Florida Network of Youth and Family Services Quality Improvement Program Report

Review of LSF NW- Currie House

on 12/03/2014

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 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

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

Keith D Carr, Lead Reviewer, FOREFRONT/FNYS

Gina Dozier, COO, Capital City Youth Services, Inc.

Tracey Ousley, Regional Coordinator, CDS Family and Behavioral Health Services Inc.

Rachel Greene, Clinical Directory, Capital City Youth Services, Inc.

Persons Interviewed

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

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

1 Maintenance Personnel
1 Program Supervisors
6 Other

Documents Reviewed

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

6 Health Records
5 MH/SA Records
17 Personnel Records
10 Training Records/CORE
10 Youth Records (Closed)
14 Youth Records (Open)
4 Other

Surveys

6 Youth | 6 Direct Care Staff | 0 Other

Observations During Review

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

Comments

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

Due to the lack of Special Populations Referrals, the agency had no official cases available for review and assessment of CINS/FINS Indicator 3.07. Special Populations includes Staff Secure, Domestic Violence and Probation Respite Referrals. In general the LSF-NW Currie Staff members, program operations and systems to serve these referrals is in tact and available if a referral should be made for the aforementioned special populations.

Strengths and Innovative Approaches

Rating Narrative

The Florida Department of Juvenile Justice (DJJ) is the State of Florida's agency responsible for Prevention and Intervention Services that provide programming and services to reduce juvenile crime and increase public safety. According to Florida Chapter 984 the state must provide a continuum of services to prevent Status Offenders from entering the Juvenile Justice system. These services are typically referred to as for Children in Need of Services and Families in Need of Services (CINS/FINS). The Lead Agency for Children in Need of Services and Families in Need of Services (CINS/FINS) Services for the State of Florida is the Florida Network of Youth and Family Services (FNYFS).

Lutheran Services Northwest (LSF-NW) is contracted by the Florida Network of Youth and Family Services to provide CINS/FINS services in the Northwest region of the Florida Panhandle. Each youth shelter operates 24 hours a day, 365 days a year and serves a range of six (6) youth up to a maximum of ten (10) CINS/FINS shelter beds in each program. At the time of this onsite Quality Improvement (QI) review, the Currie House residential program was caring for three (3) CINS/FINS youth.

The agency promotes its broad range of service offerings to those youth and families in need through Outreach efforts their immediate service region. The agency has several interagency agreements with local community stakeholders and partners. These local area stakeholders and partners include local schools, law enforcement, United Way, local area businesses, faith–based organizations, medical partners, homeless shelters, and various other community-based organizations.

The agency reports that 2014 has presented many challenges that is has had to address and has met those while continuing to grow. The agency reports that is has survived two (2) major natural disaster weather events including an ice storm in January 2014 and flood in April 2014. One LSF-NW Counselors and one Youth Care Specialist experienced major flooding at their homes and yet continued to provide services for families in their care. The agency was also tested through locally through a week-long series of emergency preparation exercises prior to possible landfall of a hurricane in June 2014. In the wake of these disasters, the agency was visited by leadership of Lutheran Disaster Response, housed in Chicago.

The agency reports that is has completed the reaccreditation process with Council on Accreditation (COA) and was successfully re-accredited.

High rate of parent/guardian involvement noted by weekly family sessions for residential youth. All case/service plans signed by parent/guardian (rather than verbal consent being obtained via phone). Needs asessments and case/service plans for residential youth were completed within 24 hours which exceeds the 72 hour Florida Network policy.

Knowing that the summer months are a challenge for meeting their contract numbers, agency counselors made new connections with community centers and Salvation Army to reach out to underserved areas.

The Non-Residential counselors are currently doing groups in three (3) schools, with plans in place to add 3 more prior to the close of the calendar year. In addition, the agency has moved its Non-residential Counseling office in Milton to the Santa Rosa Kids House, from a tiny room in the building of another agency.

The agency reports that its Care Days started off slowly, but they have been quickly making up these earlier deficits.

The agency reports that its 3 regions, NW, SW, & SE, began work on standardization of Policy & Procedure Manuals. In the process, LSF-SE has essentially adopted the NW policy and procedure Manual, or at least modeled theirs for consistency of operations and service delivery.

The agency reports an increase in staff completing training this year, including two 5-day sessions for our Behavior Management Motivational System.

The agency reports that its therapy dog, Dozer, and his "Mom", Angie Nousiainen, are monthly visitors to the shelter.

The agency now has a Life Skills Coach for the shelter, funded with the HHS Basic Grant, that also works with former clients and teen volunteers on Saturdays and works in conjunction with its Youth Advisory Board.

Veteran employee Cyndy Freshour celebrated her 20th LSF anniversary in July, our fourth staff person in the 20 year plus Club!

This has been a year of repairs and upgrades to LSF-NW facilities. The agency replaced the subfloor in the restrooms, the shelter restrooms were renovated, and a flood in the restroom in the Counseling wing allowed us to re-carpet the hall and 2 rooms. The fence on the west side of the building was replaced by volunteers on the United Way Day of Caring earlier this month,

Most recently, the agency has battled bed bugs, culminating with a complete "Tenting" or Heat Treatment for the entire building, at a cost of about $11,000. The agency reports that it is now "Bug Free Work Place"!

Standard 1: Management Accountability

Overview

Narrative

The Lutheran Services Florida Northwest (LSF-NW) Currie House youth shelter is located in Pensacola, Florida and provides CINS/FINS services in Escambia and Santa Rosa counties. Lutheran Services Northwest also operates a sister youth shelter called HOPE House that is located in Crestview, Florida located in Okaloosa County. In addition, LSF-NW is affiliated with the parent company Lutheran Services Florida which is located in Tampa, Florida.

Both LSF-NW CINS/FINS programs continue to share the positions of Regional Director, Clinical director, Shelter Services Director, Outreach Manager and Human Resources Manager. The agency's Clinical Director oversees all counseling and mental health services provided to youth and families delivered at both service locations. In addition, the agency's Shelter Services Director is responsible for supervision program operations at both residential youth shelter locations. The agency also assigns the daily operation and direct responsibility of each shelter to a Youth Care Specialist III position that acts as the Residential Supervisor at each youth shelter.

The agency continues to maintain uniform operating and performance protocols for both residential and non-residential service locations in the areas of marketing and promotion, partnerships, screening, hiring, orientation and training. The agency continues to conduct screenings prior to hiring of all staff members. All staff members receive uniform on-boarding training related to CINS/FINS residential and non-residential service at their respective service locations. In addition, many agency trainings combine staff members of both service locations to be trained on various core training topics. The agency also conducts outreach services through partnerships with local community stakeholders and various system partners. The agency has on-going initiatives with nearly twenty (20) partners including the Escambia Sheriff's Department, Escambia County School System, United Way and the Junior Achievement of Northwest Florida.

1.01 Background Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a "Background Screening of Employees and Volunteers"policy that mirrors the requirements of the standard. It indicates that the background screening must be completed prior to any offer of employment , granting of volunteer status, and /or before any direct contact or participation in agency activiites may occur. The Senior Administrative Assistant of his/her disignee is responsible for compliance with this policy.

The reviewer observed Background Screeenings for 21 new hires since November 2013, one program volunteer and one 5 year re-screening of an employee. All background screenings for new employees and the volunteer were completed prior to hire date. The 5 year re-screen was due 1/5/14 and was appropriately completed 12/13/14.

The Annual Affidavit of Good Moral Character was notarized on January 10th, for submittal to the DJJ Screening unit. All documentation that was reviewed indicated full compliance wiht FDJJ-1800, Background Screening Policy and Procedures.

No exceptions are noted for this indicator.

1.02 Provision of an Abuse Free Environment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The is a current policy (approval date 09/15/14) that addresses the provision of an environment in which youth, staff, and others feel safe, secure, and not threatened by any form of abuse or harassment.

The Abuse hotline number was posted in the shelter in the hallway near the staff office and living area where it could be viewed by both staff and residents. Signed "Corporal Punishment Acknowledge Forms" which includes a list of prohibited interventions such as corporal punishment, verbal insults, intimidation, restraints, withholding of food, etc. were observed in personnel files. Each employee also signs a " Staff / Volunteer Code of Conduct" that prohibits abuse.

Eight youth in residence at the shelter were surveyed and five of the eight (5/8) answered affirmatively to knowing that the abuse hotline is available for them to report abuse at the shelter, as well as stating they could show where the hotline number is located . Three (3) answered “no” to both questions. All eight (8) youth surveyed indicated that they had not made a call to the abuse hotline and they had not been stopped or delayed in making a report the hotline. Four of the eight indicated that the adults at the program are respectful when talking with youth. Two youth answered negatively. All eight youth indicated they had not heard profanity or threats used towards youth, that they felt safe at the shelter, and that they had never been sent to their room as punishment. Six staff members were surveyed as well. They all expressed

familiarity with mandatory reporting procedures as well as youth access to reporting. None of the staff reported having ever observed another staff member use profanity, threats, intimidation or humiliation when interacting with youth and none reported ever sending a youth to their room or isolation for punishment.

Some exceptions are noted for this indicator. Youth surveys indicated that three youth didn't know of the availablility of the hotline or the locations of the hotline number. Two (2) out of four (4) youth answered negatively regarding staff being respectful and these youth provided q name of a staff they believed to be rude. Residents reported that a certain staff is rude and has told them me several times that she did not need them to make any unecessary remarks or comments.

1.03 Incident Reporting

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has an incident reporting policy and process in accordance with the standard and Administrative Code. The program had a total of fifteen (15) incidents that were reported and accepted by the CCC within the past 6 months. There was also documentation of at least two instances where the CCC was contacted proactivly, though a report was not taken.

Two exceptions were noted. There were CCC reports on 4/9/14 and 4/24/14 that were not made within the required two -hour time frame for reporting. One was late by several hours and the other by 40 minutes. Specifically, there is one incident report that indicates that a medication error was discovered at 4:00am. The CCC report indicates that the report was called in at 5:25 am (which would be 4:25 am CST). The internal incident report documentation indicates the report to the CCC was made at 3:25am. It appears there was a documentation error as a result of trying to differentiate the time zone difference. Overall, there is an active, adequate incident reporting practice.

1.04 Training Requirements

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a comprehensive policy that outlines training expectations for staff members that includes the requirement for direct care workers to obtain 80 hours of training during the first year. The program is also licensed by DCF and, therefore, requires the 40 hours of annual ongoing training for direct care workers instead of only 24 hours.

The program has a system of ongoing monthly training in which they rotate New Hire Orientation conducted during odd numbered months and Workplace Safety duing even numbered months. New Hire Orentation includes Agency History, Philosophy, etc.; Clincal; Guardianship; Outreach; Prevention, Intervention, Teen Court, Quality Assurance Training; Shelter Services, Deaf and hard of Hearing Training; Ryan White; and Personnel topics. Workplace Safety Training covers topics of Mental Health Safety (Abuse Reporting, Condfidentiality/ Duty to Warn, Suicide Risk Evaluations/ Mental Health Plan); Safety And Accident Prevention (Role Play), Overview of Policies and Procedures; OSHA Standards (MSDS , Disaster Preparedness and Emergency Response Plan, Exposure Plan); Program Safety (Domestic Violence, Fire Drills/ fire drill logs, Incident Reporting, Vehicle Safety, Key Control, Medication Administration)

The Quality Manager has a organized tracking system for monitoring training for the staff in addition to the individual training files of each employee. Internal training is offered on on a variety of topics as well as some training being obtained from outside sources. Staff iare becoming more active with the use of online training via the FNYFS *Dizzy Baby* resource.

The reviewer inspected five (5) files of 1st year employees. Three (3)of the five (5) had over 100 hours of training recorded even though their first year was not yet completed. Two (2) of the five (5) had 75-80 hours with their first year being scheduled to end in January 2015 and August 2015, respectively. Five (5) files were reviewed for employees who have been employed for more than one year reviewed. All five had more than the required number of training hours for continuing employees. All five of the continuing employees had current/refresher training in suicide prevention, four of the five had fire safety, and all were current on CPR/First Aid. The employee needing fire safety refresher had 5-6 months remaining to obtain the training and was a counselor rather than a YCS.

1.05 Analyzing and Reporting Information

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a Performance and Quality Improvement process as a part of its Accreditation by the Council on Accreditation. This process is consistent with the elements of the indicator with regards to collection, review, and analysis of information/data.

The staff is organized into several teams that monitor, evaluate, and report on Incidents, Accidents, and Grievances; Safety/ Risk Management,

Consumer Satisfaction, Program Improvement, Outcome Measurement and Case Review. All full time staff are participants on one of the teams. Each team submits information to the Quality Manager who compile a quarterly report that is sent to the Corporate Office as well as distributed internally to management and leadership.

The reviewer observed a sample report that included data on the number of clients served in various programs, number of consumer stakeholder surveys completed, results of building inspections and follow up target dates, compliance percentages for internal case reviews, etc. The reports are shared with the Board of Directors and program managers share with staff. Adjustments to practice are typically made at the team level and sometimes practice /policy are changed program wide. This is largely dependent on the specific issue. There were no meeting minutes, memos, or specific revised policies provided to explicitly show the follow through and completion of the change cycle. The Quality Services Manager cited specific examples of areas that have been targeted for improvement as a result of the process. For example, at the time of review, the program was addressing a goal of reducing the number of medication incidents.

There are no exceptions noted for this indicator.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

Lutheran Services Florida- Northwest delivers a wide range of services including residential and non-residential counseling services. The clinical staff members include a clinical director, one counselor III (supervisor), and eight (8) counselor II positions. All clinical staff are noted to be Master's level clinicians with a licensed mental health clinician serving as the clinical director. The agency's organizational chart outlines that program services are provided across two (2) sites, Currie House and Hope House, through both residential and non-residential components.

Non-residential and residential services are provided at Currie House to eligible youth and their families across Escambia county. These services include screening, centralized intake, needs assessment, service/case plan development and oversight, as well as short term residential care and non residential individual and family counseling services.

Specifically, LSF-NW Currie House provides a broad range of intervention and case management services to Escambia and Santa Rosa counties. These services include screening, Centralized intake, Assessment, Service/Treatment Plan development and oversight, as well as short term residential (shelter) care and non-residential counseling services. The agency currently has one Clinical Director, one Counselor III (supervisor), Counselor II and Counselor I positions to provide these services. The agency is also equipped to provide adjudication services through the Case Staffing Committee and CINS petition process for cases, as needed and appropriate, pursuant to Florida Statute 984.

LSF-NW non-residential services are provided to CINS/FINS program participants and their families. The LSF-NW Currie and Hope House programs delivered Intervention and case-management services through the agency’s non-residential component. Services are provided twenty-four hours a day, seven days a week. The program participants receive program orientation materials upon their initial entry to the program. Program information provided to youth and parent/guardians includes confidentiality notices, release of information, service options and other orientation materials. In addition, participants are provided with information related to intake and grievance procedures.

2.01 Screening and Intake

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

A written policy describing centralized intake services is in place. This process includes eligibility screening within 7 days of referral by trained staff as well as written documentation provided to parents/guardians outlining available service options and rights/responsibilities of youth and guardian. Seven (7) youth files were reviewed for this key indicator including four residential files and three non residential files. Agency informed consent forms document that a parent/guardian of youth has received a CINS/FINS brochure at the time of intake which outlines available service options. In addition all files included documentation of agency grievance procedures which were all signed by the youth.

Furthermore, the screening and intake process was confirmed by interviews with one YCS staff and two clinical staff who expressed thorough knowledge and understanding of agency policy and its practice. The YCS staff described a process by which screening calls are answered 24 hours a day, seven days a week by any available staff. They reported that following a phone screening the family is informed that they will receive a call back regarding their eligibility for services within 24 hours. Once it is determined that a youth is eligible for services, the family is called and given a time of intake. Staff stated that at intake the youth and family are given a CINS/FINS brochure which outlines available services and and serves as the parent/guardian brochure. In addition, staff report the parent/guardian is given a signed copy of youth/guardian rights and responsibilities.

No exceptions are noted for this indicator.

2.02 Needs Assessment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

A written policy is in place which documents that a needs assessment will be completed for each youth within 24 hours of intake (residential) or within 2-3 face to face sessions (non-residential). It is important to note that this agency policy exceeds the Florida Network standards.

Seven (7) youth files were reviewed for this key indicator including four (4) residential files and three (3) non residential files. Of the 4 residential youth files all needs assessments were in compliance with agency policy and completed within 24 hours of shelter intake. Of the 3 non-residential files all met the agency standards of being completed within 2-3 face to face meetings. In addition, all needs assessments were conducted by a Bachelor's or Master's level staff, reviewed and signed by a supervisor.

There is an exception documented for this indicator. One (1) open residential file was included which documented a youth on site and sound due to being recently discharged from a Baker Act facility. However, the suicide assessment was not conducted within 24 hours due to staff oversight. It was conducted under the direct supervision of a licensed mental health professional.

2.03 Case/Service Plan

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

A written policy is in place which documents that a service plan is to be developed with youth and their family within seven working days following completion of the needs assessment. This procedure was confirmed by interviews with three (30 clinical staff members (two residential counselors and one non-residential counselor) as well as review of seven youth files.

Residential staff described that within 24 hours of a youth being admitted to the shelter a "clinical intake" is completed which entails a residential counselor conducting a needs assessment, developing a case/service plan and suicide assessment (if needed). Non-residential staff described that a discussion regarding a case/service plan took place with youth and family at intake and was completed at the second session. Staff descriptions were congruent with reviewed youth files.

Seven (7) youth files were reviewed for this key indicator including four (4) residential files and 3 non-residential files. All residential files reviewed onsite included a service plan initiated and completed within 72 hours. All reviewed non-residential files included a service plan completed within seven working days of the needs assessment. In addition, all reviewed case plans included individualized and prioritized needs and goals identified by the needs assessment, identified service type, frequency, location, person responsible and a target date for completion. Actual completion dates were documented in several files in which discontinuation of services was planned. In files where services were discontinued abruptly, an actual completion date was not documented as objectives were not able to be reached within the limited time frame. All reviewed service plans included necessary signatures of youth, guardian(s), the assigned counselor and supervisor. It is noted that all reviewed files included the signature of a parent or guardian (rather than verbal consent over the phone) which outlines this program's commitment to family/guardian involvement in services.

Due to case/service plans being completed at the time they are initiated (at clinical intake for residential youth and at the second session for non-residential youth) a separate "date initiated" tab is not included on the case/service plan. All applicable files included a 30/60/90 day progress review of the case/service plan.

This are no exceptions documented for this indicator.

2.04 Case Management and Service Delivery

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy in place which outlines the process of ensuring the delivery of client services. This process includes establishing referral needs and coordinating referrals, service plan implementation, monitoring progress and providing support for families.

This practice was confirmed by interviewing one (1) residential youth and three (3) clinical staff. The residential youth stated the name of her assigned counselor, identified one goal from her case/service plan, articulated that she felt supported by staff and was making progress towards resolution of her identified needs. This youth reported meeting with her identified counselor twice a week and discussing progress made towards her goals. In addition, youth surveys confirmed this practice with all youth surveyed articulating that they have a counselor and know what goals they are working on.

The two clinical staff interviewed articulated a thorough understanding of how the goals of a youth's service plan inform service delivery. In addition they explained to the reviewer the importance of weekly counseling sessions with youth in order to implement the service plan, provide support and establish referral needs. Furthermore they articulated a process in which a residential youth is referred to in-house non-residential counseling upon discharge from residential services.

In addition to formal interviews, seven (7) youth files were reviewed for this key indicator, including four (4) residential files and three (3) non-residential files. All reviewed files satisfied this indicator by documenting an assigned counselor, a clear outline of service plan implementation, counseling session summaries indicating youth/family progress in services and ongoing support of youth and their families. This ongoing support was documented through counseling session summaries, as well as summaries of parent/guardian phone calls. No files reviewed held applicable material to review for monitoring out of home placement or referrals to case staffing committee or court/judicial involvement. All files

reviewed had appropriate case termination documented.

This indicator has no documented exceptions.

2.05 Counseling Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a current written policy which addresses all key indicators for this standard. The key indicators were validated using a methodology which included interviews with 2 clinical staff (one non-residential counselor and one residential counselor), a clinical director and one youth. Additionally, seven (7) youth files were reviewed including four residential files and three non-residential files.

All interviewed staff outlined a clear and consistent process for facilitating counseling services. All staff interviewed articulated the importance of providing individual and family counseling, as well as addressing a youth's presenting problem in the needs assessment and case/service plan. In addition, staff described an on-going internal process of clinical review and case consultation. The clinical supervisor reports that weekly staffings are held on Wednesdays at 1pm to address case coordination, referrals needed, youth behavior and other issues that may arrise. This process is not formally documented or reflected within a youth's file. In addition, clinical staff report a collaborative and "open door" environment in which they can at any time access a supervisor for support with counseling services. The youth interviewed reported receiving weekly individual and family counseling at which time the goals of her case/service plan were discussed, as well as access to daily group sessions.

All seven (7) youth files reviewed for this indicator met all of the indicator standards. In each file documented case notes, needs assessment and service plans were consistent in addressing a youth's presenting problem. In addition, each youth's contact sheet outlined dates and times of daily group sessions. Each file contained case notes which documented each youth's progress in counseling sessions.

No exceptions are noted.

2.06 Adjudication/Petitiion Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

A written policy is in place which addresses all key indicators for this standard. The key indicators were validated using a methodology inclusive of staff interviews and review of one case-staffing committee process.

Two (2) clinical staff reviews were interviewed. Each staff articulated knowledge of the policy and process of a case-staffing committee. Both staff members described the procedure for convening a case staffing committee including the process of notification of family and committee no less than five (5) working days prior to staffing. They also described representatives needed at the case staffing to include a local school district representative and a DJJ representative or CINS/FINS provider. In addition, a process of regular communication with committee members was described.

The review of one case-staffing committee file indicated the person initiating the case staffing and documented that the youth's family was notified by phone five (5) working days prior to the meeting. Documentation reviewed indicates that at least a 5 day notification of the meeting was not provided to the staffing committee. Documented emails indicate notice was given the day before one scheduled meeting, the day of a subsequent meeting and documentation is not present for date of notification of the initial meeting. Case staffing committee notes indicate that the two meetings included a local school district representative, a DJJ representative and/or a CINS/FINS provider representative. The subsequent meeting did not include a school representative (although it is documented that she was invited) and therefore this meeting was not considered a formal staffing.

In addition, case staffing documentation indicates the youth and family were provided with a new case/service plan and a written report was provided to the parent/guardian within 7 days of the case staffing, outlining recommendations of the committee.

An exception is noted for this indicator. Documentation reviewed indicates that at least a 5 day notification of the meeting was not provided to the staffing committee. Documented emails indicate that the notice was given the day before one scheduled meeting, the day of a subsequent meeting and documentation is not present for date of notification of the initial meeting.

2.07 Youth Records

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy in place which outlines its procedure regarding youth records. The current policy dictates that all records are to be marked "confidential" and kept in a secure room or locked file cabinet and maintained in a neat and orderly manner. All seven reviewed youth files were in compliance with this agency policy.

The procedure for maintaining youth records was validated by a review of the records room which was located behind a locked door. This room where client files are kept is marked confidential on the outside. Observed inside the file room were several locked filing cabinets in which youth records were stored in a neat and orderly manner. All closed files and open non-residential files are organized by year and open clinical residential files organized in a separate cabinet by youth ID number. Interviews with staff members onsite further validated this policy as they demonstrated that records were easily retrievable. Additionally, open, non-clinical, residential files were observed to be kept within the shelter office, in a locked filing cabinet. Both clinical and YSC staff interviewed reported a working knowledge of the youth records policy, including that records are accessible only to program staff.

No exceptions are noted.

Standard 3: Shelter Care

Overview

Rating Narrative

The LSF-NW Currie House residential program has designed to provide a total of three CINS/FINS residents. According to the agency's organizational chart the Currie House youth shelter staff consists of a Shelter Services Manager, a Youth Care Specialist (YCS) III, a Dietary Specialist, over two (2) YCS II, and nearly twenty (20) YCS I staff members. At the time of this QI program review, there are a total of seven (7) CINS/FINS youth in the youth shelter. The residential shelter is co-located on the same property with the agency's administrative offices. The administrative offices are connected to the main structure of the youth shelter so that all counseling staff have easy access to the residential facility to provide counseling, supervision and other support services.

The LSF-NW has on-going contract with the Florida Network of Youth and Family Services to provide CINS/FINS services. The Currie House youth shelter also serves multiple residential group care populations including Dependency, Staff Secure, DJJ Domestic Violence and DJJ Probation Respite. This contract serves youth that are considered status offenders. These services include entry level of intervention and treatment for youth and families that are at risk for legal complications such as chronic runaway, lockout from the home or repeated school truancy. The agency also has a contract with the Family First Network (FFN), which is a division of the Lakeview Center. The Lakeview Center is a provider under the Department of Children and Families (DCF) network. Under the terms of this contract, LSF-NW is required to provide reunification and or placement care for youth that are in the Foster Cares. Both the CIN/FINS and FFN residents receive similar service offerings interventions and treatment.

The overall shelter environment is orderly, clean and staff seem positive. The agency has an established program orientation for all new residents admitted to the program that is provided during the intake process. The program orientation includes all the required elements outlined in CINS/FINS Standard 3 and is well documented in the client files. Room assignments are completed by the Youth Care Staff at time of intake and are thoroughly reviewed, ensuring that any youth placed in a room with another resident is not a threat to the safety of him/herself, another resident, and the staff in the program.

The agency had a very well established behavior management system that was consistently implemented to influence the youth to make positive choices and increase his/her personal accountability and social responsibility. The program is still using a Boystown-like model and encourages staff to interact with the youth and implement corrective teaching to help modify ill adapted behavior. There were no incidents of manual restraint to review over the past year.

3.01 Shelter Envonment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program maintains a twelve bed shelter with an attached administration building. The shelter consists of six bedrooms each with two twin size beds, two dressers and a standing metal closet. Each bed has a colorful quilted bedspread and pillow. Each room is numbered and has a dry erase board on the wall to allow clients to write or draw. The rooms were neat and clean as were the bathrooms. The dining room is very attractive with a beach scene painted on the wall and the common area is nicely decorated with appropriate quotations on the wall. There is a nicely kept back yard area that has a basketball area and a nice lawn area. The grounds are well landscaped and maintained. Health and fire safety inspections are all current.

The program maintains a Weekday, Weekend and Holiday, and a Monthly schedule of outings and activities. A variety of activities and events are offered and youth have the opportunity to participate in physical activities, as well as voluntary faith based activities. Reading, homework and quiet time are provided daily. The schedules are posted and accessible to youth and staff.

The program does a nice job of maintaining the buildings and grounds. The rooms are pleasant and friendly in appearance. There are nice scenes and quotations on the walls. The bedrooms have nice colorful quilted bedspreads. The grounds are nicely landscaped and the backyard is very attractive. Health and fire safety inspections are all current.

There are no exceptions noted for this indicator.

3.02 Program Orientation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program policy and procedure covered all the elements required in program orientation. The agency practice is to orient youth individually

as part of the intake process. A review of six residential files confirmed the process as all files contained the documentation of the orientation components.

There are no exceptions noted for this indicator.

3.03 Youth Room Assignment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy that governs the process for making room assignments. The policy addresses all of the required elements of the indicator. The intake staff records all classification information used in making the room assignment on the CINS/FINS Client Intake Package. Efforts are made to separate dangerous youth from those who might be victimized.

During the intake process, the program assesses each youth for potential harm to self by using the Evaluation of Imminent Danger for Suicide instrument. Mental health, substance abuse, potential harm to others physical health and security risk factors are also assessed. An alert is initiated if applicable.

Six residential files, four open and two closed were reviewed for this indicator. All six files contained the required elements used for room assignment. Four of the six were appropriate for alerts and had one or more initiated.

There are no exceptions noted for this indicator.

3.04 Log Books

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure that includes all the required elements of the indicator. The program uses a bound record book with blank sequentially numbered pages. Glued into the front of each logbook is a list of staff phone number, LSF program numbers, and a long list of other relevant numbers. It also has a list of logbook users who list their printed name, signature and initials for verification. A detailed bound logbook is used to record appropriate program information. A standard color code system is used to denote specic types of logbook entries. Oncoming staff document a review of previous shifts.

A color code legend is also posted in the front of each logbook. Five colors are used to highlight specific types of entries. Black ink is predominately used with two exceptions: Red ink is used to document incidents, accidents,fire drills, injuries. Green ink is used to document medications and special medical conditions. Oncoming staff and shift supervisors document their review of the previous shifts. The program director writes a review of the logbook by noting the pages reviewed and provides information or feedback as appropriate; however this is not done consistently on a weekly basis.Youth Care Specialists use the appropriate format for documentation but ofter use their initials rather than a signature after an entry.

An excpetion is noted for this indicator. The Program Director does not consistently document a weekly review of the logbook as required in the indicator. Youth Care staff often use initials rather than a signature at the end of a logbook entry.

3.05 Behavior Management Strategies

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a very detailed policy and procedure outlining the Behavior Management System that meets all the requirements of the indicator. Policy prohibits group discipline and allows only staff to discipline youth. Room restriction is used as a time out to give youth and opportunity to regain control over themselves away from the group, Youth are monitored by staff during room restriction.

LSF NW uses the Behavior Management Motivation System based on the Boys Town Model to provide a systematic , positive and consistent approach for reinforcing positive behavior and correcting problem behaviors. The system uliizes the teaching of social skills using effective praise and corrective teaching among other techniques. Youth enter the shelter on Assessment System and are given two target skills to master. On day four the youth moves to the Daily System and is given two more skills. Each youth has a system standing of 140,00 to 210,000. Points are accrued throughout the day and are subtracted from the system standing. A daily point total of 10,000 is needed to earn privileges for the next day. When a youth reaches a zero system standing and displays the ability to use basic skills and shows improvement in their referral

behaviors, he/she may move to the highest level which is Achievment. Inappropriate behaviors result in the youth being placed on Subsystem and have to earn extra points to get back in good standing.

Staff are trained in Crisis Prevention Institute (CPI) and the policy dictates that manual restraint is used as a last resort to protect youth and others. Two debriefings are done after a manual restraint is used. LSF prohibits locked seclusion, chemical or mechanical restraints.

A review of personnel files showed that staff receive training in both CPI and Behavior Management System. Three of the four personnel files reviewed had Behavior Management System skills assessed in the evaluation. Direct onsite interviews conducted with the Youth Specialists revealed that they felt that the program is effective. Three of the youth in the program were asked about the behavior management system and they were each able to speak with a high degree of knowledge about it. In general, the interviews resulted in very thorough explanations of the behavior management system in the policy and procedures. Staff and youth were able to explain the system.

There were no exceptions noted for this indicator.

3.06 Staffing and Youth Supervision

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has established policy and procedures relating to staffing and youth supervision that meets all the required elements of the QI indicator. Agency policy prohibits two males from being on shift without a female staff member.

A review of the schedule for the past six months shows that the agency adheres to the policy when scheduling the shifts. The program exceeded the 1 to 6 ratio on the day and evening shifts on most days by scheduling 3 staff. The shelter exceeds the required ratio for most day and evening shifts by scheduling three staff members rather than the required two. There were occassions where two females worked some shifts without male coverage. The Program Director spoke to the difficulty they have hiring and maintaining male staff. Their efforts to hire males is ongoing. The schedule is posted in the Youth Specialist office and is easily accessible to shelter staff. A list of staff and phone numbers is in the inside cover of the logbooks.

Agency policy requires that bedchecks are done every 10 minutes when youth are in their sleeping room. Bedchecks are documented in the program logbook. A review of the logbooks indicate that the bedchecks are being done and documented within the required time frames. A review of the video tape for two different nights showed that bedchecks were being done according to policy and within the required timeframes.

An exception is documented for this indicator. Some shifts throughout the review period regularly had evidence that two females and no male staff were scheduled and on duty. The Program Director spoke to the difficulty they are having hiring male staff. Efforts to do so are consistent and ongoing.

3.07 Special Populations

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has policy and procedures for the special populations of Staff Secure and Domestic Violence Respite and Probation Respite and seems programmatically prepared to serve these populations. At the time of this onsite QI program review, there have been none of these special populations referred for services under these contracts during the review period.

There are no exceptions noted for this indicator.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The LSF-NW Currie House program has comprehensive policies that address program requirements related to health admission screening, behavior management, mental health and suicide risk assessments, medication distribution, general alert systems and medical and mental health alert. A review of the agency's protocol regarding the shelter environment was conducted and contains policy and language that meets the general requirements of this indicator.

The agency's current suicide assessment practices and policies have been reviewed and approved by the Florida Network of Youth and Family Services. To execute these services, the agency utilizes master's level counselors, a Residential Supervisor, a Shelter Services Manager and a Licensed Mental Health Clinician. The Shelter Services Manager oversees the agency's residential services and the Licensed Mental Health Counselor oversees all counseling and assessment services on a daily basis.

4.01 Healthcare Admission Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a Healthcare Admission Screening policy 4.01 and is last documented as being reviewed and updated on September 26, 2014. This policy requires that the program perform a reliminary physical health screening for each yotuh at the time of admission to the shelter. The preliminary screening requires the program to perform duties that include screening for current medication; existing (acute and chronic) medical conditions; Allergies; recent injuries or illnesses; presence of pain or othe physical distress; observation for evidence of illness, injury, physical distress, difficulty moving, and observation for the presence of scars, tattoos, or skin markings.

The agnecy file protocol entails 2 differrent files. One file is called the Shelter and the second file is called a Clinical file. The shelter file capture mental, medical and risk identified during the screenign and assessment process.

Two clients are marked as having Asthma. The agency form indicates that the program is required to a follow-up and initiate the medical alert system and follow up notification policy. The shelther intake assessment form captures all personal and demographics information and physical client information on client identification such as height, build, complexion, eye color, hair color, scars, tatoos and body piercings.

The reviewer assessed a total of six (6) randomly selected open and closed files. Of these files five (5) were open and one (1) was closed. The file reviewed provided evidence that the agency captures client health and medical screening information in 2 parts. The residential file includes a detailed intake assessment that includes physical body descriptions. The clincial files include the FNYFS Intake Assessment that screens for any obervable injury, illness or health related issues; recent hospitalization; currently receiving medication; allergies; dietary restrictions and twenty-four (24) medical conditions questionnaire/screening checklist. All six (6) client files have evidence of completing the overwhelming majority of health and medical conditions screening process on both forms.

There is an exception documented for this indicator. A review of one residential health screenign file indicates that the one health screening question is left blank or is missing and response for the question has the cleint been treated or hospitalized for any medical condition(s) in the past year. This question was left blank.

4.02 Suicide Prevention

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The reviewer of this indicator assessed the contents of this policy. The agency has a detailed policy addressing Suicide Prevention 4.02 that meets the general requirements of this indicator. The policy indicates that it was last reviewed and approved by the Regional Director on September 26, 2014. The agency's Director and Clinical Supervisor both have clinical licenses. The agency conducts a suicide assessment on suicide risk clients. This assessment is executed by the clinician or non-licensed counselors under the supervision of the licensed mental health professional. In addition, the agency has documentation verifying parent or legal guardians had been notified. The agency's suicide assessment policy was been approved by the Florida Network in 2014 and has not had any substantive changes. In addition, all files reviewed on site had evidence that bachelor and master level staff members have had their suicide risk assessment results reviewed and signed by the agency licensed clinician.

The agency is now utilizing a document titled as a Needs Assessment instead of Psycho-Social Assessment used in the 2013-2014 fiscal year.

The Suicide Assessment is completed by Masters Level Counselors. All counseling positions are currently occupied by Masters level staff members that are supervised by a licensed supervisor. At the time of this onsite QI Review, Supervisors are now reviewing all staff members a total of 5 sessions of the proper execution of the suicide assessment. Counselors are required to complete the intake and keep track of their administration of the Suicide Assessment Review sheet by a licensed LMHC.

Initial risk behavior is initially at the very first contact and the child is asked if they are suicidal and homicidal on the Screening Form. The secondary methods of screening include the use of the Suicide Risk Evaluation (SRE) to determine the risk and degree. This form determines if they need to be initially referred out to an offsite receiving facility or placed on sight and sound. A CINS/FINS Intake form is then used to ask additional Risk Screening question 1-6 required by the FNYFS contract. If there are yes responses on any of the 1-6 questions for suicide risk on the CINS/FINS and the Suicide Risk Evaluation as a double check and balance to ensure the current risk of the child being assessed for suicide. This redundant practice also helps check for inconsistencies in the assessment process. The agency also asks general suicide risk issues on Needs Assessment that also screens for any suicidal or homicidal red flags.

The agency executes close watch supervision process according to their one-to-one or constant supervision status. In these cases, the agency documents the youth's supervision status in the shelter's daily log. The agency assigns a staff person to monitor the youth on each shift. The monitoring process calls for the agency to observe and document the youth's behavior/status every 30 minutes or less. Of the 5 files reviewed, all cases contained evidence of the agency documenting supervision counts in the log as required. All 5 suicide cases contain evidence of the agency on initial suicide screen being conducted by the agency; evidence of results being reviewed and signed by supervisor; documentation of youth meeting being placed on sight and sound supervisor until assessed by licensed staff or assessment is reviewed by licensed staff; proof that youth are being placed on the correct level of supervision based on the assessment; and if applicable the supervision level of youth were not changed or reduced until reviewed by a licensed staff person. Interviews with staff indicate that the programs practice is to designate and document sight and sound counts in the daily log.

There are exceptions documented for this indicator. Documentation of residents placed on elevated supervision is consistent in almost all cases. One case out of 5 did not highlight the initial placement of the resident on sight and sound in the logbook.

The agency also conducts routine 10 minute checks on all residents on elevated supervision status. A review of elevated supervision counts was conducted on five (5) client files for this indicator. Two (2) out of 5 client file was missing documented evidence a 10 minute check over a 24 hour period. There was no documentation found in the file explaining the absence of this check.

All counts conducted on residents under elevated supervision are being captured, logged and signed. However, furhter assessment indicates that the actual times documented are generally not done in real-time. The reviewer's finding indicate that times are exactly marked in 10-15 time frames.

4.03 Medications

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The reviewer of this indicator assessed the contents of this policy. The agency has a detailed policy on the agency's Medications 4.03 that meets the general requirements of this indicator. The policy was last reviewed and signed by the agency Regional Director on September 26, 2014. The agency's general practice of distributing medication is acceptable. The review witnessed an AM medication pass. All general medication distribution practices were executed as required with no issues. All documentation for close files includes documented examples of good practice. Staff interviewed were trained and performed all counts over the 2 day review period as required.

On site observations found that all medications in the shelter are stored in a separate medication room. This room is secure with a two-way lock that requires key access in and out of the room. This room is inaccessible to residents. All medication in the room is stored in a four (4) drawer cabinet with a total of 4 pad locks affixed to the metal cabinet. Oral medications are also stored in this 4 drawer cabinet. Each drawer requires a key to access the content located inside. The oral and topical medications are stored in a separate contains or in the pill jar or box used to originally house the medication.

The agency does provide over-the counter medication. The agency distributes Triple Antibiotic Ointment, Pepto Bismol, Acetaminophen 500 mg, Acetaminophen Jr. (Tylenol), Ibuprofen 200 mg (Motrin), Antacids (Pepto Bismol, Milk of Magnesia). The agency maintains a weekly sharps form for each over the counter (OTC) medication. The shelter has a system in place for the refrigeration of medication. At the time of this on site review, there were no medications requiring medication on site.

There are exceptions documented for this indidcator. There is an additional incident that the a topical medication was not provided to a resident. This missed medication distribution incident was detected through a routine medication log check.

A review of all documented DJJ CCC incidents was conducted by the reviewer to determine if there was evidence of any medication error related to incidents within the last six months. This review of DJJ CCC incidents indicates that a total of ten (10) incidents were reported. Of these reports, the majority are for medication errors due largely to missing the medication distribution time. This missed medication distribution incidents are occurring on both the first shift (5) and second shift (5). The agency's Follow Up Section documents a counseling and re-education session in only 1 out of 8 incidents. However, the agency has identified this as a program improvement issue in its monthly meeting for the past quarter. In addition, the agency has had a recent training delivered by the DJJ OHS and has a developed a mapping table to analyze and assess major trends.

A review of the medication log of 1 out of 3 medications prescribed to a child that is currently in the shelter does not have documented evidence that the medication was verified.

Agency practice of detecting when youth are close to running out of medication is not consistent. Staff report different time frames for noticing parents/guardians prior to youth lapsing or running out of medications.

4.04 Medical/Mental Health Alert Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The reviewer of this indicator assessed the contents of this policy. The agency has a detailed policy on Medical and Mental Health Alert Process 4.04 that meets the general requirements of this indicator. The policy was last reviewed and signed by the agency Regional Director on September 26, 2014.

A review of six (6) randomly selected files on day 1 of the on site program review. Of these files, all files included identification using a dot to ensure notice of a resident's medical, physical or mental health alert status. The alert system also captures notificiation for residents that are prescribed medications, allergies, on elevated supervision status, physical activity restrictions, aggressive behavior, gang affiliation, history of sexual assault or misconduct, chronic runner, history of substance abuse use and client currently placed on a safety plan. The agency utilizes a marking system that indicates all residential clients that a on medication and have a medication record. The agency's dot system includes a Red dot for clients place on High Risk and a Green dot for clients that have a medical issue or are currently on medication. The agency uses a Blue dot for client in the shelter for a domestic violence respite stay.

The agency uses a Pass down binder. This binder provides a brief summary of the status the status of all residents on alert from shift to shift.

The agency also utilizes a colored folder system to diffrentiate the colors of each client type being cared for at the shelter. The folders include Blue for general status CINS/FINS clients; Red for Staff Secure CINS/FINS clients; and Yellow for Families First Network clients.

No exceptions are documented for this indicator.

4.05 Episodic/Emergency Care

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The reviewer of this indicator assessed the contents of this policy. The agency has a detailed policy on emergency/episodic care 4.05 that meets the general requirements of this indicator. The current policy requires that the agency have a written plan that explains the program's must ensure that the provision of emergency medical and detnal care is intact. The requirements must include obtaining off-site emergency services; parental notification requirements; incident reporting to the CCC and Florida Network; development and implementation of a daily log; and upon a youth returning to the shelter, verification of receipt of medical clearance, discrharge instructions and follow-up care.

The agency still maintains annual emergency and episodic trainings with both LSF-NW Currie and Hope programs and direct care staff members and supervisors on an annual basis. The agency has certified safety training specialists on staff to provide trainings to staff in CPR and First aid. In addition, the agency requires that all staff receive CPR and First Aid training, as well as other safety and security training.

The agency has record of mock and real episodic and emergency drills in May, September, October. Of the 3 documented incidents, the agency had evidence of 2 out 2 required drills are documented in the program logbook.

There are excecptions noted for this indicator. Of the 2 documented events, both were documented in the logbook, however, each is documented as a late entery in the logbook.

The agency has a record of an accepted DJJ CCC incident involving a resident that complained of dizziness and trouble breathing. This same incident is also documented in the agency's DJJ CCC Incidents and Accidents binder. However, this incident is not referenced or documented as a Episodic Care Drill in the agency's Episodic Care Drill Log. All incidents involving the offsite medical treatment should be documented as an episodic/emergency incident.