Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Florida Keys

on 01/29/2014

CINS/FINS Rating Profile

Standard 1: Management Accountability	
1.01 Background Screening	Satisfactory
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Satisfactory
1.05 Analyzing and Reporting Information	Satisfactory

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

Standard 2: Intervention and Case Management	
2.01 Screening and Intake	Satisfactory
2.02 Psychosocial 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

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

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

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

Overall Rating Summary

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

Rating Definitions

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

Satisfactory Compliance	No exceptions to the requirements of the indicator; limited, unintentional, and/or non-systemic exceptions that do not result in reduced or substandard service delivery; or exceptions with corrective action already applied and demonstrated.
Limited Compliance	Exceptions to the requirements of the indicator that result in the interruption of service delivery, and typically require oversight by management to address the issues systemically.
Failed Compliance	The absence of a component(s) essential to the requirements of the indicator that typically requires immediate follow-up and response to remediate the issue and ensure service delivery.

Review Team

Members

Marcia Tavares, Lead Reviewer and Consultant, Forefront LLC

Marie Boswell, Prevention Specialist, Department of Juvenile Justice

Brian Dye, Residential Services Manager, Stewart Marchment Act

Crystal Westman, Clinical Supervisor, Arnette House

Mary Williams, Program Director, Center for Family and Child Enrichment

Persons Interviewed

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

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

1 Maintenance Personnel
1 Program Supervisors
0 Other

Documents Reviewed

- [ ] Accreditation Reports
- [x] Affidavit of Good Moral Character
- [x] CCC Reports
- [ ] Confinement Reports
- [ ] Continuity of Operation Plan
- [x] Contract Monitoring Reports
- [ ] 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
- [ ] 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
- [ ] Vehicle Inspection Reports
- [x] Visitation Logs
- [x] Youth Handbook

3 Health Records
2 MH/SA Records
12 Personnel Records
6 Training Records/CORE
2 Youth Records (Closed)
4 Youth Records (Open)
0 Other

Surveys

1 Youth | 3 Direct Care Staff | 0 Other

Observations During Review

- [ ] Admissions
- [ ] Confinement
- [x] Facility and Grounds
- [x] First Aid Kit(s)
- [x] Group
- [ ] Meals
- [ ] Medical Clinic
- [ ] Medication Administration
- [x] Posting of Abuse Hotline
- [ ] Program Activities
- [ ] Recreation
- [ ] Searches
- [ ] Security Video Tapes
- [ ] Sick Call
- [ ] Social Skill Modeling by Staff
- [x] Staff Interactions with Youth
- [ ] Staff Supervision of Youth
- [x] Tool Inventory and Storage
- [ ] Toxic Item Inventory and Storage
- [ ] Transition/Exit Conferences
- [ ] Treatment Team Meetings
- [ ] Use of Mechanical Restraints
- [ ] Youth Movement and Counts

Comments

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

Strengths and Innovative Approaches

Rating Narrative

The Florida Keys Children's Shelter, Inc., is a non-profit community-based corporation sub-contracted with the Florida Network of Youth and Family Services (Florida Network) to provide temporary Children In Need of Services/Families In Need of Services (CINS/FINS) residential and non-residential services to youth and families in Monroe County. The agency provides a full range of services to both male and female youth ages 10-17 years of age. The program is located at the Tavernier's Jelsema Center, at the north-end of Monroe County next to the Tavernier Government Center.

In May of 2012, the Florida Keys Children's Shelter (FKCS) was re-accredited by the Council on Accreditation (COA) and has been continuously re-accredited by the Council on Accreditation (COA) since its accreditation in May 2004.

During the QI visit, an interview with the new Executive Director, Greg Brown, was conducted to ascertain agency and programmatic strengths and innovative approaches utilized by the provider. Mr. Brown was hired in August 2013 and, since his hire, has created a Strategic Action Plan to improve the marketing and fund development of the agency and expand program services. The action plan was created during a two day retreat that included 35 staff and Board members.

Another initiative implemented since the last onsite visit is the development of eight Task Forces within the organization whose roles are to improve overall agency and program outcomes through advancing youth life skills and development, health and wellness, transitional housing, and fundraising.

The agency's Education Initiative effort continues to develop relationships with Universities near and far to provide experiential learning opportunities for Interns and training/skill development opportunities for staff. The agency has partnered with the University of Miami and Universities across the country to collaborate on web-based training, conferences, and other activities focused on dealing with youth issues. The program utilizes interns to assist with counseling and case management and has mutually benefitted tremendously from this assistance. Funded by an Eckerd Grant, this education initiative will help in bridging the gap and establish relationships that will facilitate the recruitment and utilization of interns and potential staff. Another education initiative is the collaboration with FKCC that provides opportunities for youth to get into a community program.

Another successful Mayor's Ball fundraiser was conducted in January 2014 and the agency had its highest attendance rate of 318 people and raised $25,000 from the event. The ball is known to attract many high ranking local officials and businessmen and is a great publicity event for the agency.

Standard 1: Management Accountability

Overview

Narrative

FKCS has been in operations since 1985. The agency has an eight-member Board of Directors, including a youth member, with representatives from the upper, middle, and the lower keys, to oversee the agency's goals, objectives and activities. The FKCS building houses the CINS/FINS shelter located on the first floor and the agency's administrative offices, on the second floor. The shelter provides separate female and male dormitories to children ages ten to seventeen years that are locked out, runaway, ungovernable and/or truant, homeless, abuse, neglected, or at risk.

The program has a Senior Management team that is comprised of the President/Chief Executive Officer, the Chief Operating Officer (COO), the Chief Financial Officer (CFO), the Chief Learning and Evaluation Officer (CLEO), and the Chief Development Officer (CDO). In addition, the program has a Counseling Services Coordinator and a residential Program Coordinator. There were no staff vacancies at the time of the review.

The COO oversees the activities of both the residential and the non-residential programs. Shelter program staff includes: a Program Coordinator, three Team Leaders, a Youth Advocate, ten Youth Support Staff, a Food Service Manager, and a Maintenance staff. In addition to the Counseling Services Coordinator, the clinical component has three community-based Counselor positions, assigned to the upper Keys, Marathon, and Key West, and one Residential Counselor.

The program has an Annual Training Plan for all staff and all employees receive ongoing training from the program's CLEO, local providers, and the Florida Network. Orientation training is provided to all personnel by the CLEO. Each employee has a separate training file that contains a training plan and corroborating documentation for training received. Annual training is tracked according to the employee's date of hire.

FKCS 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, with participation of all program staff, with emphasis on the designated high crime zip coded areas. Community based staff provide services throughout the county and maintain offices in schools located in the upper, middle, and lower Keys.

1.01 Background Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policies and procedures, 1.12, 1.12.1, and B.17 to ensure that background screening is conducted for all employees and volunteers. The program's procedures comply with the Background Screening Unit (BSU) requirements. Prior to an offer of hire, the program submits the appropriate forms to BSU, obtains an eligible rating, and retains proof of eligibility in the employees' personnel files.

A total of twelve (12) background screening results were reviewed for nine (9) new hires, two (2) 5-year re-screened employees, and one (1) volunteer who was active during the review period. All of the new hires were screened and received eligible screening results prior to hire date. As required, the provider conducts a background screening for all volunteers who have direct contact with youth. However, the background screening for the volunteer (Intern) was not conducted until three months after the volunteer's start date.

The provider had two employees who were eligible for a five-year re-screening. Both re-screenings were submitted to the Background Screening Unit and the results were obtained prior to the employees' five-year anniversary dates.

During the review period, two separate staff informed the provider about their arrests. One of the employees was arrested for unemployment fraud and was subsequently terminated. The other employee was arrested for DUI. The employee was issued a hardship license and is not approved to drive the agency's vehicle.

In addition to the DJJ Background Screening, the provider also conducts quarterly local background checks for all employees, annual driver's license checks through Greg Roe Insurance Company, and drug screenings at hire and randomly thereafter.

The Annual Affidavit of Compliance with Good Moral Character Standards was emailed to BSU on January 14, 2014, prior to the January 31, 2014 deadline.

Exception:

The background screening for the program's Intern was not conducted until three months after the Intern's start date. The Intern started on 10/7/13 but the screening result was not obtained until 1/14/14.

1.02 Provision of an Abuse Free Environment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policy and procedures in place that address all elements of the indicator to ensure that youth, staff, and others are provided an abuse free and safe environment. In addition, the program has a comprehensive Personnel Policy and Procedure Manual that covers the rules and expectations in effect at the FKCS. The Code of Conduct is described in Section E of the manual and outlines all rules concerning physical abuse, use of profanity, threats, or intimidation. Upon hire, staff receives a copy of the Employee Handbook and an acknowledgement of receipt in writing is maintained in the employee's personnel file.

The program also has a detailed policy and procedures regarding Child Abuse Reporting, policy # 1.07.01-1.07.03. Staff's responsibility and protocols for reporting child abuse are clearly outlined in the procedures. Orientation training was conducted on abuse reporting requirements with the three new program staff whose training files were reviewed. In addition, the Abuse Hotline telephone number and client Rights and Responsibilities are visibly posted in the lobby, youth living room area, and are also included in the Client handbook. A review of four calls made to the Abuse Hotline was conducted. The Abuse Hotline reports are maintained in a binder. None of the four calls were related to complaints against the staff or the facility.

All youth are provided with a Client Handbook upon admission to the program. Included in the handbook are the youth's rights, information on the grievance process, the abuse hotline number, and the code of ethics. During program orientation, the youth and the youth's parent or guardian are advised of the program's mandatory abuse reporting requirements. The youth and parent or guardian sign the orientation checklist acknowledging receipt of the handbook and their understanding of the information provided during orientation. This form was located in three residential files that were reviewed.

The program has a two locked grievance boxes and forms accessible to youth; both are located at the entrance to the male and female dormitories. The program coordinator reviews the grievances on a regular basis. A review of seven youth grievances was conducted. All seven grievances were related to youth's complaint about staff; three of the seven complaints were from the same youth. None of the grievances indicated youth were deprived of basic needs and all were resolved between the youth and staff in a timely manner.

There was only one CINS/FINS youth present in the facility during the review. The survey completed by the youth demonstrated knowledge of the abuse hotline and location of the Abuse Hotline telephone number. The youth also indicated that she felt safe in the shelter.

The three staff surveyed said they have never witnessed another staff prohibit youth from calling the abuse hotline and have never heard another staff use profanity, threat, intimidation, or humiliation when interacting with youth.

Per the provider's Administrative Assistant, there were no incidents of physical and/or psychological abuse, verbal intimidation, use of profanity, or excessive use of force that required management to take action and/or reprimand staff.

No exceptions noted.

1.03 Incident Reporting

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a written policy in place and is in compliance with the indicator. A total of 9 incident reports that have happened since the last review were reviewed. The incident forms had 2 different program code numbers. The provider's Chief Learning and Evaluation Officer informed Reviewer that the program code has been changed and that all forms have not been updated to reflect that change. All incidents were

reported within the 2 hour time frame as required in the standard.

Seven (7) of the nine (9) incident reports identified who was a staff member and who was a youth. Five (5) of nine (9) had nothing noted in the "other important information which management should know" section. It is recommended for staff to at least put "none" or some other comment rather than leaving it blank. Seven (7) of nine (9) had a corrective action taken.

The logbook was reviewed to verify that the times on the forms matched those of the logbook entries. Four (4) of the incidents (7/14/13, 8/28/13, 8/31/13 & 10/18/13) were not logged in the logbook. Three (3) of the incidents (9/21/13, 10/18/13 & 1/20/14) times on the forms matched the times in the logbook. One (1) incident (11/29/13) was logged in the logbook at 11:08 p.m. but the form has the call being made at 9:53 p.m. and one (1) incident (1/8/14) is logged in the logbook but there is no time for the logbook entry. The form has the call being made at 7:35 p.m. After reviewing CCC reports the times were approximately the same as the staff reporting times. Description of incidents: 3 physical altercations between youth, 2 contraband, 1 medical emergency, 2 staff arrested & 1 self-mutilation.

During the review of background screening it was discovered that an Intern had not been screened prior to starting and that should have been called into CCC. The intern started on 10/7/13 & was not screened until 1/14/14. Shelter Coordinator was aware but did not make call until Reviewer brought it to their attention.

1.04 Training Requirements

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There is a policy and procedure in place that ensures that all direct care staff are appropriately trained within the first year of hire to adequately meet the needs of the CINS/FINS youth. The policy and procedure, # 5.01, also ensures that all direct care staff is appropriately trained on an ongoing basis. A copy of the provider's Training Plan for FY 2013-2014 was submitted via email to the Florida Network on September 11, 2013.

Training is provided by the Chief Learning and Evaluation Officer, supervisors, and other personnel or agencies such as the Florida Network. Each employee has a separate training file which includes: an individual training plan which documents the required and recommended training topics, dates of training, number of hours of the training, renewal date, and cumulative total. In addition, each training file includes supportive documentation such as certificates, agendas, or sign-in sheets for trainings completed.

The training files for three (3) First Year staff were reviewed. Two of three staff exceeded/met the standard requirement for 80 hours of training and the third staff is one training hour away from meeting the requirement. The Florida Keys Children's Shelter provides first year training for their employees on Program Orientation, Crisis Intervention/Safety, Suicide Prevention, CINS/FINS Core Training, Title IVE Procedures, Fire Safety Equipment, CPR, First Aid, Signs of Symptoms of Mental Health and Substance Abuse, Universal Precaution, Cultural Competency, as well as an In-Service Component. Additional trainings completed by the new hires included Medication Management for Non-Licensed Staff, Behavior Management, and Child Abuse.

Three (3) in-service staff training files were also reviewed. Training hours for all three staff exceeded the 40 hours required annually. Following the first year, employees are provided refresher trainings such as Fire Safety Equipment, CPR, First Aid, Crisis Intervention Skills, Suicide Prevention, Signs/Symptoms of Mental Health and Substance abuse, Universal Precautions, Cultural Competency, Behavior Management, and Medication Management.

As of the current Fiscal Year, the Department of Juvenile Justice is also requiring providers to complete the Motivational Interviewing (MI) and Prison Rape Elimination Act (PREA) training. None of the provider staff had completed any of these trainings as of the date of this QI review; however, per the agency's CLEO, staff are scheduled to complete the PREA training in the upcoming weeks and nine staff are registered and awaiting the MI training date.

No exceptions noted.

1.05 Analyzing and Reporting Information

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a written policy and procedures for analyzing and reporting data for case record reviews, incidents, accidents, grievances, customer satisfaction, outcome data, and monthly review of Netmis data reports. In addition, there is a comprehensive Agency Performance and Quality Improvement (PQI) Plan that outlines the agency's PQI philosophy, staff responsibilities, overview of the PQI process, strategic planning, and delineation of the organizational outcomes and indicators.

The agency's CLEO is responsible for the implementation and oversight of its PQI activities. In practice, the agency's PQI program includes many activities that are conducted by various staff to ensure all aspects of analyzing and reporting data are consistently implemented and documented.

Quarterly peer case record reviews are conducted quarterly by the program staff as directed by the CLEO who randomly selects 40% of client and human resource records. Using the records review checklist, staff conducts the reviews the first week of each quarter beginning in January. The provider submitted Case Record Review Reports for the 3rd and 4th quarters of 2013 showing a total of 20 residential and 16 non-residential cases reviewed for the period.

Upon completion of each record review, the CLEO aggregates the results and provides a copy of the aggregated report to the Executive Council, Leadership, and Direct Care Staff. Program supervisors ensure appropriate follow-up is taken by their staff and responded to in a timely manner. Deficiencies are corrected within two weeks of the records review.

The CLEO conducts quarterly reviews of all issues regarding employee and client safety. The Safety Review consists of statistical information compiled from risk management, human resources, performance quality improvement, direct care and program staff. Management and direct care staff meet to discuss safety issues, licensing audits, and reports related to safety and risk management. The provider submitted Risk Prevention and Management Quarterly Reports for the 3rd and 4th quarters of 2013 showing a summary of the number and/or types of: incidents reported to CCC, fire drills, staff or client grievances, and work related injuries/accidents as well as results of health and fire inspections. Data and reports are aggregated by the COO and CLEO and presented at management and staff meetings for review.

Consumer surveys are administered for staff and stakeholders annually and quarterly for the youth served in the program. The annual employee satisfaction surveys and Stakeholder survey data are aggregated by the CLEO and presented to the agency constituents. Reports of the annual surveys conducted during the current FY for stakeholders and staff were provided along with two semi-annual client satisfaction survey results for the period 4/1/12-9/30/12 and 9/30/12-3/31/13.

Outcomes data is entered into and analyzed through the provider's ETO software and the reports generated are included in the Practice Review report. ETO allows the organization the ability to collect data on program effectiveness, client outcome tracking, and continuous quality improvement. The outcomes data incorporates all of the contract, NetMIS, and program outcomes required by the Florida Network and DJJ QI. A copy of the FKCS Annual Performance Report for October 1, 2012 - September 30, 2013 was provided. The report provides an evaluation of various programmatic outcomes such as: environment safety; academic success; healthy behaviors; and employment readiness for the period.

The provider conducts reviews of NetMIS data on a monthly basis and the data is presented at the FKCS Action Team (Administrative staff and Program Coordintor) meeting by the COO. Copies of the agendas for the monthly meetings held during the past six months were reviewed during the visit.

No exceptions noted.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

FKCS is contracted to provide both shelter and non-residential services for youth and their families in Monroe County. The program provides centralized intake and screening twenty-four hours per day, seven days per week, every day of the year. Trained staff are available to determine the needs of the family and youth. Residential counseling services are provided by a Master's level Counselor who conducts individual, family, and group services. Case management and substance abuse prevention education are also offered.

The Community-based program offers both school and home based services that are divided between two (2) full time counselors under the supervision of the program's Counseling Services Coordinator who is a Licensed Clinical Social Worker (LCSW). It was reported that within the past year the facility has served a total of one hundred and thirty-six (136) youth in the community. The counselors are responsible for providing case management services and linking youth and families to community services. The community based services span the entire Monroe County. The program's non-residential counselors work out of local schools in the upper, middle, and lower Keys in Key West, and provide prevention services to youth in the county utilizing several schools as the base of operations in their respective communities.

Referral and aftercare services begin when the youth are admitted for services. Aftercare planning includes referring youth to community resources, on- going counseling, and educational assistance.

FKCS 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.

The review of the charts shows that all documentation is in place and it has been documented that all services are being provided to the youth and families in a timely manner by the counselors and case managers.

2.01 Screening and Intake

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The policy and procedure stated that every youth is assessed and screened to determine eligibility for services in the facility. It is stated in the policy that all initial screenings are to be completed using the NETMIS Youth Screening and CINS/FINS intake form within initial contact or within twenty-four (24) hours of admissions.

The policy and procedure also states the comprehensive assessment (Psychosocial Assessment) is to be completed within seventy-two (72) hours of admission.

Six (6) files were reviewed; three (3) charts were open case management charts and three (3) were open residential charts. All six files had an eligibility screening that was completed within 7 calendar days of referral. Of the three (3) residential charts, two (2) had screening forms that were documented confidential and consisted of two (2) pages of screening information completed and signed by a counselor but no credentials were noted on the screening forms. One (1) of the residential charts had a one (1) page screening form of the youth's documentation, but this form was not signed or dated by either a counselor or a supervisor for approval. It was also noted that on all six (6) files credentials were missing from all documented forms.

Documentation in the six files validated that the youth and parents/guardians received in writing: available service options, rights and responsibilities, and the Parent/Guardian (P/G) CINS/FINS Brochure. The service options, rights and responsibilities, and grievance process are included in the Client Handbook and/or Intake documentation that is signed by the P/G. Possible Actions occurring through involvement with CINS/FINS services are outlined in the Parent Brochures that were distributed to the P/G.

Best practice would be that all screening forms are consistent in all charts as well as signed by either the counselor and/or the supervisor with credentials and a completion date and credentials.

One (1) of the residential charts was missing a photo of the youth who is still open in the shelter.

2.02 Psychosocial Assessment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The policy and procedure stated that every youth complete a comprehensive assessment which is initiated within seventy-two (72) hours of the residential intake assessment or within 2 to 3 face-to-face contacts for non-residential youth. The information that is obtained on the assessment includes social, emotional, educational, health, behavioral, substance abuse, employment, abuse/neglect/exploration, family history, DCF/WHFS history, suicidal thoughts or history and drug history.

Six (6) files were reviewed for three (3) open non-residential case management charts and three (3) open residential charts. Of the six (6) files that were assessed, all six (6) had psychosocial assessments completed within seventy-two (72) hours of intake. All psychosocial assessments had a signature for both the counselor/ case manager completing the assessment and the supervisor, but they all were missing credentialing after all signatures from counselors, case managers and supervisors. All of the assessments had the appropriate documentation noted on the assessment form. It was noted that one (1) case management chart did not meet face to face with a youth due to the youth being in a residential facility, but it was noted that the case manager did contact and speak with the youth on the phone to gather the assessment documentation.

Best practice would be that all psychological assessment forms show the credentials after the signatures of all counselors and supervisors.

2.03 Case/Service Plan

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The policy and procedure stated that for every youth receiving services, a service plan is created to help assist the youth and or family in reaching goals. The policy and procedure also states that a service plan is developed with the youth and family within seven (7) working days of the completion of the assessment process and is documented on the service plan. The policy and procedure states that a review of the service plan will be completed every fourteen (14) days throughout the duration of the plan to monitor progress towards achieving goals.

Six (6) files were reviewed for three (3) open non-residential case management charts and three (3) open residential charts. All six (6) files contained documentation of active service plans. All six (6) service plans had initiation dates within seven (7) working days of the intake assessment. All six (6) files have initiation dates, goals, frequency, type of services, location, person responsible, target date, and goals met were all completed in the service plan in all charts. Five (5) of the six (6) charts all had participating signatures and dates of initiations. One (1) case management chart does not have a youth signature due to the fact that the youth was in a residential facility and was only available via phone. All six (6) charts documented case plan reviews every fourteen (14) days of initiation date of the services plan. Three (3) residential chart reviews have brief documentation on the service plan regarding outcomes/progress of goals. All six (6) charts have signatures and dates of the completion of the reviews on each service plan.

One (1) youth was surveyed during our visit. The youth admitted to knowing his/her counselor and providing input into service plan goals and development.

2.04 Case Management and Service Delivery

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The policy and procedure stated that every youth that comes into the facility will be provided with the most appropriate services available to meet their identified needs. It is also stated that services will be available through referrals to in house services or services through other county providers if needed. The policy and procedure says that all case management staff will assist youth and their families in preparing for planned exits or discharges from services and assist in identification of any aftercare and/or follow-up services that is needed or desired by the youth or family to ensure a successful transition.

Six (6) files were reviewed for three (3) open non-residential and three (3) open residential charts. One (1) residential chart showed a referral for a psychological evaluation that was needed for the youth. The same chart also had a referral for a case staffing committee, which was noted as a need for this youth and family. It was documented in the chart that all referrals were completed within a timely manner and progress was noted in the chart. The three (3) residential charts reviewed also had documentation of monitoring the youth's behaviors while placed in the shelter setting.

The three (3) non-residential case management charts showed documented referrals for case staffing, providing support for the families and the youth. It was also documented that all case management charts have appropriate documentation of case monitoring and documentation of court hearings.

2.05 Counseling Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The policy and procedure stated that every youth that comes into the shelter will have group sessions five (5) times per week conducted by a trained and experienced staff member. The policy and procedure also state that all service plans will identify the services needed to assist the youth and their family in reaching all identified goals. The goals to be addressed are identified through the psychosocial assessment. The service plan is developed within seven (7) working days of the completion of the assessment. The policy and procedure state that all service plans will be reviewed at fourteen (14) day intervals throughout the duration of the plan to monitor progress towards achieving goals.

Six (6) files were reviewed. Of the six (6) open files, three (3) files were non-residential case management and three (3) files are residential charts. All the charts had service plans which were developed within seven (7) days of the assessment.

Of the three (3) residential charts it was noted that all youth were receiving group at least five (5) days a week which was documented in a group binder that identified the groups that were being conducted an the youth that were present at the time of the group. All charts had active service plans which addressed the presenting problems that were documented on each psychosocial assessment that was completed. All the service plan reviews had identified problems, target dates, location of services provided, the identified participants and the completion date. All service plans had documented reviews every fourteen (14) days with a short sentence of progress on the goals. All of the review documentation is located on service plan and is also noted in the progress notes when a review was completed with the youth and the family if possible.

All six (6) charts had documented progress notes and the appropriate sections of the chart listed progress notes. The notes were in order and all notes showed documentation of services that were being provided to the youth and the family. Similarly, the charts documented on on-going process of clinical reviews by the supervisor. All charts had supervisory signatures and initials when needed for the chart reviews.

2.06 Adjudication/Petitiion Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There is a policy in support of this indicator. The policy states that all families and youth are provided with the most appropriate services available to meet the youth and family needs. The policy and procedure states that a case staffing committee is made up of counselors, school personal, DJJ, youth and family members. The police and procedure for scheduling a case staffing is documented by contacting the family within seven (7) working days of the meeting for confirmation of attendance.

Six (6) charts were reviewed; three (3) charts were open case management charts. Three (3) case management cases that were reviewed showed that two (2) of the three (3) charts were open for a total of ninety (90) days and closed, then re-opened within one (1) day.

The first (1) chart reviewed showed the chart closed on 11/27/13 and re-opened on 11/28/13 with all completed intake paperwork and a new psychological assessment and treatment plan with a case staffing recommendation form on 1/28/13 that is still current at this time. It was noted in this chart that all court documentation and case management paperwork which include case staffing letters, case staffing recommendation forms, court documentation and all case presentation documents are all present in the open charts. It was noted that this youth has had a case staffing as well as case reviews on a monthly basis. The chart had documented letters send to all parties of the date and time of the case staffing. The chart also had the case staffing recommendation in writing in the chart with signatures and dates of everyone who was in attendance.

The second (2) chart that was reviewed was also opened and closed within 90 days. The closure date of this chart was 1/21/14 and re-open date was on 1/22/14. All the paperwork in both charts have been completed and in order.

It was noted that all court documentation and case management paperwork which include case staffing letters, case staffing recommendation forms, court documentation and all case presentation documents are all present in the open charts. It was noted that this youth has had a case staffing as well as case reviews on a monthly basis. The chart had documented letters send to all parties of the date and time of the case staffing. The chart also had the case staffing recommendation in writing in the chart with signatures and dates of everyone who was in attendance.

The third chart showed all the court documentation and case management paperwork which include case staffing letters, case staffing recommendation forms, court documentation and all case presentation documents are all present in the open charts. It was noted that this youth has had a case staffing as well as case reviews on a monthly basis. The chart had documented letters send to all parties of the date and time of the case staffing. The chart also had the case staffing recommendation in writing in the chart with signatures and dates of everyone who was in attendance.

Best practice would be to keep case staffing charts open past the 90 days, instead of closing and re-opening the charts. Best practice would be to update service plans every six (6) months and consent forms every year or when needed.

2.07 Youth Records

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There is a policy in support of this indicator. The policy and procedure states that all youth's records are stamped "Confidential" and stored in a locked area within program sites. All case records are marked "confidential" and are kept locked in a file cabinet or file room with access limited on a "need to know" basis.

Six (6) charts reviewed all were stamped confidential on the front cover of the charts as well as on all the face sheets in each of the sections of the charts both for residential and non-residential case management. The records are maintained in a consistent manner and are neat and well organized so that staff can quickly and easily access information.

Standard 3: Shelter Care

Overview

Rating Narrative

FKCS is located in Tavernier, Florida and serves the entire Monroe County. The shelter is a nineteen bed facility that provides residential services to youth in the Department of Juvenile Justice (DJJ) CINS/FINS program and youth from the Department of Children and Families (DCF). At the time of the quality assurance review, the shelter was providing services to two (2) DJJ youth. The shelter is not designated by the Florida Network to provide staff secure services and is not licensed under Chapter 397.

During the tour, the facility was found to be in good working condition and the furnishings in good repair. No sign of graffiti was observed on the walls or furnishings. The facility boasts tiled floors, professionally painted murals on the walls in the dormitories, new furnishing, exterior painting and well maintained landscaping. The shelter consists of a computer/game room, a large day room/dining hall, dormitories, kitchen, two laundry rooms, staff offices and a conference room. The dormitory, restrooms and common areas were clean.

The dormitory is divided into two separate areas, one for the boys and one for the girls. The sleeping rooms house two youth each with an individual bed, bed covering and pillows. The most recently added bedroom contains three beds; the addition raised the number of beds in the facility to nineteen.

The youth have access to the game/recreation room, basketball court, and a nearby park. The Counseling Services Coordinator/CINS/FINS Counselor is a Licensed Clinical Social Worker (LCSW)/Certified Addictions Professional (CAP). Services provided include individual, group and/or family counseling, and any other applicable intervention required. The youth admitted to the program are screened using the Network Management Information System (NETMIS) Youth Screening Form, the CINS/FINS Intake Form, a brief FAM (Family) General Scale or Teen Screen, and a Substance Abuse Subtle Screening Inventory (SASSI), when applicable. If a youth answers “yes” to any of the six questions pertaining to suicide risk on the CINS/FINS Intake form or if the staff member’s observations of the youth’s behavior would indicate any area of concern, an Assessment of Suicide Risk (ASR) is completed. The ASR is completed by either licensed professional or a non-licensed counselor under the direct supervision of the LCSW. A medical and mental health alert system is in place and the shelter staff that administers medications have been trained in the distribution of medication.

3.01 Shelter Envonment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has policies and procedures in place that ensure that the facility is clean, safe & well maintained. During the onsite visit, a shelter tour was given by the Program Coordinator. The Fire Safety and Health Inspections are current and do not list any citations per inspection reports from the Islamorada Fire Inspector conducted 9/4/13 and the Department of Health Residential Group Care Inspection conducted 9/25/13, respectively.

The shelter is treated bi-monthly for insects. They also have an agreement that if services are needed in between services the company will come to shelter and treat problems. The appearance of the shelter inside and out was attractive and well maintained. On the inside, murals are painted on the walls in both the common areas and in the youth’s bedrooms which make the shelter warm and inviting not only to youth but visitors as well.

All furnishings appeared to be well kept as evidenced by very minimal graffiti. All beds in the youth’s bedrooms were made up with linens, pillow, and blanket. The lighting in the rooms was sufficient. In three of the bedrooms, the overhead light coverings were cracked or broken. The Maintenance staff was informed and started the process of having them replaced. One bathroom light over the sink was out and the Program Coordinator called to have it fixed when Reviewer pointed it out. The bathroom still had the light/fan which was working properly and provided sufficient light. The bathrooms were a little dirty around the toilet area but no foul order was observed. The youth are provided hygiene baskets that are kept in the laundry room when not in use.

There are two safes that youth can have personal items locked up securely and have access to while in shelter. One of the Safe is located in the file room and the other is located in the Program Coordinator's office. All staff have access to this safe as well.

The youth have the opportunity to participate in structured activities. There are three schedules posted: 1) school weekday schedule, 2) weekend schedule, and 3) summer/non-school day schedule. These schedules are also included in the handbook youth receive at intake. Additionally, the program has a monthly activity calendar posted that shows various recreational activities such as movies, martial arts, card games, arts and craft, and other outdoor activities. The youth are provided the opportunity for one hour of physical activity. The youth are also given the option to participate in faith based activities.

Three fire drills and three medical emergency drills were reviewed. Fire drills are conducted at a minimal monthly. All the drills were documented in the logbook and highlighted except the 1/19/14 medical drill. Six (6) staff training files were reviewed and all fire and medical trainings are up to date.

3.02 Program Orientation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has policies and procedures in place that ensure that youth are given a residential handbook and orientation about the program within 24 hours after the intake. The program staff is responsible for discussing the program's philosophy, goals, services and expectations. The documentation is located in each youth record reviewed and signatures of the youth and staff involved is maintained in the individual youth records. The Florida Network guidelines require staff to be trained in how to orient a youth to the program so that they are welcoming and respectful. The Program Orientation package includes: staff introductions, introduction to the program such as chores; non-smoking policy; personal items; visitors; phone calls and letters; school and work attendance; counseling groups; confidentiality; notice of privacy, grievance policy, and sample report form; programs goals; rights & responsibilities; behavior management system; family visitation and home passes; rules, expectations, and consequences; daily schedules; chores; activity schedule; room searches and confiscation; contraband; valuables restricted and inappropriate items; and medical, dental, and mental health care. In case of fire, Jelsema floor plan/emergency evacuation routes are posted throughout the facility. Also posted are the abuse registry and DJJ hotline telephone numbers; these numbers are included in the resident handbook.

All three youth files reviewed showed that the youth received a comprehensive orientation and handbook provided within 24 hours. The orientation explained disciplinary action, grievance procedures, emergency disaster, contraband rules, physical/facility layout map, suicide prevention and alert notification. The program orientation as outlined in the CINS/FINS policy manual included each youth’s signature and parent/guardian signature. The daily activity was reviewed with the youth as well as the Abuse Hotline number.

3.03 Youth Room Assignment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policy in place that includes an initial classification of the youth for purposes of room assignment with consideration given to potential safety and security concerns to include: review of youth's history, age and gender, alerts, and observations.

Three residential files were reviewed and all three files included classification documentation based on the aforementioned criteria. Alerts are immediately entered into the program's alert system when a youth is admitted with special needs and risks of suicide, mental health, substance abuse, physical health or security risk factors. None of the clients had a history of violent behavior. The files reviewed did not have any documentation of any gang affiliation, suicide risks, or sexually aggressive behaviors-gender identification. All files have initial interactions and observations reviewed. The reviewer viewed the rooms; the beds were all made up and the linen was clean. The bathrooms were in order and clean as well. The rooms were provided with a desk and a chair. The artworks on all the walls in the rooms were exceptional and beautiful!

3.04 Log Books

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The shelter has a policy and procedure in place so that information is recorded for all events and ensures information necessary for staff to provide the appropriate care and services to the youth.

Upon reviewing the logbook it was observed that all entries were written in ink and no white out appeared to be used. When errors occurred they were crossed out appropriately but some were missing initials and all were missing "void" per the shelter policy. It was observed that staff were reviewing the logbook as required by the shelter policy and QI indicator. Reviewer also observed that an administrative review was done at least weekly by the Program Coordinator or designee. Significant items were highlighted in the logbooks according to the shelter’s policy and procedures; reviewer recommends using a different highlighter color to identify when staff reviews the logbook.

The shelter policy states when an error is made, the word "void" is to be written; however, staff is writing "err" or "error" instead of “void”.

Rating Narrative

The shelter has policies and procedures in place to encourage positive behavior of the youth, increase the youth’s accountability in addressing behaviors, and enhance social skills and improve their level of compliance.

The program’s behavior system is comprised of three levels - Orientation, Level I, and Level II. There are rewards and consequences associated with the youth’s behavior. A comprehensive description of the behavior management system is included in the resident handbook that is given to the youth at intake. The youth signs a form on the last page in the handbook that acknowledges that the system was explained by the program’s intake staff. The parents are also given a copy of the handbook and sign for receipt. The signed forms are then put in the youth’s file.

Reviewer interviewed staff about the system and its effectiveness. Staff was very knowledgeable of the behavior management system. The schedules and activities are posted in accessible places throughout the shelter. Staff feels the behavior management system is effective for the population they serve. All six staff training files reviewed are current on trainings of the behavior management system. The staff are evaluated on their knowledge of the system annually on their yearly evaluations. The staff also receives trainings in their staff meetings and throughout the year from the Florida Network and their onsite trainer/CLEO.

3.06 Staffing and Youth Supervision

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The shelter has policies and procedures in place that ensure the safety of both youth and staff through supervision. Staff schedules for the past six months show a consistent ratio of 1 staff to 6 youth and both male and female staff are included on the schedules. The schedules are posted in the staff office which is accessed by all staff. There is also an on-call list to be used when staff coverage needs to be acquired. Phone numbers for staff to be accessed are available on the on-call list.

Logbooks were reviewed and entries showed that the youth were checked by staff while they were in their rooms. The times appeared to be calculated and not in real times. There were some checks that were over the 15 minute time frame required. Also a recommendation would be that the use of the word "hall" written in the logbook be replaced with "rooms" or "bedrooms" as this was very confusing in identifying where the kids were during the night.

The shelter also has a video surveillance system. The system has 24 cameras and the main monitor is in the staff office/monitor station. All of the cameras were operational during the visit. The backup is for available for 30 days.

Some bed check entries in the logbook were over the 15 minute required time frame. Also, bed check times appear to be calculated and not documented in real time.

3.07 Special Populations

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The provider has applicable policies and procedures in place for the intake and service provision to Staff Secure and Domestic Violence Respite (DVR) youth. The policies and procedures were reviewed and were adequate in meeting the requirements of the indicator.

The agency has did not have any cases in the last 6 months or since the last onsite QI review; consequently, the reviewer was unable to review practice for Staff Secure population. However, written procedures are documented for all components of the requirement to serve this population.

One applicable youth file was reviewed to assess the program's practice with regards to DVR population. Compliance with the requirement was evidenced by the following: prior approval was given by the Florida Network for shelter placement of the youth; a pending DV charge and evidence of screening by the JAC facility was documented in the youth's file; the youth's length of stay did not exceed 14 days; documentation in the file showed that the youth was transitioned to CINS/FINS; the youth's case plan included goals to address anger management; and services provided to the DVR youth were consistent with all other general CINS/FINS program requirements.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The FKCS has specific procedures related to the admission, interviewing and room assignment of youth to ensure the safety and appropriate supervision of youth admitted into the program. Upon admission, Youth Support staff will interview youth and complete the intake. An initial intake 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 room which can change after further assessment. Room assignment is documented on page 2 of the CINS/FINS Intake Assessment form.

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 Coordinator or Program Coordinator is 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 board that discreetly mounted in the staff control room and in the youth files using a color coding system.

Youth admitted to the shelter with prescribed or over the counter medication will surrender those medication to staff during admission. Medications are stored the medication room in a double locked medication cabinet and topical and/or injectable medications are stored separately from oral medication. Refrigeration is available for medication requiring cool storage. The program has a list of staff who are authorized to distribute medication. Medication records for each youth are maintained in a binder.

4.01 Healthcare Admission Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policy and procedures in place to ensure medical care for youth admitted with chronic medical conditions. Each youth admitted to the program receives a healthcare admission screening. The healthcare screening is documented on the second page of the CINS/FINS Intake Assessment and is conducted during intake. Information gathered includes: current medications used by the youth; existing medical conditions; allergies; recent injuries or illnesses; presence of pain or other physical distress; observation for evidence of illness, injury, physical distress, movement etc; and observation of scars, tattoos, or other skin markings. The program requires the parent/guardian to be actively involved in the coordination and scheduling of follow up of medical appointments.

Three residential youth files were reviewed. One file reviewed showed the youth's medical referrals on a daily log. The youth with chronic medical conditions also had a referral for medical care in the file. The client file also showed current medication indicated for ADHD and Amphetamine for a contusion to the head. The reviewer viewed the following documents in the file pertaining to healthcare: Florida Keys Children's Shelter statement of Monroe County Health Department services, Medication Permission, Individual Client's Medication Distribution Record, and Individual Client's Medication Log.

4.02 Suicide Prevention

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written plan that details the program's suicide prevention and response procedures. These comprehensive procedures are contained in the Florida Keys Children's Shelter, Inc. Comprehensive Master Plan.

One of two applicable charts reviewed indicated the youth reported 'yes' to attempting to harm themselves. It was reported that once the youth have answered yes to any of the risk screening questions then the youth is placed on consent sight and sound which was reported accurately on the close supervision form-visual check log. The log started at the time the youth reported a yes answer to the risk questions on the intake form. The youth remained on close supervision until an assessment of suicide risk form was completed by a counselor under the direct supervision of a licensed professional. The counselor then makes recommendations on the form about continued sight and sound or placement of the youth on standard supervision. Once the counselor has completed the form and recommendations, they communicate with the staff

regarding what the recommendations are for the youth. This youth was placed on standard supervision and documentation in the charts shows the date and time the youth is taken off of close supervision. All of the documentation is located in section five (5) in the chart.

All staff reported room checks being done every fifteen (15) minutes. It was reported by the staff that if a youth expresses suicidal thoughts, direct care staff are responsible for, notifying a mental health authority, placing the youth on constant sight and sound supervision, documenting the supervision and searching the youth, and the youth's room for hazards.

During the review of the second applicable suicide risk case file, the "Risk Screening" section of the CINS/FINS Intake form completed on 12/16/2013 does not indicate any suicidal ideations. Similarly, the "NETMIS Youth Screening" form under Suicide Risk indicates that child is not actively suicidal. However, on the "NETMIS Youth Profile completed the same day for the youth, in the section under psychological issues located in Risk Factors, it is indicated "yes" for "youth suicidal". The latter information did not trigger staff to complete an Assessment of Suicide Risk. It was observed that the NetMIS Youth Screening form was not signed/approved by a supervisor.

On 12/23/13, the youth was subsequently Baker Acted. There is inconsistent documentation of what is included in the file and the log book entries. Case notes reflect that the youth was hospitalized for four (4) days and then returned home. The log book entries reflect that youth was hospitalized from 12/23/2014 through 01/08/2014. Communication dated January 2, 2014 to the hospital inquired of the youth's status and indicated youth had been released from the hospital. Log book entries still reflected youth to be in the hospital through 1/8/2014. Administrative review of the log book entries should have noted the discrepancy. Recommendation is that pertinent information on youth is communicated to appropriate staff in a timely manner.

Upon return to the shelter on 1/8/14, the youth was placed on precautionary observation which continued until 1/15/14. Counselor notes reflect that youth was to be removed off close supervision status at 4:30 p.m. on 1/15/14; however it is reflected on the observation log that the youth was removed off at 2:00 p.m., prior to the Counselor's recommendation.

4.03 Medications

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There is a written procedure that addresses the safe and secure storage, access, inventory, disposal, and administration/distribution of medications.

Observation during the onsite visit showed that all medications are appropriately stored in the medication room, which is secured behind two locks. Narcotics and controlled medications are stored in a double locked cabinet located in the medication room.

At the time of this review, there were no injectable medications stored. Similarly, there were no medications requiring refrigeration. However, the provider does have a locked refrigerator in the medication room to store medication requiring refrigeration. Also, at the time of this review, there were no syringes. Sharps, Razors and Nail Clippers are stored in a locked cabinet.

Inventory and running balances are maintained for controlled substances and Over the Counter medication. Over-the-Counter Medications are inventoried weekly. Medication Distribution Logs are used to document distribution of medication. Youth Medical records contain the appropriate information required by the indicator. Staff trained in Medication Management are designated to have access and to administer medication to youth.

Medication storage, disposal and administration are consistent with the agency's policy and procedure. Medication in need of disposal are taken to the Sheriff's office across the street and placed in a medication disposal drop box.

The three (3) staff surveyed reported they all assist youth in the delivery of medication and are informed of medication side effects in the medical alert log. One (1) staff reported being informed of medication side effects in the physician's desk reference, one (1) reported being informed in the shift transition, and one (1) reported being informed at the staff meeting of any side effects of medications.

It is recommended that the provider get confirmation from the sheriff's office that the medication was placed in the medication disposal drop box.

4.04 Medical/Mental Health Alert Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program maintains written policy and procedures to ensure information concerning a youth's medical condition, allergies,

common side effects of prescribed medications, food and medication contraindication, and other pertinent treatment information is effectively communicated to all staff through an alert system. The Provider's Alert system includes 13 different alert types including medications, medical and mental health conditions. Each alert type is represented by alphabetic abbreviations. Alerts for youth present in the shelter are posted daily on the reverse of the control room door. Staff have the codes for all alerts printed on the reverse of their ID cards for easy verification of alert codes. Alerts for each youth are displayed on the outside of the client file, written on dot stickers, using the same alphabetic codes.

The three (3) staff surveyed reported they are informed of the youth's medical alerts/mental health alerts from the alert form. One (1) staff reported that they hear about the alerts at the shift meeting, one (1) reported they can look at the log book and one (1) staff reported they can look in the youth's file. A review of the youth files indicate that practices are consistent with policy and procedure.

4.05 Episodic/Emergency Care

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program maintains written policy and procedures that comply with the standard to ensure the provision of emergency medical and dental care. The program's procedures include the following mandatory components relating to obtaining off-site emergency services: 1) parental notification requirements, and 2) development/implementation of a daily log.

Training on first aid and emergency medical procedures are completed and current for all staff. Emergency medical care is logged and that log book is maintained in the medication room.

Knife for life and wire cutters are located at the Monitor Station. Seat belt cutters and window breakers are located in both of the vans. First Aid Kits are located in the Medication Room, kitchen and in both vans.