser for the program. During the 18th annual race they were able to raise $80,000.

Staff regularly attend DJJ Advisory Board meetings and minutes are maintained in a binder.

There were no exceptions noted for this indicator.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

Crosswinds is contracted to provide both shelter and non-residential services for youth and their families in Brevard County. The counseling/case management program is staffed by a Program Coordinator, two Residential Counselors, and three Non-Residential Counselors. The Counselors' offices are located in an Administrative wing in the Shelter building.

The program provides centralized intake and screening twenty-four hours per day, seven days per week, and each day of the year. Trained staff are available at each program site to determine the needs of the family and youth. Upon referral, a screening for eligibility is conducted and the screening is the initiation of the assessment process. Information regarding the youths' presenting problems, living situation, etc. is collected. Upon intake into either program (residential shelter or non-residential services), a more thorough assessment is completed. After all assessments are completed, the assigned counselor develops a case plan with the family during the initial family session. If the assessment indicates the need for a referral to a more intensive or specialized service such as substance abuse or mental health treatment, the counselor makes the necessary referral for service. After the development of the case plan, the counselor works with the family to implement the plan. Counselors document progress towards completion of the service plan goals. Crosswinds is also licensed through DCF to provide Substance Abuse Prevention Level I and Substance Abuse Intervention services.

Crosswinds 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 and procedure for screening and intake includes all the required elements in this policy, including the requirement for youth, parents/guardians to receive written information at intake. This policy was last updated in October 2014.

The file documentation reflects the policy for this indicator. The specific forms used for this purpose are the Florida Network Screening Form to determine the date of referral and issues of concerns; the CINS/FINS Shelter Voluntary Placement Agreement to determine the parent has received the brochure for parents, that also describes possible actions through CINS/FINS services; and the Client Right & Responsibilities Form that discusses service options, grievance procedures, as well as client rights and responsibilities.

There were four non-residential files reviewed (two open and two closed) and four residential files reviewed (two open and two closed).

All the files contained the required elements of the indicator. Also, the intake forms have been designed to meet the requirements.

Exception:

In one residential file, the box to acknowledge receipt of brochure was not checked.

2.02 Needs Assessment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The policy and procedure for needs assessments includes all the required elements and was last updated in August 2014. Additionally, the policy indicates that completed assessments must be reviewed and signed by the Shelter Manager or designee within seven calendar days of the completion of the assessment.

There were four non-residential files reviewed (two open and two closed) and four residential files reviewed (two open and two closed).

All eight of the files reviewed had the Needs Assessment completed in two to three face to face contacts. In several instances they were completed in one session. All assessments were completed by master's level clinicians and all but one was signed off by a licensed supervisor. The one missing signature was signed during the review and had numerous interactions and Suicide Assessments by the supervisor. All of the files were identified as low risk for suicide, including the one on sight & sound at intake. This youth was removed from sight & sound prior to the Needs Assessment being completed and was not assessed as demonstrating current ideation or risk.

The assessments included input from the client and parent, when available, and addressed a broad range of psychosocial functioning.

In addition to the Needs Assessment, the shelter files also contained Anger/Violence Evaluation and Alcohol & Drug Involvement Scales. According to the Clinical Supervisor, all shelter clients get both of these tools at intake. For non-residential services, the tools are used as needed.

These tools are used to aid in the Needs Assessment process and to give the staff a heads up regarding the youth's disposition on these topics, in reference to what behaviors staff may expect in shelter.

There were no exceptions noted for this indicator.

2.03 Case/Service Plan

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The policy covers service planning and all of the required elements. Additionally, it includes a detailed list of things to consider prior to making a referral, which affect the likeliness of the family following through with the referral. The policy also includes consideration of rationale for approaches, timing of use, and the impact on the individual's right to self-determination. This policy was last completed in August of 2014.

There were four non-residential files reviewed (two open and two closed) and four residential files reviewed (two open and two closed).

All eight files reviewed were individualized and prioritized according to the Needs Assessment. The Service Plans included service type, frequency, and location, as well as the persons responsible and target dates. All eight files included the signatures of the youth, parent, counselor, and supervisor. Five of the files included timely progress updates with all required signatures. The other three files did not require an update due to timing. Seven of the eight files reviewed were completed within the required seven days from the completion of the Needs Assessment. One file was four days late.

Exceptions:

None of the eight files reviewed contained the date the service plan was initiated. According to the Clinical Supervisor, the date the Service Plan is signed is the date it was initiated.

None of the four closed files included actual completion dates.

2.04 Case Management and Service Delivery

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The policy and procedure for case management and service delivery covers all the required elements and was last updated in August 2014. In addition to the required elements, the policy emphasizes the details of the efforts to coordinate services on behalf of youth including the following: information gathering, supportive linking, advocating, coordination, monitoring of services, case review, and termination.

There were four non-residential files reviewed (two open and two closed) and four residential files reviewed (two open and two closed).

All eight files reviewed, indicated a counselor was assigned and coordination of service plan implementation was conducted with the youth and family. Only one file contained a referral to the Case Staffing Committee. All records reviewed showed documentation in the chronological notes of the Counselors' efforts to engage families. The notes included phone calls, home visits, school visits, and office visits.

All four closed files reviewed contained the case termination notes, which include recommendation for aftercare services in addition to summary details. Two files required follow-ups, and while they weren't in the file initially, they were found in the "waiting to be filed" stack. A review of the Florida Network Report Card for Crosswinds shows their most recent rating of 98% for 30-day follow-up reviews and 100% for 60-day follow-up reviews.

There were no exceptions noted for this indicator.

2.05 Counseling Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The policy and procedure for counseling services aligns with all the required elements for Shelter and Non-Residential cases. The policy details the program's procedure for selecting topics and capturing each youth's performance on a group member's performance sheet. At the end of the week, the individual performance sheets are to be placed in the resident's case file.

The policy also specifically details the procedure for the counseling services to include the following requirements: case files reflect coordination between presenting problems and assessment, case planning, case management, and follow-up. This policy was last updated in August 2014.

There were four non-residential files reviewed (two open and two closed) and four residential files reviewed (two open and two closed).

All eight files reviewed showed efforts to engage the families in services in accordance with their case plans. The files reflected individual and family chronological notes. The youth's presenting problems were consistently addressed in the Needs Assessments, Service Plans, and Service Plan reviews. Chronological notes indicated client activities.

The Clinical Supervisors for residential and non-residential services explained that they provide weekly supervision for their staff.

There were ten random weeks in the last six months reviewed to determine if groups were being done five

times per week. In one week, only two groups were documented; in another week, three groups were documented; for five weeks four groups were documented; and for three weeks, five groups were documented.

Exception:

Group note documentation reviewed for ten random weeks revealed seven of the weeks did not document groups being conducted at least five days.

2.06 Adjudication/Petitiion Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The policy and procedure for the adjudication/petition process includes all the required elements and further details, per the Florida Statute, the members that shall be included on the Case Staffing Committee. The policy also notes other representatives that may be included on the Case Staffing Committee. This policy was last updated in October 2014.

There were three files that went to Case Staffing. In all three cases, the counselor was the person initiating the case staffing. In all three cases the family and the committee was notified of the Case Staffing within the five day time-frame. The committee included the required members from the local school district and the DJJ representative or CINS/FINS provider. The standing committee also includes representatives from the Community Mental Health and Substance Abuse Agencies.

As a result of the Case Staffings, new/revised service plans were created and within the seven day time-frame, the families received a written report from the meeting that included the recommendations from the committee and reasons for them.

None of the cases went to the judicial intervention level. In all three cases the counselor completed a summary prior to the reviews. Each file showed consistent documentation supporting the CINS/FINS Case Staffing Process.

There were no exceptions noted for this indicator.

2.07 Youth Records

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The policy covering youth records denotes adherence to confidentiality laws and specifically addresses the manner in which documentation is completed and the expectation for completion. This policy was last updated in December 2016.

All eight files reviewed were marked confidential and were maintained in a neat and orderly manner. Each section is labeled with a sheet indicating what is in the section. The file room and file cabinets were marked "confidential" and the lock boxes used for transporting files was also marked "confidential".

There were no exceptions noted for this indicator.

Standard 3: Shelter Care

Overview

Rating Narrative

Crosswinds operates its residential program, the Robert E. Lehton Children's Shelter, which was built in 2002 and is located in Cocoa, Florida. The shelter provides emergency residential program, 24 hours a day, 7 days a week for youth under the age of 18 years. The facility is licensed by the Department of Children and Families (DCF) for twenty-eight beds and provides residential services to youth in the Department of Juvenile Justice (DJJ) CIN/FINS program and youth from DCF. Residents can utilize a wide range of support services. These include individual and group counseling, life and social skills training, educational and cultural activities, recreational and community service, transportation and they are able to link up to all community programs. At the time of the quality review, the shelter was providing services to seven CINS/FINS youth.

The shelter has large day room, dining room, kitchen, separate male and female living area and a laundry area. There is a privilege room located in the loft area that is used for indoor recreational activities, watching television, playing board and video games. Youth must earn a minimum of 10,000 points to use this room. The sleeping rooms each house two youth. Each youth has an individual bed, bed coverings, and pillows.

The shelter has a fully functional kitchen. The shelter does have a current operating permit with the County Health Department conducting inspections. The youth are screened at intake for special dietary needs and this information is posted in the kitchen.

The youth care workers are responsible for conducting admissions and related services for the youth, including the program orientation and facility tour and for conducting the day-to-day activities. The youth admitted to the program are screened using the Florida Network's NetMis Youth Screening Form and Florida Network Youth and Family Services CINS/FINS Intake Form.

3.01 Shelter Envonment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place for shelter environment that was last reviewed in October 2016. The program provides daily programming to engage youth in activities related to health, social, emotional, and physical development.

Outside grounds were well-kept and there were no visual safety hazards. All shelter furniture was in good condition. All fire and safety inspections were current. There was some graffiti on furniture and a plumbing issue on the female side of shelter. However, it was resolved by the Shelter Manager before the end of the business day. There was no contraband found in any of the youth's rooms. All daily shelter activities were posted and visible for all to see. The youth are engaged in meaningful structured activities. At least one hour of physical activity is provided. All surveillance cameras were operable and the playback of videos was easy to view. There were numerous laminated physical layouts of the facility posted. Also, there were numerous laminated Abuse Hotline signs located throughout the facility.

There were no exceptions noted for this indicator.

3.02 Program Orientation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place for program orientation that was last reviewed in October 2016. All youth

are given an opportunity to be informed of the program's expectations at orientation or within twenty-four hours of orientation. Program staff review the program's philosophy, goals, and expectations with the youth.

Each component of orientation must be documented by staff. All staff and youth involved in orientation should provide a signature of acknowledgement of orientation and this shall kept in the youth's individual record.

There were three residential files reviewed. All files documented staff reviewed program rules and behavior management strategies with the youth at intake. All youth were provided with a shelter handbook, explained dress code, and were given a tour of the shelter identifying emergency exits.

There were no exceptions noted for this indicator.

3.03 Youth Room Assignment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place specifically for youth room assignment that was last reviewed in October 2016. The program uses a classification system to ensure the most appropriate sleeping room assignment to protect all youth in shelter. Alerts are entered in the program's alert system at the youth's admission including the youth's special needs, suicide risk, mental health, substance abuse, physical health, and security factors.

At the time of admission to the shelter the youth are interviewed by the shelter staff to determine the most appropriate sleeping arrangements. An alert is entered into the shelter's alert system when a youth is admitted with risks factors that include: suicidal issues, mental health issues, substance abuse, health problems, and security risks. The program utilizes the CINS/FINS Intake Form to collect information that determines a youth room assigned and alerts.

There were three youth files reviewed for a completed CINS/FINS Intake Form, room assignment, and alerts. All three had completed the CINS/FINS Intake forms. All three had room assignments listed. Any applicable alerts were entered into the shelter's alert system.

There were no exceptions noted for this indicator.

3.04 Log Books

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There is a log book policy in place that was last reviewed in October 2016. Logbooks document routine daily activities, events, and incidents in the program. A review of the logbook should be completed by direct care staff and supervisory staff.

Important information is highlighted in different colors outlined in the policy and placed on a label in the front of the log book. Blue is for intakes, pink is for discharges, yellow is for medical, green is for self-release, orange is for important information, and lavender is for transitional living. There is evidence of date, time, staff names, youth names, and information on activities. The staff signs every entry and they are legibly written. There is evidence of the Shelter Manager reviewing the log book weekly.

Exceptions:

There were instances of errors in the log book not crossed out with a single line with the word “void” but were instead scribbled out.

There was inconsistent documentation that the direct care staff were reviewing the logbook for the previous two shifts.

3.05 Behavior Management Strategies

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The Behavior Management Strategies policy was last reviewed in October 2016. The program has a behavior management system that is designed to promote positive youth behavior, accountability, and social responsibility. The program has a written description of the behavioral management system that includes positive incentives to encourage participation.

Staff uses a point system that promotes positive youth behavior from the youth that are in shelter. Daily, all the youth participate in group to evaluate their day and their point system card. If youth exhibit maladaptive behaviors, they are given an opportunity to redeem back points and privileges prior to the end of the day. All consequences appear to be fair according to the behavior management system. This writer interviewed a staff member and a youth that were knowledgeable of the behavior management system.

There were no exceptions noted for this indicator.

3.06 Staffing and Youth Supervision

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Crosswinds’ Staffing and Youth Supervision policy was last revised in August 2014 and reviewed by the COO in October 2016. The policy meets the staff to youth ratio requirements: 1 to 6 during awake hours and 1 to 12 during sleep hours.

Per policy, there is always one staff on duty of the same gender as the youth. A minimum of one staff must be trained in First Aid/CPR. During an interview with the Shelter Manager, it was shared that the schedule is set up to include leads to ensure there is appropriate coverage at all times. A review of a sample of staff schedules revealed staffing ratios were consistently being met.

The video surveillance system was reviewed and two days were randomly selected to review the staffing ratios as well as ensure overnight bed checks were being done consistently, and were in line with documentation in the log book. The review confirmed that overnight shifts consistently maintained two staff members and that at least one staff is of the same gender as the youth. Bed checks are conducted timely and consistently-- every fifteen minutes.

In addition, beginning in February 2016 to date, the COO has provided an additional checks and balances to this system by performing bi-weekly reviews of cameras. Areas of non-compliance are immediately addressed and feedback is provided to staff/management. All reviews are documented in a log book maintained by the COO.

Exception:

Agency policy states a minimum of one staff must be trained in First Aid/CPR. However, agency's practice is all staff are CPR and First Aid certified. Change in policy would align with Florida Network requirements.

3.07 Special Populations

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Crosswinds' policy regarding serving staff secure youth was last revised in September 2016 and reviewed by the COO in October 2016. Services are designed to serve court ordered youth who are experiencing serious problems and/or have a history of family issues that have not been resolved. Staff secure services are court ordered for up to 90 days with a possible three day extension.

Crosswinds' policy regarding serving Domestic Minor Sex Trafficking was created in September 2016 and reviewed by the COO in October 2016 and is in line with Standard 3.07. There is language that staff assigned to youth under this provision will be documented in the daily log book and will document activities in the log book as well. Length of stay is to not exceed seven days.

Crosswinds' policy regarding providing Domestic Violence Respite was last revised on December 1, 2014 and reviewed by the COO in October 2016.

Crosswinds' policy regarding providing Probation Respite was last created on September 28, 2016 and reviewed by the COO in October 2016.

More individualized services are to be provided to youth under this category. This can be evidenced in the youth's case plan and level of supervision and when applicable, additional screening tools, for example, Human Trafficking Screening tool.

There has been one staff secure youth served since the last review. Evidence of orientation specific to this population was reviewed in the file with the Shelter Manager and a copy was provided. The review includes a review of the youth's legal status, expected length of stay, and youth's goals. A location chart provided evidence of the youth being assigned to one staff member.

There were three files reviewed of youth receiving Domestic Violence services. Case plans were reflective of service needs and length of placement is in compliance with the standard. When applicable, youth were transitioned to CINS/FINS or Probation Respite as evidenced by documentation in the file and census.

There was one Domestic Minor Sex Trafficking youth served since the last review. Evidence of approval of youth's admission was provided during the review by the Clinical supervisor in the form of an email. In addition, per an email from Florida Network staff, placement for this youth beyond the seven days was authorized. Supportive services was provided to youth as well as discussion regarding the coordination of specialized counseling services during the youth's placement.

At the time of the review, there were no Probation Respite youth served in the previous six months.

There were no exceptions noted for this indicator.

3.08 Video Surveillance System

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The Video Surveillance System policy was last reviewed in October 2016. Policy details that video cameras are visible and operable 24 hours a day/7 days a week and are placed in the interior and exteriors of the shelter, in the hallways for sleeping rooms and where youth and staff congregate.

Cameras are not in bathrooms or sleeping quarters. The system can capture and retain video images, including facial recognition as evidenced by review of the cameras with the Shelter Manager. Video can be retained for thirty days and records date, time, and location.

Only the CEO, COO, Clinical Supervisor and the Shelter Manager have access to the surveillance videos.

The COO is the single point of contact for any requests by a third party to review video recordings.

A well detailed log of all reviews of the video footage, areas of discrepancy, and corrective action are documented in a log book. This is completed bi-weekly by the COO.

Signs were placed in the shelter during the review stating that video recording was in progress.

Exception:

Cameras can only operate during a power outage for fifteen minutes. As reported by the COO, budgetary constraints have unfortunately impacted the shelter’s ability to remedy this issue at this time.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

Crosswinds Youth Shelter 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. An initial assessment occurs 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 bed which can change after further assessment. Room assignment is documented on the CINS/FINS Intake Assessment on page 2.

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 Licensed Clinical Professional and Program Manager are notified immediately if risks and/alerts are present and recommendations regarding placement and supervision are provided to the direct care staff. This information is documented on the Alert System Form that is maintained in a binder and is accessible to all staff.

Youth admitted to the shelter with prescribed or over-the-counter medication will surrender those medication to staff during admission. Medications are stored in the Pyxis Med-Station 4000 Medication Cart which provides thumb print access and added security to the maintenance and distribution of prescribed medication. Topical and/or injectable medications are stored separately from oral medication. Refrigeration is available for medication requiring cool storage. The program has designated Super Users for the Med-Station and a list of approved staff who are authorized to distribute medication. Medication records are maintained for each youth and stored in a Medication Distribution Record Binder.

4.01 Healthcare Admission Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place for Healthcare Admission Screening that was last reviewed in October 2016.

Non-healthcare shelter staff will complete the CINS/FINS Intake Assessment on all youth during the intake process, which includes a physical and mental health screening and assessment. If present on premises, Crosswinds' nurse will conduct the health screening. If a youth presents with a condition, or a condition is identified during the course of services, the staff member conducting the screening must immediately notify the Shelter Coordinator and shelter staff via the "alert system".

Youth with chronic health conditions must have a written contingency and referral plan which documents the symptoms or indicative trigger mechanism for emergency treatment or an acceptable time period for necessary follow-up medical treatment. This plan must be documented in the youth's file and reviewed by all program staff. The youth's parent or guardian shall be actively involved in outlining an appropriate plan and coordinating referrals, appointments and follow-up medical treatment.

Staff will also document the noted condition in the program log book highlighted in yellow along with any specific preventative or emergency measures non-healthcare staff should take to assist the youth with a chronic or acute medical or mental health condition.

There were eight files reviewed. All eight files documented that the physical health portion of the

CINS/FINS Intake Assessment was completed on the day of admission. Out of those eight youth, none of the youth had chronic or acute health condition requiring monitoring or follow-up care. Five of the youth documented a mental health condition and were on medication. This was documented on the form. Two youth had some type of allergy and this was also documented on the form and entered in the alert system.

Two additional files of youth who had been admitted with a chronic condition were reviewed. Both of the youth had asthma. The youth's inhalers and instructions for care were documented inside the file. An interview with the shelter manager revealed the shelter does not complete the written contingency and referral plan as outlined in the agency's policy. The shelter's process is to contact the youth's parent for any follow-up care needed and they are responsible for taking the youth to necessary doctors' appointments relating to their chronic condition. The two youth reviewed did not require any type of follow-up during their stay in shelter.

Exception:

The policy does not state that the nurse will review the health screening within five business days if it is completed by non-healthcare staff.

4.02 Suicide Prevention

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has eight different policies relating to suicide prevention. The policies were all last reviewed in October 2016 by the COO.

All youth will be screened at intake using the CINS/FINS Intake Form. The results are reviewed and signed by the supervisor and documented in the youth's file. If the youth answers "no" to all six screening questions the youth will be placed on standard supervision. If the youth "yes" to any of the six questions or the youth is coming to the shelter directly from a Baker Act facility or returning to the shelter from one, the youth is immediately placed on continuous sight and sound supervision until a Suicide Assessment is conducted by a counselor. The assessment will occur no later than twenty-four hours after the screening.

The assessment must be completed by a licensed professional or by an unlicensed professional working under the supervision of a licensed mental health professional. If at any time during the screening or while a youth is on continuous sight and sound, any staff observes or believes a youth presents as an immediate threat to themselves or others, the youth will be placed on one-to-one supervision and staff will immediately call 911 and follow Baker Act procedures. The youth must be maintained on precautionary observation until he/she has received an assessment of suicide risk or follow-up assessment of suicide risk by or under the direct supervision of a licensed mental health professional.

The first file reviewed, documented the youth was placed on continuous sight and supervision at intake due to answering "yes" to at least one of the six screening questions. The youth was seen within twenty-four hours and a Suicide Assessment was completed by the Licensed Mental Health Counselor (LMHC). The youth remained on continuous sight and sound supervision and met with the LMHC again the next day. Another Suicide Assessment was completed and this time the youth was placed on standard supervision. This same youth was also Baker Acted on a later date during this same stay in shelter. Upon returning to the shelter the youth was placed on continuous sight and sound supervision until assessed by a counselor. The youth was seen within twenty-four and a Suicide Assessment was completed by the LMHC. The youth remained on continuous sight and sound supervision and was still on this same status at the time of the review.

There was also documentation of an additional Suicide Assessment being completed by the LMHC and documenting the youth is to remain on this same status. All parental notifications were documented in the chronological notes in the youth's file. There were thirty minute observations of the youth the entire time the youth was on suicide precautions. All observation sheets reviewed documented each shift was

reviewed and signed by the on-duty supervisor and each sheet was reviewed and signed by the LMHC. A yellow sticker was located inside this closed file indicating that at admission this youth was appropriately placed in the shelter's alert system.

A second file was reviewed and this youth also answered “yes” to at least one of the six screening questions. This youth was placed on continuous sight and sound supervision. This youth was seen and assessed by the LMHC, using a Suicide Assessment, within five hours of admission. The youth was placed on standard supervision by the LMHC after the assessment was completed. There were thirty minute observations of the youth the entire time the youth was on suicide precautions. All observation sheets reviewed documented each shift was reviewed and signed by the on-duty supervisor and each sheet was reviewed and signed by the LMHC. A yellow sticker was located inside this closed file indicating that at admission this youth was appropriately placed in the shelter's alert system.

A third file was reviewed and this youth answered “yes” to at least one of the six screening questions as well. This youth was placed on continuous sight and sound supervision and assessed by the LMHC, using a Suicide Assessment the following day. The youth was removed from precautions and placed on standard supervision. There were thirty minute observations of the youth the entire time the youth was on suicide precautions. All observation sheets reviewed documented each shift was reviewed and signed by the on-duty supervisor and each sheet was reviewed and signed by the LMHC. A yellow sticker was located inside this closed file indicating that at admission this youth was appropriately placed in the shelter's alert system.

A review of the log books revealed there was documentation in the log book when all three youth were placed on suicide precautions. The LMHC notes in the log book when youth are removed from suicide precautions and this entry is highlighted in orange.

An interview was conducted with the Clinical Supervisor, who is the LMHC for the residential program. The LMHC is the only counselor completing suicide risk assessments for the residential program. The file review completed confirmed this practice. A new Master’s level counselor was recently hired; however, has been through the training process to complete suicide risk assessments. The LMHC has a very in-depth training process for all new counselors regarding the completion of the suicide risk assessments. The counselors are required to go through a full training program before they are allowed to begin completing their five supervised suicide risk assessments with the LMHC. The LMHC reported only master’s level staff with the appropriate degree are allowed to complete this training. There have been no newly hired counselors since the last on-site review that have needed to go through this training.

All non-residential counselors are also supervised by a LMHC and are required to complete the same training process prior to completing suicide risk assessments. There have been no newly hired non-residential counselors since the last on-site review who have needed to complete this training.

The Clinical Supervisor completes weekly supervisions with all unlicensed counselors.

There were no exceptions noted for this indicator.

4.03 Medications

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

The agency has three different policies in place relating to the medication process. The three policies are Medication Verification at Admission and Consent, Medication Storage, Access, Inventories, and Disposal, and Medication Supervision and Monitoring. All three policies had a revision date of September 2016 and were reviewed by the COO in October 2016.

Upon admission, using the CINS/FINS Intake Assessment form the youth and parent/guardian shall be

interviewed about the youth's current medication. An interview with the Shelter Manager also concluded that the Registered Nurse (RN) will conduct the healthcare admission screening, if available on campus. Otherwise, the interview will be conducted by the on-duty staff and reviewed by the RN within five business days. Procedures for verification of medication include one of the following: contacting the pharmacy, using the Lexi Comp feature of the Pyxis Medication Station, verification by the RN, or using the Physicians' Desk Reference (PDR.net). The method used to verify medication must be documented.

All medications are stored behind at least two locks, in the Pyxis Med-Station 4000 Medication Cabinet and/or locked medication box in the medication room/closed file room. Only staff designated to have access to medication, delineated in his/her job description can access and administer medication. Medication inventory will be conducted by the Shelter Manager, nurse, or other designee. A controlled substance inventory shall be completed each shift with a witness. A weekly audit of non-controlled medications will be conducted. All medications in the Pyxis Med-Station will be inventoried by an RN or Super User if RN is not available within seven days from the last inventory. Controlled and non-controlled medications for disposal shall be inventoried prior to disposal and disposed in the presence of a witness. Medications must be disposed by utilizing bio hazard bags and disposed at the local Fire Department.

The shelter provided a list of staff who are trained to assist in the delivery of medications. There were eleven staff on that list, four of those staff are Super Users.

The shelter does not currently have an RN employed to provide medication oversight. An RN was hired; however, only worked for approximately two months before having to be let go by the agency. The RN was not working the required twenty hours each week. The agency has attempted to hire RN's; however, they either do not accept the position or resign right after starting. The agency is currently advertising in the local nursing school down the street from the shelter, at the local hospital and has tried using a nursing agency with no success. Currently, the Shelter Manager is training all staff on the Pyxis Med-Station and the medication administration process and is the one currently overseeing the medication process at the shelter.

A review of the Pyxis Med-Station was completed with the Shelter Manager. At the time of the review there were no open discrepancies. However, there were twelve discrepancies for the month of January that were all cleared out on February 1st. This indicates discrepancies were not consistently being cleared out by the end of the staff members' shift. All discrepancies documented the reason for the discrepancy which was due to "wrong previous count".

The agency is not currently using the knowledge portal to print or run any reports. The Shelter Manager did not know how to run reports from the portal.

The shelter has a system in place to alert staff who are on medications and times to be given. There is an alert board in the medication room that list all youth on medications and the times they are to be given. The Shelter Manager also encourages staff to print out a report from the Pyxis Med-Station each shift of all youth in the shelter who are on medications, just in case the board is not updated immediately.

There are only two staff members in the shelter who enter new youth/medications into the Pyxis Med-Station-- the Shelter Manager and one Youth Care Worker (YCW) who has been trained and is comfortable with the procedures. New medications that enter the shelter are stored in a locked box next to the Pyxis Med-Station until one of the two staff members mentioned above can enter it into the Pyxis Med-Station. There are two locked boxes, one for the males and one for the females.

Drawer one in the Pyxis Med-Station is used to store PRN's, drawer two and three are used to store all prescription medications, and the bottom drawer is used to store prescriptions that come in bubble packs. Currently, over-the-counter (OTCs) medications are not being stored in the Pyxis Med-Station.

The shelter has five OTCs available for the youth. The five OTCs used at the shelter are Acetaminophen, Ibuprofen, Milk of Magnesia, Maalox, Pepto Bismol, and Antibiotic Ointment. Inventories of the OTCs were not consistently being completed weekly. The Milk of Magnesia, Maalox, Pepto Bismol, and Antibiotic Ointment all documented a gap of eight months, from May 2016 to January 2017 with no weekly inventories. All the OTCs documented running balances with a perpetual inventory documented each time given.

The shelter has a sharps box located in both the male and female dorms. There was documentation that all sharps have been inventoried weekly for the last six months. There is also a sign in/out sheet for razors that documents every time a razor is handed out and to whom.

The shelter's disposal procedures include dissolving the pills in the pill container with water and then disposing of them. The Shelter Manager also reported the medications can be taken to the local fire department to be disposed of if needed. There have been no medications needing disposal since the last on-site review.

An interview with the shelter manager revealed medications are refilled when the count is down to fourteen remaining pills. The Shelter Manager will fill out a form and give to the youth's counselor for them to contact the guardian to have the medication refilled. If it is not refilled timely, shelter staff will also assist in trying to reach the guardian to have the medication refilled.

There were three youth files reviewed of youth who had been on medications. The youth's Medication Distribution Record (MDR) is maintained in the youth's individual file after release. For the current youth, the MDR is maintained in a binder in the medication room. All MDRs reviewed documented the youth's name, date of birth, physician, allergies, medication the youth was taking with dosage, route, times to be given, and reason. A picture of the youth is located in front of the MDR in the Medication Log Book. Side effects of the medications are attached to the back of the MDRs. The youth also signs the MDR.

All MDRs reviewed on site document that perpetual inventory counts with running balances are being maintained on each youth. All MDRs reviewed for the youth also documented that all medications were given at prescribed times. Inventories of the medications were documented on each shift. Controlled medications were being inventoried each shift. Non-controlled medications were generally being inventoried each shift as well, but at a minimum were inventoried once per day. Medications were being verified by calling the pharmacy. This was documented on the Medication Receipt, Transfer, and Disposition Form.

The shelter has had no CCC reports relating to medication errors in the last six months.

Exceptions:

The shelter has not had a registered nurse for a majority of the time the Pyxis Med-Station has been in place. An RN was employed for approximately two months; however, failed to meet the twenty-hour minimum working hours a week and was not fulfilling all the requirements of the position when on-site.

The shelter is not utilizing the Knowledge Portal due to not having a RN on-site and other staff are not being trained on how to use it.

There was an eight month gap in the weekly inventories of liquid and topical OTCs.

Discrepancies were not being closed out by the end of the staff members shift. All twelve discrepancies for January 2017 were closed out on February 1, 2017.

4.04 Medical/Mental Health Alert Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a Medical/Mental Health Alert Process policy in place that was last reviewed in October 2016 by the COO.

Upon completion of the CINS/FINS Intake Assessment, shelter staff notify the Director of Counseling and other shelter staff of any condition(s) the incoming youth present with through the use of the "alert system". The alert system consists of a color-coded dot placed on the front of the youth's file and on the alert board in the staff office in the shelter. The color-coding alerts are as follows: yellow is for suicide, red is for medication/medical, green is for allergies, blue is for sight and sound, orange is for mental

health/substance abuse, purple is for physical aggression, and black is for staff secure. Staff will also document the noted condition in the program log book highlighted in yellow, along with any specific preventative or emergency measures non-healthcare staff should take to assist the youth with a chronic or acute medical or mental health condition.

There were six youth files reviewed. All files documented all intake screening paperwork was completed at admission and any alerts were noted. All six youth had applicable color-coded dots on the front of the file indicating alerts that were identified. For the youth that were still in the shelter, the alert board located in the staff office of the shelter was updated with the appropriate color-coded dots for the applicable alerts. Staff interviewed during the review were knowledgeable of the alert system.

There were no exceptions noted for this indicator.

4.05 Episodic/Emergency Care

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy on Episodic and Emergency Care that was last reviewed in October 2015 by the COO.

If a youth presents a medical or dental condition at intake, or a condition is identified during the course of services, staff and the Director of Counseling are immediately notified via the “alert system” and appropriate first-aid and/or off-site services will be obtained. All medical, dental, or mental health related incidents that arise during the youth’s stay in the shelter trigger incident reporting procedures, including parental notification, and may necessitate a change to the youth’s alert system status. All changes to the youth’s alert system status are to be promptly reflected on the alert system board, the logbook, and the youth’s case file. All emergency medical and dental treatment must be documented in the youth’s case file and the shelter log book including all findings, referrals, and follow-up care.

The shelter maintains an Emergency Medical/Dental Care Log. There was one incident in the last six months documented in a CCC report of a youth being transported off-site for emergency medical care. This incident was documented on the Emergency Medical/Dental Care Log. The log documented the youth’s name, the date, time, physical complaint, parent contact, treatment facility, and outcome. The event was also documented in the shelter log book. The youth was taken home after the incident by her parent so follow-up was not documented as it was not necessary.

Knife for life and wire cutters are located in the staff office on the male dorm side.

First aid kits are located at the front desk in the shelter in the female dorm, in the male dorm, the control room, the kitchen, and the van. A review of the First Aid Inspection Sheets binder revealed all these kits are reviewed once per week and restocked as needed. A list is maintained for all items that are to be inside that kit.

The shelter has conducted six emergency medical drills in the last six months. Two of the drills consisted of providing first aid for different injuries-- two were CPR drills and two drills involved a youth injury.

There were no exceptions noted for this indicator.