



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of CHS Treasure Coast, WaveCREST

on 09/10/2013

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Standard 3: Shelter Care

3.01 Shelter Environment	Satisfactory
3.02 Program Orientation	Satisfactory
3.03 Youth Room Assignment	Satisfactory
3.04 Log Books	Satisfactory
3.05 Behavior Management Strategies	Satisfactory
3.06 Staffing and Youth Supervision	Satisfactory
3.07 Special Populations	Satisfactory

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

Standard 2: Intervention and Case Management

2.01 Screening and Intake	Satisfactory
2.02 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/Petition Process	Satisfactory
2.07 Youth Records	Satisfactory

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

Standard 4: Mental Health/Health Services

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

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

Overall Rating Summary

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

Rating Definitions

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

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

Review Team

Members

Marcia Tavares, Lead Reviewer- Forefront, LLC

Raylene Coe, Coordinator, Crosswinds Youth Services

Tina Levene, Delinquency Prevention Specialist, Department of Juvenile Justice



Derrick Meyers, Shelter Manager, Lutheran Services Florida Southeast

Persons Interviewed

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

Documents Reviewed

- | | | |
|---|--|--|
| <input type="checkbox"/> Accreditation Reports | <input checked="" type="checkbox"/> Fire Prevention Plan | <input checked="" type="checkbox"/> Vehicle Inspection Reports |
| <input checked="" type="checkbox"/> Affidavit of Good Moral Character | <input checked="" type="checkbox"/> Grievance Process/Records | <input type="checkbox"/> Visitation Logs |
| <input checked="" type="checkbox"/> CCC Reports | <input type="checkbox"/> Key Control Log | <input checked="" type="checkbox"/> Youth Handbook |
| <input type="checkbox"/> Confinement Reports | <input checked="" type="checkbox"/> Logbooks | 3 Health Records |
| <input checked="" type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 3 MH/SA Records |
| <input checked="" type="checkbox"/> Contract Monitoring Reports | <input type="checkbox"/> PAR Reports | 8 Personnel Records |
| <input type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 6 Training Records/CORE |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 9 Youth Records (Closed) |
| <input type="checkbox"/> Escape Notification/Logs | <input checked="" type="checkbox"/> Sick Call Logs | 14 Youth Records (Open) |
| <input type="checkbox"/> Exposure Control Plan | <input checked="" type="checkbox"/> Supplemental Contracts | 0 Other |
| <input checked="" type="checkbox"/> Fire Drill Log | <input checked="" type="checkbox"/> Table of Organization | |
| <input checked="" type="checkbox"/> Fire Inspection Report | <input type="checkbox"/> Telephone Logs | |

Surveys

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

Observations During Review

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

Comments

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

Rating Narrative

Strengths and Innovative Approaches

Rating Narrative

Children's Home Society of Florida is one of Florida's oldest non-profit provider of services to children and families. The statewide agency is over 110 years old and currently provides a variety of services for families in crisis, children at risk, and foster families, including children in the protective services system and in residential care. The Treasure Coast Division, WaveCREST (Counseling Residential and Evaluation Services for Teens), was established in 1991 and currently operates the CINS/FINS program in St Lucie, Martin, Indian River, and Okeechobee Counties. CHS of Florida has been continuously accredited by the Council on Accreditation (COA) since 1982 and has received full re-accreditation continually since then, demonstrating CHS' commitment to maintaining the highest level of standards and quality improvement.

The Treasure Coast Division is also committed to providing the most effective services to youth and families it serves. During fiscal year 2011-2012, CHS Florida Treasure Coast served 11,977 children and families. The programs in the Division operate a myriad of services in their local communities including:

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

Since the last DJJ QI review in November 2012, CHS WaveCREST has received increased funding from the Department of Health and Human Services, Administration for Children and Families, for Basic Center services to runaway and homeless youth. The Basic Center funding was also renewed for three years. In addition, a Pre-Prevention Program funded by the Department of Juvenile Justice provides support for a new part time position to increase early prevention services to at-risk youth.

During the QI visit, staff were observed wearing agency-logo polo shirts. The uniform shirts offer a variety of benefits for the staff and agency such as: clear identification of agency staff; improved brand identity/free agency advertising; feeling of pride and responsibility for the company; elimination of competition between workers which can often result in a costly experience for the employees; and ensure the appropriateness of all workers' attire. The provider had provided other shirts in the past through gifting or for purchase. However, each employee will receive three of the new black polo shirts and may purchase additional if needed.

Standard 1: Management Accountability

Overview

Narrative

WaveCREST provides shelter and non-residential services for youth and their families in Martin, St. Lucie, Okeechobee, and Indian River Counties. The program, located at 4520 Selvitz Road in Ft. Pierce, Florida, is under the leadership of a Program Director, a Program Supervisor, and a CINS/FINS counseling services Supervisor. Shelter staff includes: a Residential Supervisor, Secretary, Group Living Manager, seven fulltime Youth Care Staff (YCS), and seven part time/relief Youth Care Staff. In addition to the supervisor, the counseling/case-management component has four counseling positions. At the time of the quality improvement review, the shelter had four (4) vacant Relief YCS, one (1) part time YCS, and one Counselor position.

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

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

On March 4, 2013, the provider submitted a copy of the program's Division Emergency Response Plan (DERP) to the Florida Network; the DERP shows a current revision of May 16, 2013. A Universal Agreement for Emergency Disaster Shelter is also in force and was signed by the Executive Director.

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

1.01 Background Screening

Satisfactory Limited Failed

Rating Narrative

The agency has a policy and procedures in place that address the background screening of all employees and volunteers. The program met all the requirements of this indicator. The program provided a copy of its policy which requires all potential employees, volunteers and interns to successfully complete a background check prior to an offer of employment or provision of service within the program. The program's policy requires potential direct care personnel, including volunteers and interns, to undergo a Level 2 Employment Screening pursuant to Rule 65C-14.023, Florida Administrative Code. Additionally, the provider conducts a background check with the Division of Motor Vehicles prior to hiring.

A sample of eight employee/intern files were reviewed: 5 new hires, 2 interns, and 1 established employee due for a 5-year background screening renewal. All eight personnel had timely background screenings completed. The program maintained the records of employee background screenings in electronic form and was able to expediently provide this reviewer with evidentiary copies of each completed background screening requested.

The program provided a copy of its Annual Affidavit of Compliance with Level 2 Screening Standards and evidence that it was received by the BSU by January 31, 2013.

Based on the documentation, observations, and personnel file reviews, the requirements of the indicator have been met by this program.

1.02 Provision of an Abuse Free Environment

Satisfactory Limited Failed

Rating Narrative

The program has a comprehensive policy established to ensure the provision of an abuse free environment. The policy requires the prominent posting of the Abuse Registry phone number. Compliance was evident after touring the program's facility as the number is displayed for all youth to see in several locations. The policy also requires staff (both paid and volunteer) to abide by rules of conduct that foster an abuse free environment and prohibit intimidation, physical abuse or force. The program's policy specifically complies with DCF and DJJ policies related to incident reporting, and requires program employees to report all known or suspected cases of abuse and or neglect to the Florida Abuse Hotline.

The program also has an established grievance policy. The policy requires families and youth to be informed of their right to grieve and youth acknowledge their understanding of the process by signature at intake, which is maintained in each of the six (6) youth files reviewed. The program maintains blank grievance forms prominently in the common areas accessible to youth. When touring the facility, this reviewer observed that youth rights and responsibilities concerning the grievance process were posted in common areas accessible to, and in plain view of, youth.

The program provided a notebook of all compiled grievance forms filed in the facility. Since the last QI Review in November 2012, the program has had only four (4) grievance forms filed and all four were resolved and acknowledged as such by each youth at the informal phase as outlined in the program's grievance policy. Therefore, there were no personnel actions taken based on any of the grievances filed.

Three youth were surveyed for this review and all indicated that they knew the Abuse Hotline was available to them and where the number was located in the facility. None of the youth surveyed were prevented from making a call to the hotline and none had ever used it. All three youth indicated that staff were respectful to them and no adult had ever threatened or cursed at them or another youth. The grievance process was known to all three youth surveyed. The facility was observed to be free of graffiti and all of the youth surveyed indicated that they feel safe at the facility.

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

1.03 Incident Reporting

Satisfactory

Limited

Failed

Rating Narrative

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

The program maintains their log of incident reports via a paperless computer database system called AirsWeb. The program had 21 incidents included on their system log during the six month period immediately preceding the review and three (3) of those were reportable incidents. All three reportable incidents were called into the CCC within the two hour time frame per the program's policy and procedures and the DJJ CCC accepted all three incident reports. A review of the remaining 18 incidents on the database log for the preceding six month time period indicated that none of the other incidents were reportable to the CCC due to either not being a reportable incident type, the CCC not accepting the report, or the incident not involving a DJJ youth (foster care youth).

The incident details were very legible as they are printed out from the database system, thereby eliminating problems with legibility. The database system is the sole means of recoding incidents and no handwritten logs are maintained any longer. The database printout of all incident reports does not include the name of youth. Incident types are described in the report only by use of a numerical code for each type, thereby making it necessary for the program to print the individual incident detail reports from the system for review during this QI visit. Furthermore, it is difficult to reconcile the program's incident reports with documentation from CCC because the program relates incident report(s) to each youth involved (or type of incident), while CCC relates strictly to the date and time of the incident. The program's incident report number is automatically generated by their database log and so does not match the incident number assigned by CCC. The program may want to consider revising the database report to indicate the type of incident in words rather than coded type and also consider adding to the report an indication of type of youth (CINS, Foster Care, etc.) involved in each incident. The program staff manually indicated on their database list whether a particular incident was reported to the CCC and accepted, or reported to the CCC and not accepted. Interviews with three staff members indicate that the staff are familiar with the reporting procedures and requirements.

Although no exceptions to the indicator were noted for the 6 month review period, this reviewer noticed that the program had documented three (3) incidents of missed/omitted medication administrations, which occurred after the last QI review, two of which concerned the same youth and

occurred in February 2013, which had been reported to and accepted by, the DJJ CCC on March 14, 2013. Program staff explained that the call to CCC concerning this youth's missed medications on both February 14th & 21st occurred as a result of staff learning at a training March 12, 2013 that missed medication was a reportable incident. The other missed medication incident documented by the program as incident #28072, occurred January 9, 2013, and does not appear to have been reported to the CCC. The program was advised to report the incident to CCC immediately and completed the call during the QI visit.

1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

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

The program provided both individual employee training files, as well as a master training log to show that an array of training courses are provided to staff through-out the year from a variety of resources. The program maintains sign-in sheets, agendas and facilitator information in the master training log.

The training files of two new hire employees who just completed, or are about to complete, their first year at the program were reviewed. Both new hire employees completed the 40 hours of training required by the program's training policy procedures within their first 90 days of employment and, as required by the indicator, both had completed more than 80 hours of training in the required and recommended courses. The employee who will be at the program a year in November, lacked only one course (Crisis Intervention) to meet all the requirements of this indicator. A third employee, hired in March 2013, had already completed 67 hours of all the indicator's required and recommended courses toward the required 80 hours of first year training.

The program advised this reviewer that after an employees' first year, the training schedule is uniformly based on the yearly calendar from January to December (instead of individual employees' hire date). Based on this, the three in-service employee files reviewed had until December to complete the annual training requirements of the indicator. None of the three had completed the required refresher CPR/First Aid or Crisis Intervention courses and all but one had yet to complete their annual Suicide Prevention training. However, the program has a CPR/First Aid training scheduled September 24, 2013, and Suicide Prevention training scheduled for October 2, 2013. All three established employee training files reviewed had completed at least 28.5 hours of the 40 hours required by the indicator and one of those was just 4.75 hours shy of meeting the 40 hour requirement. Therefore, these employees should meet the indicator's annual training requirement by December 2013.

Of note to this reviewer was the good-practice offering of annual Medication Administration training to staff, as well as having "Epi-pen" instructions posted prominently on the wall in the control room of the program's facility. Copies of the Medication Training materials used by the program were provided and the trainings are scheduled in the master training log.

1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

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

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

Quarterly case record reviews are conducted by the program clinical staff as directed by the program supervisor and are due on the last day of the 3rd month of each quarter. A copy of the program's schedule for records review was provided to this reviewer. Upon completion of each record review, the QMS aggregates the results and provide a copy of the aggregated report and Quality Management Division Evaluation to the program supervisor to discuss themes, trends, and any areas of concern. Program supervisors include review of these data in their monthly staff

meetings, as documented by the agendas and minutes of each meeting, which includes training and remediation where appropriate. The QMS also follows-up at a later date to spot check specific files to verify completion of the corrective actions.

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

Consumer surveys are administered twice a year during the second and fourth quarters. The QMS addresses consumer surveying via email and at a management team meeting and notifies the program supervisors of the outcome of the surveys. The surveys are aggregated by the QMS and provided to supervisors, DPO, and ED. A copy of the Consumer Satisfaction Aggregation Tool for FY 2012-2013 was provided for review.

Outcomes data is reviewed monthly, quarterly, and annually. This information is conveyed to staff at monthly staff meetings, where patterns and trends are noted and quality improvement strategies are solicited and discussed for potential implementation. Monthly and quarterly data is entered into the agency's Division Quality Performance Report (DQPR) into the following areas: program performance, program team minutes, safety, record review, consumer satisfaction, and outcomes. The outcomes data is incorporated into the program's Annual Program Performance Report, which compares all of the contract, Netmis, and program benchmarks required by the Florida Network and DJJ QI to the program's actual performance. A copy of the year-to-date Annual Program Performance Report - Florida Network Outcomes, for FY 2012-2013 was provided and reviewed on site.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

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

The program has a very strong, efficient, well run centralized intake process in place. All staff are well trained on the process, display a knowledge of motivational interviewing, crisis counseling, and gathering all pertinent information in a very professional way.

The counseling component consists of a total of four (4) counselors' positions and a supervisor. The counselors are responsible for completing assessments, developing case plans, providing case management services, and linking youth and families to community services. At the time of the quality improvement review, the non-residential component had twenty-six (26) open cases.

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

2.01 Screening and Intake

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy in place that outlines the screening eligibility for services and intake assessment process. The procedures describe availability of access to services, the time frame for initiating a screening when a referral is received, delineates persons who complete the screening, and establishes approved assessment tools, the criteria for eligibility for CINS/FINS services, and the process for referring families that are not eligible for services.

The program provides referral services 24 hours per day, 7 days per week and 365 days per year. The direct care, clinical staff, outreach staff and management staff are all fully trained on the completion of the referral form and the process. Referrals are reviewed daily by the Program Supervisor, CINS/FINS Manager, or Residential Supervisor. The staff completes a full referral on everyone who calls in for services (parent, youth, law enforcement, school social worker etc.) When referrals were completed and the youth/family are not eligible for services, appropriate referrals to services are made. During the evening, weekend, and holiday periods, there is always a Counselor on call to assist as needed with any difficulties arising from a request for services.

During this review, 8 of the 8 files (5 non-residential and 3 residential) reviewed have satisfied all screening and intake practices by complying with policies and procedures. Youth and parents/guardians received in writing during intake the available services, rights/responsibilities, possible actions through involvement with CINS/FINS, grievance procedures, and parent/guardian brochure.

All 8 of the 8 files (5 non-residential and 3 residential) reviewed complied with eligibility screenings within 7 calendar days of the referral. Each screening was completed in a timely manner with organized files and legible writing/typing.

This reviewer had the opportunity to observe an Intake and Screening Process with a new youth. The staff was very caring, patient and thorough while completing the Intake and Screening Process. This staff member has very nice handwriting and is organized.

At 10:00am on 9/11/13, the staff was observed during an intake with a new youth. The area in which the intake and screening process was conducted was not private, and very disruptive with constant interruptions (i.e. copier in location being used, phone ringing, staff walking through this office area, staff talking loudly in the next room). This reviewer observed over 16 times other staff interrupting the Intake and Screening Process with this new youth.

After one hour of observing this new youth being questioned for Intake and Screening, it was observed that the youth would occasionally look confused and ask questions like "What does that mean?" This reviewer, out of curiosity, asked the new youth the following questions: 'Do you know why you are here? What is this place? How long will you be here? What do you hope to do here?' The youth answered with the following: "I have no idea why I'm here. I don't know what this place is. I don't know how long I'll be here. I hope to listen to music when I'm here."

This reviewer recommends a private, quiet location for Intake and Screenings to be conducted with new youth. This reviewer recommends that youth are explained at the beginning of the Intake and Screening Process why they are there, what this place is and how long they may be staying here. This reviewer recommends that staff do not talk about other youth in front of youth, especially during the Intake and Screening Process. This reviewer recommends staff use basic language while conducting Intake and Screening questions (i.e. affiliation to gangs=are you in a gang?)

2.02 Psychosocial Assessment

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy on Psychosocial Assessments in place. The policy includes but is not limited to time frames on the completion of a Psychosocial Assessment on both residential and non-residential clients. The procedures for the program designate who will complete Psychosocial Assessments, who reviews the completed assessment, the procedures for youth having suicide risk factors during the assessment, the information to be included in the assessment, and the approved assessment tools.

During this review, 8 out of 8 files (5 non-residential and 3 residential) completed psychosocial assessments in a timely manner which complied with policies and procedures of the agency. All 8 files reviewed had psychosocial assessments completed by Master's level staff and signed by the supervisor.

The psychosocial assessments contained demographic information, dates of assessment, who was present for the assessment, reason for the referral/presenting problems, input from the youth and family on what s/he wanted to change, psychiatric/counseling history, mental, physical, emotional status, education history, family history and involvement, youth residential history, development history, medical history, legal history (DJJ/DCF), financial/employment history, drug and alcohol history, peer relationships, potential for violence/abuse, history of violence/abuse, strengths and weaknesses, and interests. All of the assessments were organized and legible to review. Staff completed a summary with their impressions and comments.

The Brief FAMIII, EIDS, and risk factors were completed in all cases. None of the eight files indicated a youth was a suicide risk.

2.03 Case/Service Plan

Satisfactory

Limited

Failed

Rating Narrative

The program has a written policy on Service/Case Plans - Implementation, Review and Revision. The policy addresses who will complete the Service/Case Plan, who is involved in the planning, the time frames for the completion of the plan, the time frames for the review of each plan, what is to be included in the plan, and who is required to sign the plan.

During this review, eight (8) of the eight (8) files (5 non-residential and 3 residential) reviewed had case plans that were developed within 7 working days of psychosocial assessments. One file did not have a case plan developed yet due to the admission date being September 9, 2013. Signatures of the youth, parent/guardian, counselor and supervisor were found in the eight files reviewed.

Five (5) of the eight (8) files reviewed did not have actual completion dates indicated on their case plans due to not having a review yet because

they were admitted the end of August or beginning of September. All (8) files reviewed identified needs, goals, type of goals, frequency, location of services, person (s) responsible, target date of completion, actual completion dates, signatures required and dates the plan were initiated.

2.04 Case Management and Service Delivery

Satisfactory
 Limited
 Failed

Rating Narrative

The program has a written policy on Case Management and Services Delivery/Family involvement. The policy clearly details the roles of the counselor/case manager, the youth, the parent/guardian and the program.

During this review, all 8 of the 8 files (5 non-residential and 3 residential) reviewed are open files. Five (5) of the files were Non-Residential cases, hence the N/A for monitoring out-of-home placements. All of the 8 files had a counselor/case manager assigned for service delivery.

That counselor/case manager coordinated referral needs, services and monitored youth's/family's progress. Support was provided to families and referrals to the case staffing committees were also utilized when necessary. All contact with the family was documented in the case file progress notes. The counselor/case manager accompanied 6 of the 8 files indicated to court hearings and related appointments. Since all 8 of the 8 files are open, there was no documentation for termination. All files were legible, organized and completed according to policies and procedures.

2.05 Counseling Services

Satisfactory
 Limited
 Failed

Rating Narrative

The program has a written policy for Counseling Services. The policy outlines and addresses the different types of counseling to be provided in both the non-residential and residential programs, based on the needs of the youth and family, as identified during the intake process.

Seven (7) files of the eight (8) files reviewed indicated that youth received counseling services in accordance with the case/service plans. The 1 file that did not receive counseling service yet was a recent intake. Referrals were accepted from schools, law enforcement, and Department of Juvenile Justice, as well as other agencies within the community. Three (3) of the eight (8) files reviewed were for residential youth. The youth and their family received counseling through individual and group counseling. All of the 8 files addressed presenting problems through a psychosocial assessment, initial case/service plan, case/service plan reviews, case notes, and on-going internal process that ensures clinical reviews of case records and staff performance. All files were organized, clean and legible.

As indicated on the youth survey, 3 out of 3 youth reported having a counselor that asks what they think and like to do. The youth reported on the survey that they are currently working on these goals: controlling anger coping with change dealing with frustration, my anger problems/short temper, finishing school and keeping peace, listening, anger. The youth stated that if they have a complaint about something in the shelter they would go get a grievance form and fill it out, or either talk to one of the workers or can also put a complaint letter in the brown box on the wall. One (1) out of the three (3) youth surveyed stated that they are receiving Mental Health or Substance Abuse services.

2.06 Adjudication/Petition Process

Satisfactory
 Limited
 Failed

Rating Narrative

The provider schedules a case staffing to review the case of any youth or family that the program determines is in need of services or treatment if the youth/family is not in agreement with services or treatment; youth/family will not participate in services, or the program receives a written

request from the parent/guardian or any other member of the committee. Case Staffing Committee Meetings are convened within 7 working days from the receipt of a written request from the parent/guardian.

Three (3) out of the 8 files had case staffing committee meetings with letters included in the legal section of the youth's file. The three case staffing meetings were convened with the case staffing committee and the meetings held had a local school district representative, DJJ representative or CINS/FINS provider present. Two (2) of the 3 files with case staffing committee meetings held, had a mental health representative present. One (1) of the 3 files with case staffing committee meetings held, had a representative from a substance abuse agency and 1 of the 3 files had a DCF representative present. All three (3) youth and their families participating in the case staffing committee meetings were provided a new or revised plan for services, written recommendations within 7 days of the meeting, and a review summary was provided by the case manager/counselor. The program established the case staffing committee meetings and has regular communication with committee members. The program schedules committee meetings as needed.

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

During this review, 8 of the 8 files (5 non-residential and 3 residential) reviewed had "confidential" marked on the outside of each file. All of the 8 files were kept in a locked cabinet in the Youth Care Worker station that is accessible to program staff. All youth records are maintained in a neat and orderly manner and quickly/easily accessible to staff. All youth records are created and maintained for each youth upon their admission. The policy and procedure are followed correctly.

The legal and correspondence log and client file review forms make each youth record easily manageable to navigate. The school attendance records in each file are a great addition to youth records. The typed progress notes make youth records easier to read.

This reviewer interviewed a staff member about youth records. The staff was very thorough and explained the directives of navigating the files clearly.

All records are to be in a secure locked file cabinet marked 'confidential'. The youth records were not locked in the file cabinet which is located in the youth care worker station and it is not marked 'confidential' on the actual cabinet.

Standard 3: Shelter Care

Overview

Rating Narrative

WaveCREST Shelter is located in central St. Lucie County. The facility is licensed by the Department of Children and Families for 12 beds and the license is current through February 28, 2014. The Department of Juvenile Justice (DJJ) contracts for six CINS/FINS beds. The shelter also admits youth from the Department of Children and Families (DCF) and also for the Basic Center and Street Outreach Programs. In addition, the provider has a contract to provide residential services for youth referred by DJJ for domestic violence. At the time of the quality improvement review, the shelter was providing services to a total of ten (10) youth: 6 CINS/FINS, 3 Domestic Violence, and 1 United for Families (UFF) foster care youth. Two new intakes were also scheduled by the provider to occur during the onsite visit. The shelter is not designated by the Florida Network to provide staff secure services and is not licensed under Chapter 397.

The building occupied by the shelter program is over forty years old, and is leased by Children's Home Society from St. Lucie County. During the tour, the facility was found to be in good working condition and the furnishings in good repair. The bedrooms, kitchen, and restrooms were clean but the flooring in the living and dining areas looked scuffed and dirty. The bathrooms are the age of the building and staff has tried to clean the mildew and maintain a clean look in the shower stalls but with minimal success. The program supervisor stated that she is currently appealing to the local group that remodeled the kitchen to replace the bathrooms and existing flooring and extend it to the hallways of the dormitories.

Each sleeping room is numbered and the beds are identified with letters. Four of the bedrooms house two youth, each with an individual bed, bed coverings and pillows. The other two bedrooms (male and female rooms) are equipped each with a bunk bed and a twin bed which gives the program the flexibility to accommodate more youth of one gender when necessary. Youth have access to a screened porch with free weights, a piano, pool table, and a large backyard with a basketball court. There is a gazebo in the backyard but it is not being utilized because the roof is in need of repair, another project for the donor group volunteers.

During a walk through with the Program Supervisor, the Reviewers observed two pipes extending from the wall in the boys shower area and advised the program of the imminent safety risk. As recommended, the pipes were covered the following day which significantly reduces the risk of injury. The Reviewer also noticed that the patio area has loose sports equipment that could be used as potential weapons, i.e. pool sticks, billiard balls, free weights, and suggested that the provider secure these items when not under the supervised use by youth.

3.01 Shelter Environment

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy to ensure the upkeep and maintenance of the facility. Weekly inspections, maintenance work orders, lawn service, waste management, and pest control invoices are maintained in a house keeping/maintenance binder. The program has a contract with a local pest control vendor, whereby pest control is provided on a quarterly basis.

During the tour, the facility was observed to be clean and in good order. Sleeping quarters, restroom and common areas were well-maintained and functional. Furnishings are in good repair and appear to be comfortable. There were no visible graffiti markings on the furniture, walls, or doors.

The shelter layout includes a living and dining area centrally located with the male and female dormitory on either side. There are a total of six (6) dorm rooms, four house two (2) beds, and two (2) of the dorm rooms have a bunk bed with an additional twin bed, allowing the program to accommodate more youth of a particular gender when needed. There are bed coverings and pillows on individual beds. Beds are labeled with letters for identification. All youth areas observed had lockers and clothes were hung in their individual rooms. Each area observed is well lit. The front living room area house a bed specifically for suicide watch and medication observation.

All inspections reviewed during the visit were found to be current. The St. Lucie County Fire Marshal's Office conducted a satisfactory annual fire inspection on 7/22/2013 and approved the provider's Emergency Response Plan on the same date. No safety violations were noted. Semi-annual Alarm testing and inspection as well as a semi-annual Range Hood inspection are conducted along with quarterly fire equipment inspections. Fire extinguishers reviewed were serviced and tagged and are valid. The most recent satisfactory annual residential group care combined with food service inspection was conducted on 11/20/12. No violations were noted on the inspection.

The program provides a daily schedule (Mon-Sun) that provides structured activities throughout day, with large muscle activity included. Faith-based activities are included in the weekly schedule, as well as alternatives for non-participating youth. The daily schedule includes down time for youth to read and do homework. Age appropriate books are kept on a bookshelf in the living room. The daily schedule and monthly calendar of youth activities are posted on a wall in the dining area for youth and staff.

3.02 Program Orientation

Satisfactory

Limited

Failed

Rating Narrative

The program has a written policy that describes the orientation process for youth. The provider also has a Resident Handbook that provides a comprehensive overview of the program and youth expectation.

During a youth's orientation into the shelter, he/she is provided with a Resident Handbook, which he/she indicate receipt of on a checklist that is in Section 1 of the youth's individual file. The handbook addresses the following: contraband items, disciplinary actions, dress code, access to medical and mental health services, procedures for mail/phone use/visitation, and the grievance procedures. Disaster preparedness instructions are documented in the monthly fire drill log, postings of egress plans throughout the facility, and monthly episodic/emergency drill reports. Additionally, per CHS policy & procedures, whereby the practice was verbalized by staff, incoming youth receive a facility tour as a part of their intake. During said tour, youth are shown each component of the building, introduced to staff and peers (including roommate); roommate pairing is contingent upon the youth and his/her needs/issues. Suicide prevention / alerting staff of potential risk is addressed by documentation in the log book and on an alert board in the control room (near staff time clock).

The three (3) resident files reviewed documented completion of orientation within 24 hours of the intake date and time.

3.03 Youth Room Assignment

Satisfactory

Limited

Failed

Rating Narrative

The youth room assignment indicator is addressed via CHS policy and procedures to ensure steps are taken to ensure the safety and security of all residents in care. The intake process includes an initial classification of the youths to include: youth's history and exposure to trauma; age; gender; history of violence; disabilities; physical attributes; gang affiliation; suicide risk; sexually aggressive or reactive behavior; and gender identification.

Upon intake, youth are interviewed to determine appropriate classification, sleeping arrangement, and bed assignment. Information gathered about the youth is documented on the CINS/FINS Intake Assessment Form along. As a result of the intake screening, identifiable alerts are noted on a red alert form, the program logbook, and marked on the census board. The alert form list specific alerts, identifying resident with special needs. Additionally, the youth is assigned an appropriate room and bed and this information is noted on the CINS/FINS Intake Assessment Form.

During the review, three (3) resident files were reviewed. Alerts were documented and entered required. As indicated on the youth's individual CINS/FINS Intake Assessment Form, the youth were appropriately assigned rooms and did not have any special alerts requiring special accommodations.

3.04 Log Books

Satisfactory

Limited

Failed

Rating Narrative

The program has a process for log book documentation to record daily activities, events, and incidents. The logbook documents important information such as: all information occurring during each shift including intakes, youth activities, youth counts, visitors, incidents/accidents, specific information about youth's behavior, staff signing in/out and review of the logbook, and alerts.

Entries are written in black ink unless otherwise specified and include the date and time and are signed by the individual making the entry. Log

book entries that represent risk or could impact safety & security are hi-lighted (in yellow), to draw the reader's eye to the concern. The date and day is written at the top of each page.

The majority of the entries into the log books during the past six months reviewed were legible and all were written in ink. The following is noted that the shelter staff uses an abbreviation system that indicates the type of entry being documented by staff. A reference list providing explanation of the abbreviations used was provided to the reviewer. In the logbooks reviewed, dates and times are accurately used, youth and staff names are appropriately documented, statements are concise and brief, and each entry has the writer's name next to the entry.

Recording errors are struck through with a single line and the writer's initials; the date/time of the correction is noted chronologically by the entry itself in the log book. There is evidence, via the documentation, that a weekly chronological note is being made by the Program Director's designee demonstrating review of the logbook. The entry is always being made in red ink.

There is documentation evidence in the log book that the oncoming supervisor reviews the log book, but there is not any reference as to the time frames which are being covered. Direct care staff reviews the log book, as evidenced by their notation into the log book, for each shift.

It should be noted that the log books are well maintained and catalogued by dates once a log book has been exhausted.

Reviews of the logbook by supervisors and staff must indicate the dates reviewed to document the review.

Rating Narrative

The program has written policy & procedures for behavioral management that is supported by an orientation process that makes youth aware of the behavioral strategies by verbal explanation, written explanation in the resident handbook, and with laminated hand out (Minor/Major/Maximum Discipline Behaviors chart) used during the verbal explanation. The behavior management system outlines minor, major, and maximum discipline behaviors of resident.

Inappropriate behaviors and relevant consequences are visibly posted in the living room of the shelter and in each bedroom. Staff, who have been trained in the use of the BMS, score youth's behavior daily before house meeting. The youth care staff reviews the point sheets with each youth daily. Points are earned based on rule compliance, attitude, peer/staff interaction, participation in activities, use of leisure time, and school behavior. The program uses a variety of rewards to encourage residents to comply with the program rules and expectation. It also provides positive reinforcement and feed back to resident concerning consequences and choices. Points earned can be used to purchase items from the point store. The program displays items in the point store allowing resident to make purchases using their points earned from the behavior management system.

The provider's BMS was determined to meet the requirement in that:

- Consequences for rule violations are applied with consistency, logic, and common sense.
- The program encourages positive behaviors with immediate verbal recognition and tangible reinforcement with its points store.
- Staff is trained monthly on the behavior management, as it is a part of their monthly staff meetings/trainings
- Supervisors are trained to monitor behavioral interventions, and subsequently reiterate that training with monthly staff trainings that apply the techniques
- The facility uses its intake orientation as its foundation for the behavioral interventions used moving forward, whereby staff counsel youth about issues, verbally de-escalate and intervene when necessary
- Physical intervention is always a last resort, per policy/procedures and staff interview
- Youth discipline is only administered by staff, per policy/procedure, staff interview, and youth interview
- Group discipline is not used at the facility, off task youth is taken aside and addressed individually
- Room restriction is not used as a consequence, youth may be counseled individually by staff in their room, but sent to their rooms as a consequence
- Deprivation is not used within the facility's behavioral management strategies, thus meals/snacks/clothes/sleep/physical & mental health services/education/exercise/correspondence privileges/contact with family/legal representation/DJJ staff are not withheld under any circumstances; per policy & procedure, staff interview and youth interview.

3.06 Staffing and Youth Supervision

Satisfactory Limited Failed

Rating Narrative

The agency has a policy for staffing and youth supervision to ensure adequate staffing is provided that optimizes the safety and security of all youth and staff. The program maintains minimum staffing ratios as required by Florida Administrative Code and contract. The shelter is licensed for 12 beds and the staff schedules reviewed for the review period reflect:

- Staff to youth ratios are maintained at 1 to 6, during awake hours, as evidence by client census forms and staff schedule
- Staff to youth ratios are exceeded, whereby 1 to 6 is maintained, where 1 to 12 is the standard for sleep hours
- Staff scheduling shows there is same gender staff as the youth; additionally there are part-time/standby staff if required
- The staff schedule is located within the control office and is highly visible
- The holdover/overtime roster is accessible and visible with part-time/standby staff listed
- Staff document every 15 minutes during awake hours and exceed the expectation and provide 10 minute observations during sleep hours; both are documented in the log book

3.07 Special Populations

Satisfactory Limited Failed

Rating Narrative

CHS WaveCREST is not a designated Staff Secure Program or Probation Respite provider. However, the provider is funded to serve domestic violence respite youth who meet the criteria.

During the review, the provider had three active domestic violence youth on it's census. A review of the three youth files was conducted to ascertain compliance with the indicator.

The three youth files reviewed had documentation of a pending DV charge. Each youth was screened by a JAC/Detention staff and appropriately referred to the shelter for Domestic Violence Respite services. The three youth files reviewed indicated that placement did not exceed 14 days as none of the youth was in the program prior to 9/5/2013. During the review, none of the youth were yet transitioned to CINS/FINS from DVR and were still within the 14 days of service. Each file reviewed reflected individual goals for aggression management/family involvement/ATOD. In addition, the services provided mirror those services provided to CINS/FINS youth.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

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

Staff on duty at the time of admission immediately identifies youth who are admitted with special needs and risks, such as risk of suicide, mental health, substance abuse, physical health, or security risk factors, etc. The residential supervisor and/or CINS/FINS supervisor is notified immediately if risks and/or alerts are present. Staff follows through with the recommendations regarding placement and appropriate supervision is provided by the direct care staff. This information is documented in various places such as the census board, youth alert form, and in the program logbook. Youth admitted to the shelter with prescribed or over the counter medication will surrender those medication to staff during admission. Medications are stored in a double locked red medication cabinet and topical and/or injectable medications are stored separately from oral medication. Refrigeration is available for medication requiring cool storage.

The program has a list of staff who are authorized to distribute medication. An approved staff is scheduled on each shift and their name is highlighted on the staff schedule. Medication records are maintained for each youth and stored in the youth's file on the Medication Log Record (MLR).

4.01 Healthcare Admission Screening

Satisfactory Limited Failed

Rating Narrative

The provider has a policy in place, CHS/7401, that includes procedures for the healthcare screening of youth during the admission process. Upon intake, youth are screened by non-healthcare staff for health related conditions. The results of the healthcare screening is documented on the Physical and Health Screening Form as well as in the Physical Health Screening section of the CINS/FINS Intake Assessment Form. Notation of scars, marks, and tattoos are documented on a Body Chart Form. The preliminary health screening completed by the provider assesses all of the physical and medical health related conditions required by the indicator.

Three files were reviewed and all were found to include screening for current medications, existing medical conditions, allergies, recent illnesses and injuries, observation for evidence of illness, injury, pain or physical distress and difficulty moving as well as observation for presence of scars, tattoos, and other skin markings. The health screening was also completed in all three files for chronic medical conditions of diabetes, pregnancy, seizure disorders, cardiac disorders, asthma, tuberculosis, hemophilia and recent (previous two weeks) head injuries.

The indicator requires that the procedures include " a thorough referral process" for medical care as required or needed. The provider's procedures indicate that staff will document discussion of this need; however, no detailed procedure regarding the referral process and documentation is included in the procedure. The provider revised their policy and procedure during the visit to include a detailed process for referrals.

4.02 Suicide Prevention

Satisfactory

Limited

Failed

Rating Narrative

There is a written policy and procedure (CHS/7402) for suicide prevention. The policy requires that each youth be screened for suicide risk to ensure that any identified needs are referred for further assessment and/or is addressed immediately through specific procedures for observation, evaluation, and/or referral to professional services. The provider contracts with a licensed Mental Health professional (LMHC) who is responsible for completing the full Assessments of Suicide Risk. The LMHC's license is valid through March 31, 2015.

During admission, staff completes the CINS/FINS Intake assessment Form which reviews the youth's past and current use of illegal substances as well as current/past suicidal ideation or behavior. Staff also uses the Evaluation of Imminent Danger of Suicide (EIDS) as a screening tool to further assess the youth's risk for suicide and implement a Youth Safety Agreement with the youth. Youth who score a positive "yes" answer in Criteria 1 of the Suicide Risk Summary and/or score 5 or more positive "yes" answers in Criteria 2 is referred for a full Assessment of Suicide Risk (ASR) which is completed by a licensed professional or a non-licensed mental health professional under the direct supervision of a licensed professional. The provider's procedures also make provision for the observation of youth needing a comprehensive assessment if the suicide screening occurs between 5:00 p.m. on Friday and 9:00 a.m. on Monday. Youth awaiting assessment are required to be placed on constant sight and sound which is documented on a pink Suicide Prevention Observation Log.

A total of three youth files were reviewed for this indicator. The suicide alert was indicated on the alert form in the three files. Staff also completed the CINS/FINS Intake form and EIDS screening form during the intake. Two of the three youth were identified as suicide risk based on the EIDS results. The screening results were reviewed and signed by the supervisor on the second page of the CINS/FINS Intake form. The third youth was determined to be a suicide risk during a counseling session and at one additional period during care. As a result, two subsequent EIDS screenings were completed but neither of these were signed by the Program Supervisor. Parental notifications were documented on the signature page of the EIDS.

The three youth identified as suicide risk were immediately placed on precautionary observation by staff until the licensed Mental Health Counselor completed a full Assessment of Suicide Risk. The 10-minute observations were documented on a pink Precautionary Observation Log during each relevant shift and were signed by the Youth Care Staff, Program Supervisor, and licensed mental health professional. The licensed professional was notified of the suicide risk for the three youth and completed the ASR within 2 hours for two of the three youth. An interview was completed with the third youth and his father and the youth was discharged in the custody of his father with referrals for his previously diagnosed mental health disorders. None of the youth were Baker Acted or were determined to be a potential suicide risk by the licensed professional or non-licensed counselor under the direct supervision of the licensed professional.

The three youth were removed from precautionary observations upon release by the licensed professional and/or non-licensed Counselor. Per the provider's policy, removal from sight and sound must be documented in three places: program logbook, on the pink observation log, and on the pink Mental/Medical Health Care Follow-up Notes. Two of the three files did not show this documentation consistently in all three places; the removal was not documented on the pink Mental/Medical Health Care Follow-up Notes and logbook in one file, and on the Observation Log in another file.

Three staff who were surveyed demonstrated knowledge of the suicide policy and procedures and are aware of the location of the Suicide Response Kit. The Knife for Life is mounted on a wall in the medication room.

Two of the three EIDS screening results completed after the intake for one of the youth were not signed by the Program Supervisor.

In one of the youth's file, there was a contradiction in the documentation of suicide risk. The CINS/FINS Intake Assessment form noted "no" for suicide risk; however, the EIDS administered during the intake was scored as a suicide risk and the youth was placed on precautionary observation.

Documentation of the removal from precautionary observation did not consistently occur in the three places as required by the provider's policy and procedures.

4.03 Medications

Satisfactory

Limited

Failed

Rating Narrative

There is a written policy and procedure (CHS/7304) in place which addresses the safe and secure storage, access, inventory disposal and administration/distribution of medications as required by the indicator.

The procedures and practice observed provide for all medications to be stored in a separate locked cabinet that is inaccessible to youth. Prescribed medication is secured behind two locks, in a locked metal box within a locked red cabinet. The red cabinet is located in the staff's mail room. Each youth's prescribed medication is stored in a plastic zipper bag that includes the prescribed medication, script, and a picture of the youth. Oral, inhalers, topical, and eye solutions are stored in separate boxes on a separate drawer of the cabinet. Medications needing refrigeration are stored in a double locked refrigerator located in the pantry. There were no medications requiring refrigeration during the visit.

Shift to shift counts are conducted and documented for all prescribed medications. In addition, a perpetual inventory with running balances is maintained on the Medication Log Record (MLR).

The provider has a list of twelve staff who are designated in writing and trained to access and distribute medication. The list is posted on the medication cabinet and on a board in the Youth Care Office. Medication management training is provided during orientation for new staff and also offered at a minimum annually.

The provider did not have any medical sharps present during the visit. There is a separate locked box in the medication cabinet for the storage of medical sharps. Other non-medical sharps (kitchen) used in the facility are stored in three locked drawers in the kitchen. A count of the sharps is conducted weekly on the midnight shift and documentation is maintained for the inventories. The counts were reviewed and verified during the visit.

Over the counter (OTC) medications are accessed and inventoried perpetually and weekly by approved staff. The program stores OTC medication in a locked cabinet in the laundry room that is kept locked. Documentation of OTC medication provided to youth is maintained on the MLR in the youth's file.

Four (4) youth's medical records were reviewed during the visit. All four (4) medical records contained: youth's name, date of birth, allergies, medication side effects, picture of youth, staff initials, youth initials, full printed name, signature, and title of each staff member who initials a dosage, and full printed name and signature of youth receiving medication.

Medication counts were reviewed for four youth records reviewed. The records for two (2) medications prescribed for one (1) of the youth were found to have discrepancies in the documentation of the counts.

The three (3) staff surveyed assist youth in the delivery of medications and reported several ways, consistent with the provider's policy and procedures, that they are informed of medication side effects.

One of the four youth's medication records showed discrepancies in the counts for two separate prescribed medications. The initial pill count entry for one of the medications appears to be inaccurate with no explanation as to why the original 59 pills noted as received was first documented as 58 on the MLR, although none of the pills were given to the youth.

Another medication record reviewed for the same youth was missing a half pill and showed a final count of 24.5 pills instead of the 25 pills that should be present based on the prescribed dosage. The incident was called in to the Central Communications Center within 2 hours of the program's knowledge of the missing pill and was accepted by CCC.

Addendum: following the QI Visit, this Reviewer received an email from the Program Supervisor on 9/12/13, with attached picture file of a pill, indicating that the missing pill was located on the floor next to the medication cart.

4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

Rating Narrative

The program has a medical and mental health alert system in place to ensure communication to staff all information concerning a youth's medical condition, allergies, possible side effects of medications, contraindicated foods/meds, and other pertinent health treatment information. A copy of the program's plan (Comprehensive Master Plan for Access to Mental Health and Substance Abuse Services) was provided to this reviewer.

Observation and file review indicates that the system in place includes alerts/precautions relating to prescribed medications, and medical/mental health conditions.

All staff are provided ongoing emergency care training including, first aid, CPR, training on recognition of possible signs of mental health/substance abuse issues. A review of training files indicates that all staff are current on their training plans.

Three files were reviewed for youth who presented a medical or mental health alert. The youth were identified as having alerts on the census board, and the all of the applicable alerts were documented on the red alert form in the youth's files. The applicable medical alert included precautions concerning prescribed medications. In addition, staff provided adequate information and instructions on the pink Mental/Medical Health Care Follow-up notes to recognize and/or respond to the need for emergency care for the medical/mental alerts that were identified.

4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

Rating Narrative

During this review, the program procedures and practices were reviewed for emergency medical and dental care. Four (4) incidents were reported between January 2013-March 2013. All four (4) youth received off-site medical emergency services during the time frame noted between January 13 - March 2013. The parent/guardians of all four (4) youth were notified of their medical emergency incidents. A daily log is maintained for all Episodic/Emergency Care incidents. The log is clear and legible.

The program's Knife-for-life and wire cutters are located with 2 First Aid kits within the facility (1 on wall in dining/living area, 1 in kitchen). Two (2) First Aid kits are portable and are located in the staff station. The First Aid kits are updated and inventoried every month with the last update on August 30, 2013.

Three (3) in-service staff files and three (3) first year staff files were reviewed which demonstrated that all received Emergency Medical Procedures. The next Emergency Medical Procedures training for staff will be held September 28, 2013.