Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Capital City Youth Services

on 09/13/2013

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

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

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

Percent of indicators rated Satisfactory:88.89%
Percent of indicators rated Limited:11.11%
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:0.00%
Percent of indicators rated Limited:0.00%
Percent of indicators rated Failed:0.00%

Overall Rating Summary

Percent of indicators rated Satisfactory:95.83%
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 Carr, Lead Reviewer, Florida Network of Youth and Family Services/Forefront LLC

Brent Musgrove, DJJ, Office of Prevention and Victim Services

Sherri Swann, Lutheran Services Florida - Northwest

Sylvester Jones, Anchorage Children's Home

Crystal Westman, Arnette House

Persons Interviewed

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

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

0 Maintenance Personnel
0 Program Supervisors
9 Other

Documents Reviewed

- [x] Accreditation Reports
- [x] Affidavit of Good Moral Character
- [x] CCC Reports
- [ ] Confinement Reports
- [x] Continuity of Operation Plan
- [x] 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

7 Health Records
6 MH/SA Records
8 Personnel Records
7 Training Records/CORE
9 Youth Records (Closed)
18 Youth Records (Open)
4 Other

Surveys

7 Youth | 6 Direct Care Staff | 0 Other

Observations During Review

- [x] Admissions
- [x] Confinement
- [x] Facility and Grounds
- [x] First Aid Kit(s)
- [x] Group
- [x] 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

All Capital City Youth Services (CCYS) staff were professional, responsive and cooperative with the entire Quality Improvement review team. This made for a informative and productive two-day program review process.

Strengths and Innovative Approaches

Rating Narrative

The agency received a Transitional Living Program (TLP) grant award from the federal government. In addition, the agency continues to make several physical plant improvements on the property. The agency has recently completed a newly constructed building that will house its Transitional Living Program. The building is a modern structure that will house a six (6) bed program and includes a large training space for professional development and events.

The agency continues to maintain numerous interagency agreements and partnerships with local agencies. Further, the agency has focused on enhancing their internal Program Quality Improvement efforts to assess, review and implement various interventions to address areas that require attention. Surveys completed by seven (7) youth on site during the program review indicated that all shelter residents felt safe and reported favorable comments on their respective surveys regarding their shelter stay.

The agency was awarded a Health and Human Services grant award to provide Street Outreach services in the Second Judicial Circuit. The agency has hired two (2) staff persons and secured a compact utility vehicle that is wrapped with Street Outreach branding and equipped with marketing items and program materials to promote the agency's services.

The shelter and administrative offices are well appointed and organized. Observations conducted by the review team indicate that CCYS staff member interactions with youth were positive and the staff reported not observing any co-workers committing threats of intimidation, harm, inappropriate behavior or exploitation toward youth receiving services.

The agency has three (3) staff members that are licensed clinicians.

Standard 1: Management Accountability

Overview

Narrative

Capital City Youth Services is lead by Kevin Priest, Chief Executive Officer. Mr. Priest oversees Gina Dozier, Chief Operating Officer; Crystal Robinson, Human Resources Manager; Cynthia Whitaker, Clinical Coordinator; Katherine Shade, Program Services Director; and Patrick Minzie, Shelter Program Manager . Since the last on site Quality Improvement program review conducted in September 2012, CCYS has undergone some management structure and position changes. The management structure in the CCYS Someplace Else (SPE) Youth Shelter previously consisted of a single Shelter Manager that supervised three (3) Team Leaders. In July 2012, the agency formalized the new management structure and changed the Team Leader titles to Residential Supervisor. The Residential Supervisors now work 10-hour shifts 4 days per week. Their typical schedule takes place from 10:30 am to 8:30 pm. This allows them increased time on the floor with direct care staff and residents, as well as increased interaction with the youth and the Youth Care Specialists during peak activity times for the SPE program.

The agency trains all staff as required. The agency utilizes a combination of live instructor and online web-base training. In addition, the agency uses a training format that captures all training dates, topics, hours that is maintained on each staff member. The agency has an annual performance evaluation process and executed administrative reporting and issuing necessary workplace suspension on an as need basis. The agency is CAO accredited, has a comprehensive Program Quality Improvement (PQI) process and has several examples of using this process to address trends, patterns and performance issues.

1.01 Background Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The CCYS agency has a standard background screening policy that complies with the Department of Juvenile Justice, and the Department of Children and Families. Noted in the policy for requirements are the following items that include: Background screening prior to hire date; Employees and/or volunteers are re-screened every five (5) years of employment; and The Annual Affidavit of Compliance with Good Moral Character Standards is completed by the Program and sent to the DJJ Background screening Unit by January 31st of each year.

The Program's employee's files were organized with the proper documentation. The QI Reviewer was able to review new hires, hires with charges as eligible, and re-screening. In doing so, the Program, CCYS was able to demonstrate the employee files were in compliance with the above requirements by the Department.

1.02 Provision of an Abuse Free Environment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy on Abuse Reporting that requires that all staff members reports any known or suspected case of child abuse or neglect immediately. All staff members are informed during orientation that failure to report abuse may result in disciplianary action. When staff learn of of any possible child abuse allegations, at any time from the referral process through aftrcare or follow-up contacts, a report is to be made to the statewide toll-free Abuse Registry Hotline.

All clients served by the agency are informed of their rights to reports any know acts or events related to abuse. Clients are informed of their rigts to report abuse and the abuse Hotline Number via a bullentin notice that is posted in the main area of the shelter, on the back page of the youth contract and on page 7 of the Client Handbook. Client are free at any time to file their own abuse reports and will not be denied acces to telephones to report abuse.

Six (6) out of seven (7) youth reported on surveys that the had knowledge about the Abuse Hotline. Five (5) out of 7 youth completing surveys reported that they knew where the Abuse Hotline number is located. Seven out of 7 youth taking surveys reported that all adults at the shelter were respectful. In addition, all youth reported that they have not heard staff use curse words or threaten them or any other youth. Six out of 7 youth reported on surveys that they feel safe at the shelter.

None of the six (6) staff completing surveys indicated that they have observed staff using profanity when addressing youth or observed a co-worker using threats, intimidation, or humiliation when interacting with the youth.

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Some exceptions were noted. One (1) out of seven (7) resident surveys indicated that a youth was sent to their room as punishment with the door shut. Two (2) out of 6 staff completing online surveys indicated that they have observed youth being sent to their room or an isolation room for punishment.

1.03 Incident Reporting

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The CCYS agency displays a standard policy for reporting incidents for internal and CCC type incidents. Noted in the policy are organize processes for both internal and CCC reportable incidents. Furthermore, the Program's policy explains the required documentation required for internal incidents and the protocol for reporting CCC reportable incident to the Department of Juvenile of Justice.

The QI Reviewer reviewed CCC reportable incidents during the time period March 1, 2013, through September 9, 2013. The Program had five (5) reportable incidents during the time period March 1, 2013, through September 9, 2013, which four (4) were for medical reasons. The Program was non-compliance with one (1) CCC reportable incident during the time period March 1, 2013, through September 9, 2013.

The QI Reviewer reviewed the Program's internal incidents during the time period March 1, 2013, through August 31, 2013. The Program documented one hundred thirty eight (138) incidents during the time period March 1, 2013, through August 31, 2013. The Program's type of internal incidents reports included the following: Abuse report; Medication; Runaway; Client injury/illness; and Drug/Alcohol possession.

The Program's internal reports clearly describe the events and handwriting is legible within the reports. Staff was able to define the protocol for reporting CCC reportable incidents and documentation of internal incidents.

1.04 Training Requirements

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Capital City Youth Services displays an organize policy to meet training requirements for direct care staff to receive eighty (80) hours of training for new hires and (40) hours for current employees.

Within Capital City Youth Services policy to note, CCYS provides management review of documented training hours of each employee per quarter. In addition, employees who fail to keep in compliance of mandatory trainings held internally may be issued a written reprimand and up to termination.

CCYS employee's files regarding training documentation displayed:

- Type of trainings
- Date and signature of employee
- Certifications
- Total amount of hours of training within time period

The Program's employee's files were organized, easy to follow and provided the necessary documentation to validate training requirements and training provide to employees within CCYS. The QI Reviewer was able to review employee's files if they met the requirements under the standards for totals hours of training and the required trainings for employees. The Program, CCYS was able to demonstrate the employee's received proper training and are in compliance with the requirements set forth by the Department.

1.05 Analyzing and Reporting Information

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy that includes requirements on Analyzing and Reporting Information. The policy outlines how the agency reviews various sources of information, including FNYFS NetMIS data reports, outcomes data, shelter climate surveys and client satisfaction questionnaires, incidents, grievances, case record reviews to assess risk, program and operations patterns and trends. The review of this data on a consistence basis affords the agency the ability to evaluate program efficacy and identify areas where program and operational modifications are needed.

The agency provided examples demonstrating how internal oversight measures lead to actual examples that required a review and assessment resulting in an implementation of intervention to address a problem or identified issue .An example from the past year includes the review of outcome data from the agency's Resiliency Scales for Children and Adolescents (RSCA) assessment instrument. The agency reached this decision by determining that the current assessment tool in use was not optimal for younger youth served in the nonresidential program. The agency then utilized their internal Program Quality Improvement (PQI) process. This process involves utilizing the agency's clinical team to determine that an alternative measure was needed. The program created its own scale, entitled the "Family Place Treatment Measures" to be administered pre and post service. The new measure was implemented and the program began collecting data on outcomes using the new form. At the time of the QI review, only limited data from the new form was available due to its newness and had been used on a limited number of clients. Pre and post test results on the effectiveness of the survey is preliminary due to the short duration that the new assessment has been in use. Supporting documents, including meeting minutes and a sample of the form were provided to the QI reviewer during the program review.

A second example provided by the agency utilized responses to the agency's Employee Survey. The agency survey is conducted twice per year. Upon reviewing the survey results from the first survey of 2013, the Personnel Subcommittee decided to host a staff appreciation event as one of its initiatives. This event involved a week-long celebration of CCYS staff, with each day of the work week having its own theme. A post event employee survey was conducted several months later and a comparative analysis of staff responses was conducted (survey collect quantitative data as well as free responses to open ended questions).

The agency conducts reviews of data on grievances filed by residents in the shelter. The data from grievances is analyzed after the written grievance forms are forwarded to the agency's Chief Operations Officer (COO) following each documented resolution. The COO records data

related to the numbers, types of grievances (re: food, rules, staff, etc), day of the week filed, and the number individual youth filing grievances each month. The agency's PQI subcommittees receive reports on this aggregated information to look for any patterns and trends that may be present. A spreadsheet of this aggregate information for the 2013 year to date was provided on site to QI reviewers.

By tracking information related to medication / documentation errors, the agency identified the need to help simplify the process for staff. The agency created and then modified the "Someplace Else Medication Schedule Overview" form in October 2012 that provided staff a consolidated list of medications and times of distribution for all residents prescribed to received medication during their shelter stay.

The agency's Chief Executive Officer is a current active member of the Council On Accreditation (COA). In addition, the CCYS Executive Director is an active COA Reviewer. The agency utilizes COA information and assessment tools and applies these self assessment measures into their own strategies. This tool lists an array of reports and data that the agency uses to assess program trends and various risk management issues.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

All youth admitted into Capital City Youth Services (CCYS) are provided residential and non-residential case management and intervention services. The CCYS program provides Centralized Intake that includes a comprehensive screening of the youth, parent/guardian through the use of a comprehensive assessment and intervention process. The agency also provides counseling services that are design to address risks identified during the assessment phase in order to stabilize families in crisis and to decide if additional services are needed.

The non-residential program provides a broad range of intensive family intervention services to assist family in remaining intact and to reduce situations to leading out of home placements. Capital City Youth Services non-residential program has provides services that include counseling, referrals to specialized local facilities and partner agencies, family intervention/medication and aftercare. These services are designed to significantly reduce future involvement of the youth in the formal juvenile justice system.

The program also provides an intervention called a Case Staffing Committee meeting to address nonproductive outcomes for the youth and their family. The youth along with their family, a representative from the local school board, Department of Juvenile Justice attorney and other social services agencies are gathered together to address the services that are being provided by the program or entities that are not doing their part or taking part in the services. The result of the meeting is that another service plan is developed to meet the needs of the youth and family members. The Case Staffing Committee can also recommend a CINS Petition to be filed in court to order participation with treatment services.

2.01 Screening and Intake

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has separate policies for Screening and Intake. The Screening Policy details the steps taken to determine eligibility and referral to other services if the youth does not meet criteria for services with CCYS. Rights and Responsibilities, as well as Grievances are discussed in the Intake Policy. Both policies identify steps taken to explain available CINS/FINS services and possible actions to be taken. The agency's policies and procedures specifies screening is to be completed within 7 working days rather than 7 calendar days from referral.

All ten (10) files reviewed had screenings completed in the required timeframe, typically, the same day as admission to the program. All files reviewed indicated that the youth and parents were made aware of available service options and were provided the CINS/FINS Brochure. Grievance procedures were found in all files included in the Youth Handbook and Informed Consent.

2.02 Psychosocial Assessment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Current policies and procedures states that Psychosocial Assessments consist of three (3) parts (SPE Intake & Assessment Form, the Psychosocial Assessment (PSA) Form and the Psychosocial Assessment Summary) and are completed within the required 72 hour time frame.

For this program, the strength of the PSA was found in seven of ten files reviewed that contained completed PSA Summaries. The summaries were very thorough, comprehensive and clearly showed clinical synthesis of all pertinent information, including information from referral, screening, case management contacts, and ending with identified goals to be addressed in counseling.

All six (6) residential files reviewed had documentation showing that the PSA was initiated upon intake to shelter. The SPE Intake & Assessment Form was completed for this purpose. Five (5) of six files reviewed documented supervisor reviews and signatures on the form. In all cases, the YFA met with the youth either the same day or next working day, to introduce themselves, begin the PSA, and to identify any immediate needs.

The YFA involvement was documented in the chronological notes in the files of youth who had not stayed in shelter long enough to get a full PSA completed. Three of the residential files reviewed held fully completed PSAs, done in the required timeframe.

Conversation with two clinical staff and the Program Services Director confirm the process as outlined in the P&P.

For this program, the strength of the PSA was found in seven (7) of ten (10) files reviewed that contained completed PSA Summaries. The summaries were very thorough, comprehensive and clearly showed clinical synthesis of all pertinent information, including information from referral, screening, case management contacts, and ending with identified goals to be addressed in counseling.

The Florida Network of Youth and Family Services P&P #3.03 and QI Indicator 2.02: Psychosocial Assessment, indicates that Psychosocial Assessments shall be completed by Bachelor's or Master's level staff and include a supervisor review. The Program's Assessment Policy does not indicate that assessments are completed by Bachelor's or Master's level staff.

The SPE Intake & Assessment Form is identified as the first step in the PSA process and is typically completed by YCS and then signed off by licensed clinical staff. Five of the 6 files reviewed had the form completed by YCS, the remaining form was

completed by a Bachelor's level, Master's student intern.

2.03 Case/Service Plan

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The CCYS agency has a detailed policy in place that meets the requirements this indicator. The date the plan was initiated is assumed to be the date it is signed.

Three (3) of the six (6) residential files reviewed only had the initial plan of service, completed at shelter intake by YCS. The youth in these cases were not in shelter seven (7) days to have Plans of Service (POS) designed by clinical staff and therefore couldn't be reviewed for the required elements. Three other files reviewed held full POS and contained all the required elements, completed in the required seven day timeframe.

All four (4) nonresidential files reviewed contained completed POS, with all the required elements. Reviews were completed as needed, included sufficient progress reports of the cases, and included all required signatures.

2.04 Case Management and Service Delivery

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The CCYS agency doesn't have one policy that specifically covers all the required elements of this indicator however, the elements are covered throughout P&P under several different categories including: Case Management and Service Delivery; Client Assignment and Caseload; Assessment and Plan of Service; and Case Supervision.

All ten files reviewed had documentation of case management on the chronologicals, even though full POS had not been completed. It was very easy to see significant efforts made to engage families and meet identified needs.

In all files, the chronologicals showed extensive documentation of case management notes that were aligned with the reason for referral to services.

Two (2) of the non-residential files held documentation of involvement of the Case Staffing Committee. Both cases documented extensive family counseling and case management and neither case got to the judicial process.

Weekly supervision is provided on all current shelter cases. This process ensures addresses service needs and/or barriers and serves to assist the YFA in moving the case in a positive direction. Weekly supervision is documented in policy and practice.

2.05 Counseling Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The CCYS agency program has two (2) policies that address this indicator: "Chronological Records & Case Notes" and "Service Modalities and Interventions". Between the 2 policies all four (4) required elements are met to ensure that services are matched to the person being served.

Ten (10) of 10 files reviewed held documentation showing counseling services are provided. In all cases, this information is on the chronologicals and in cases where the youth was in shelter beyond seven days, the files reflected SOAP formatted progress notes. For the three files without full POS, the chronos documented interactions with counselors working to identify and address presenting issues even before the POS was completed.

Interview with a YFA revealed their practice to meet with a youth within three days of intake to begin the PSA and POS. She explained that typically they meet several times with the youth before the PSA is completed, to gather necessary info. After the PSA is completed, they are required to meet with the youth once a week. YFA explained it's often much more frequent than that because the youth always want to talk to the counselors. YFA also indicated that family sessions are primarily completed at discharge, however recently they have been having some family sessions mid-stay.

2.06 Adjudication/Petitiion Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The CCYS agency's policy and procedure includes the contents required to meed the standard required for this indicator. A total of two (2) files were reviewed that included documentation supporting this process. In both cases, the committe included the required participants. In both cases, the required timeframes were met in regard to parent and committee notification of the staffing, providing updated POS following the staffing and timely updates. Both cases showed improvement in youth behavior that prevented the case from moving forward to judicial process.

Both cases documented significant effort on the part of clinical staff to engage and maintain close communication with all necessary parties to help the youth move in a positive direction.

2.07 Youth Records

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency's current policy and procedure manual is in place. The policy indicates that all records are kept in an organized, systematic manner to ensure the accurate and thourough completion of required forms. The agency's policy and practice indicates that records are marked "confidential" and are maintained in a locked file cabinet with limited access.

The Program Services Manager explained the process files take for review and showed the file cabinets where they are maintained. The main file room is locked with limited access to staff. Throughout the process, files are kept in locked cabinets marked "confidential" or behind locked doors marked "confidential".

All ten (10) files reviewed were clearly marked "confidential" and were maintained in a neat and orderly manner for ease of accessibility.

Standard 3: Shelter Care

Overview

Rating Narrative

The CCYS Some Place Else youth shelter provides residential services 24 hours a day, seven days a week. The residential stay at the shelter is specifically designed as a respite of cool off period in order to reduce an existing crisis situation. General services provided by CCYS include supervision of youth, meals, clothing and limited healthcare as needed and permitted by the parent/guardian. The CCYS residential program also has the capacity to provide individual, family and groups counseling. Group counseling is provide a minimum of five (5) days per week or more for all youth served. The program also provides case management services to all residents as needed to make certain that all efforts implemented to return all shelter residents home, maintaining school involvement and other activities.

The agency has a three (3) building structures on the campus. One houses a multi-bed shelter that is licensed to serve up to eighteen (18) shelter residents. The second building house the staff and administrative offices and includes meeting/conference rooms. The third building is a newly constructed six (6) structure that is to house the agency's new Transitional Living Program. The agency has clean and well appointed resident bed rooms, bathrooms and common areas. The day-to-day operations and management of the youth shelter manager is the responsibility of the agency's Chief Operation Officer and a Program Services Director, who is also a Licensed Mental Health Counselor. Shelter residents admitted to the CINS/FINS SPE program must be status offenders that meet eligibility requirement that include having either been a runaway, experiencing problems with their family such as being ungovernable, truant or lockout.

The shelter also admits non-Department of Juvenile Justice youth that are in crisis or in need of respite from their families. Youth can receive services from both the shelter facility and outpatient counselor at the same time. The CCYS program serves youth that are primarily ten (10) to seventeen (17). The program is designated a Staff Secure Shelter. Staff Secure youth are court ordered for extended shelter stays. The CCYS Staff Secure component provides increased levels of supervision across all work shifts and weekly counseling sessions from agency counseling staff. Per the agency's daily schedule, youth required to attend school, are assigned chores, and are provided groups on a daily basis. The program is also serving youth referred to the agency as Domestic Violence Respite referrals. These youth are admitted to DV Respite placement have a pending DV charge and have evidence of being screened by JAC/Detention, but do not meet criteria for secure detention. These residents and their families are provided temporary respite for limited time up to 2 weeks as a result of an active domestic violence incident that occurred in the home. The CCYS program utilizes a service approach that service plans to get the youth and family to reach goals that focus on aggression management, family coping skills, or other intervention design to reduce reoccurrence of violence in the home.

3.01 Shelter Envonment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The reviewer sampled conducted a review of the past 6 months of documents that include the program's logbooks, fire drills, emergency drills and inspections. In addition, the agency completed a full inspection of the interior of the facility and exterior perimeter and grounds. The agency has a detailed written policy in place for its current disaster plan. The reviewer reviewed the last two (2) years and the plan includes all of the required components.

Fire, Safety and Health Standards were reviewed and shows that the fire marshal conducts an annual inspection of fire equipment and of the facility. All fire safety equipment is inspected and is up to date. All food services inspections conducted by the department of Health and a menu is posted and approved by a Licensed Dietician. Food is stored in the proper place and the facility is clean and well lighted. Fire drills are conduct one per month and are within the required time frame of 2 minutes. Facility is equipped with knife for life, wire cutter and all first aid kits are fully stocked.

The area is maintained and all the lights and operational. All information as for the youth to report to DJj and to the Abuse hotline is posted or in client handbook. The youth's rooms are clean and bedding is clean and on each bed. The shelter is clean and free of from hazardous unauthorized materials.

Writer reviewed logbooks for the past 6 months and noticed the logbook clearly highlights incidents, important information with dates and time and is signed by staff making the entry. It is also noted were staff and supervisor are reading and noting their entry in the book as required. Schedule is posted and reflects the gender and ratio of staff to youth during awake hours and sleep hours.

Writer reviewed the agency policy for staff secure and it reflects how the agency and the staff is to handle the youth on staff secure. It is also noted in the logbook which staff is assigned to staff secured youth on each shift.

Over all the shelter environmet is great. All the MSDS sheets and health inspections sheets are great. The shelter is clean in all the areas inpsected. The especially positive, as the program utilizes interns to staff direct care worker positions on a regular basis.

Writer reviewed sample of mock emergency drills for the past quarter and it was noticed that drills were conducted only on the 3:00pm–11:00pm workshift. The reviewer assess logbook entries over the past 6 months and detected errors in the logbook that were not marked with a void line through the entry in several places.

During the facility and exterior inspection, neither of the program's transportation vans used contain an emergency flashlight. The program was able to produce evidence that each van was now equipped with a flashlight.

3.02 Program Orientation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The CCYS agency has a policy and procedure that includes the contents required to meet the requirements for this indicator. A total of five (5) open files were reviewed and all were in compliance with the standard guidelines. In addition, five (5) closed files were reviewed and all were in compliance with the standard guidelines.

In all files reviewed the agency has a place where the youth had to initial that the information was given to them. The youth and staff had to sign off stating that the staff gave and reviewed information with the youth. Several forms had where the parent had to initial or sign off on. Generl alert dots are used for alert notification are noted on the side of the open files and on the youth's medication schedule sheet and contact authorization form. These alerts are also noted in the youth's chronological notes.

No exception were found.

3.03 Youth Room Assignment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The CCYS agency has a policy and procedure that includes the contents required to meet the requirements for this indicator. Five (5) open files were reviewed and all had documentation to support the indicator for this standard. The psychosocial assessment, suicide assessment, screening form, intake assessment, risk factor forms are all used in the process for determining a youth's classification status and room assignment. Rooms are also identified for youth that may need extra supervision and those rooms are close to the staff desk.

Five (5) closed files were reviewed and all had documentation to support the indicator for this standard. Psychosocial assessment, suicide assessment, screening form, intake assessment, risk factor forms are all used in the process for determining a youth's room. Rooms are also identified for youth that may need extra supervision.

In all files reviewed the program has a place where the youth had to initial that information was given to them. The youth and staff had to sign off stating that the staff gave and reviewed information with the youth. You all enough information within your paperwork to assist staff in making room assignments.

3.04 Log Books

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

The CCYS agency has a policy and procedure that includes the contents required to meet the requirements for this indicator. The reviewer assessed the logbook documentation for the past six (6) months. Any incidents are noted with youth's first name only,date and time. Reviewer noticed that all staffs and supervisors are reviewing and signing the logbook from the previous shift. Any special events are placed on a event sheet and a brief mention is documented in the logbook. Any offsite visits and appointments for the youth are documented. Head counts are documented at the begining of each shift.

Information at the start of each shift pertaining to the youth and their status is great. Staff and supervisors is reviewing the logbook and signing off that they have. The shift Pass On the youth information is document in the logbook.

Writer reviewed logbook documentation for the past six (6) months and any safety and security issues are not noted in the logbook. There are many errors in the Logbook that are either scribbled through are not voided correctly. A couple of highlights that are scibbled through as well. Writing in the logbook was very difficult to several entires and staff signatures. There are several over night logs sheets that are not lined through when there is a void and several room checks are not completed with the the ten (10) minute bedchecks and not signed by staff. There is no differentiation between the bedtime log and the logbook as to when a youth is awake. It is also not documented in the logbook when a youth has recieved a phone call or is making a call. It is however documented on the youth's phone call log. The temperature is to be recorded in the logbook during the summer months and it is not being recorded on a consistent basis.

Rating Narrative

The CCYS agency has a policy and procedure that includes the contents required to meet the requirements for this indicator. The reviewer assessed the intake paperwork and it has an area in which the youth and staff writes down the target skills for the youth to work on while in shelter. Target skills and coping skills are given to a youth to keep with them and to review at anytime. Target skills are posted in the classroom. The levels that a youth can advance to and any information concerning the levels is also posted for the youth to review at all times. There are positive reinforcers in place for the youth (reward closet, pass on chores, off site with a staff of their choosing, extended bedtime, etc). As a youth advances and masters the original target skills they can select new skills.

Staff has ongoing training on the Behavior Management System and that training is recorded in the staff's training file. In the event of points lost, the youth has an opportunity to do corrective teaching to redeem them self.

3.06 Staffing and Youth Supervision

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The CCYS agency has a policy and procedure that includes the contents required to meet the requirements for this indicator. The policy requires supervision ratios of 6:1 during awake hours and 12:1 during sleeping hours. The awake hours and sleeping hours for direct care staff members are noted on the youth daily schedule. Each shift schedules at least one male and one female on each shift in support of the gender reflected in the shelter. Head counts are conducted at the beginning of each shift and a random count is completed throughout the shift for unscheduled events that include fire drills, emergency situations and or a disaster. The staff members on duty are listed in the logbook at the beginning of each day. Each staff member is required to review the logbook and upon returning to duty documenting that they have done so by a signature, date and time of review. The staff's schedule shows that staff is in ratio with the head count. The schedule supports the male / female ratio per shift which is stated in the policy.

The agency has a list of everyone who is on-call and that list is e-mailed to the shelter staff, director of the shelter and the counselors who work with the children. The on-call list can also be found at the front desk in the shelter. The schedule is also e-mailed to the shelter staff, director of the shelter and the counselors who work with the children; it is also posted on the bulletin board at the front desk. The policy states that staff observes the youth and documents every 15 minutes while sleeping in rooms for any reason. The staff reported that they complete bed check every 10 minutes when any youth is in their room for any reason. The video showed that they staff has been completing all the bed checks within the allotted time frame. The staff reported that they complete bed check during sleeping times, when a youth is sick and when the youth have quiet time in their room. The agency is equipped with Sixteen (16) functioning surveillance cameras, Three (3) of which have the ability to record audio. The tapes capture the last Six (6) weeks of video recorded. The staff reported that they capture all the major incidents on tapes and transfer those incidents to a recording that they save for future reference if needed. The staff reported using color copies for the different beds checks that are being done (ie: sleeping, sick, and quiet time), which would be helpful for future reviews.

The agency not only has a hard copy of the list of who is on-call for the staff, they also use email and write in the log book to let the staff know who is on-call. The staff also does bed checks every 10 minuntes which was documeted on the vidoe surveillance that the agency has in place. The reviewer noted to the agency that video camera number 10 which showed the basketball court had debris blockign or hindering clear view of the area being recorded.

No exceptions were noted.

3.07 Special Populations

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The CCYS agency has a policy and procedure that includes the contents required to meet the requirements for the Staff Secure indicator. The Policy and Procedure had listed in-depth orientation on admission, what the assessment process and services planning looks like. This requirement is also discussed about parental involvement and the aftercare plan for each youth. It states that the requirements for the staff secure placements for each youth. The policy and procedures listed all the information needed for the staff secure.

The policies prohibit the physical restraint, isolation, or locked seclusion to be used at any time. There is documentation that new staff members are trained on behavioral and crisis interventions within 90 days of hire. The facility provides a week long training 3 times a year for all staff on all the trainings that are needed within that year. The resident handbook states the facility is hands off and lists guaranteed privileges that align with this indicator and the agency's client rights policy.

A total of Two (2) closed residential youth files were reviewed to assess the indicator. A total of two (2) files have documentation of behavioral interventions. None of the files reviewed resulted in instances of specific incidents of any type of physical interventions that violates the "hands off" policy. All files documented that youth are disciplined by staff only, disciplinary measures are used appropriately, and basic rights are never denied. There was no documentation that group discipline and room restriction was used. There were no grievances documented against staff in violation of this indicator in the last six (6) months.

Domestic Violence

At the time of this onsite program review, there is no written policy and procedure for how the agency will provide services to Domestic Violence clients. The staff reported that they treat each client the same. The goals on the service agreement forms are different for the Domestic Violence clients that are in case staffing.

A total of four (4) closed and one (1) open residential youth files were reviewed to assess the indicator. The four (4) charts that were reviewed did not exceed more than 14 days. Three (3) of the files had a prior approval letter accepting the youth into the program one (1) chart did not have a letter from JAC or Detention. All of the charts reviewed had a youth that was pending a DV charge. The four (4) charts that were reviewed all had a plan of services agreement which included services that the youth and family would receive they also had goals that were specific to anger management, coping skills and family communication, four (4) of the charts had a discharge summary with follow up services listed, as well as any referrals that were made for the youth and family.

The agency treats each client the same as for the staff securea nd the domestic violence. It was noted that each plan of service did have different goals and objectives that the child was working.

One exception was noted. The agency did not have a policy to address how it will serve and address all needs of Domestic Violence Respite client referrals.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The Capital City Youth Services CINS/FINS program utilizes several methods to ensure that staff members are properly trained to screen, assess and notify all staff members of conditions and risks of all youth admitted to CCYS residential and non-residential programs. The agency uses a redundant mental health and health related risks alert system in the youth shelter. Specifically, the agency utilizes a general alert board and colored dot system to inform all staff members across all work shifts. In addition, the agency has an effective health screening process that screens all youth for acute medical, as well as mental health conditions.

Further the agency maintains a secure and detailed medication distribution system that provides training on providing medication distribution assistance, first assistance and suicide prevention and intervention techniques. The agency specifically designates and post a list all staff members that have been identified to assist distribute medication.

The agency has the benefit of three (3) licensed clinicians and an employee with a doctorate degree on staff. The agency has strategically place licensed clinicians to directly oversee both the residential and non-residential program respectively. The agency has a full complement of staff members across all three (3) work shifts. Staff member training files indicate staff members received annual crisis intervention, first aid, CPR, suicide prevention and medication distribution training.

4.01 Healthcare Admission Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy/procedure that ensures all youth admitted to residential programs are not in need of immediate medical attention. All youth are provided a preliminary physical and mental health screening at the time of admission to make sure that they are suitable for placement. The Capital City Youth Services CINS/FINS program utilizes several methods to ensure that staff members are properly trained to screen, assess and notify all staff members of conditions and risks of all youth admitted to CCYS residential and non-residential programs. The agency utilizes a general alert board and colored dot system to inform all staff members across all work shifts about behaviors (Green Dot), allergies (Yellow Dot), medical conditions (Red Dot), and medication (Blue Dot) that the youth is currently taking. In addition, the agency has an effective health screening process that screens all youth for acute medical, as well as mental health conditions. The health screening form addresses all elements of the indicator: history of suicide attempts/self injury, current or prior substance use/abuse, current medications, existing medical conditions, physical/dental health issues, specific inquiry as to symptoms of allergies, recent injuries or illnesses and the presence of pain or other physical distress. Staff makes observations for evidence of abuse and neglect, substance abuse and/or intoxication, illness, injury, physical distress or disability. Staff will also observe client for presence of scars, tattoos, or other skin markings.

The procedures indicate youth have unimpeded access to emergency medical care at all times. The procedures indicate if a major medical condition exists the youth will be immediately referred to their physician, emergency room or a public health care department. The policy lists examples of major medical conditions to include, but are not limited to: bleeding disorders, cardiac disorders, diabetes, head injury, seizure disorders, severe chest/abdominal/head pain, poisoning/drug overdose, severe shortness of breath/wheezing, loss of consciousness or breathing, prolonged bleeding from any site, sudden change in mental status (disorientation, threats of violence or suicide, delusions/hallucinations), convulsions/seizures, sever multiple injuries (including multiple fractures, burns or bleeding), allergic reactions accompanied by swelling of the face lips and wheezing or hoarseness, Cyanosis (blue discoloration of the lips and skin), 103 or higher fever and vomiting that looks like coffee grounds.

Seven (7) files were reviewed Three (3) closed files and four (4) open files. Seven (7) out of the Seven (7) files had all contained documentation of the Healthcare Admission Screening Form, All Seven (7) files were dated on the day of admission in the program. Of the Seven (7) files, five (5) youth are currently on medications and all are properly documented on the Medication Oversight & Inventory Record within the file; two (2) has an allergy; one (1) has a recent injury; two (2) had an observation of physical injury and One (1) had observations for the presence of scars, tattoos or other skin markings. One (1) of the youth needed medical care while in the facility. It was documented in the chart that this youth was transported to doctor by the youth's guardian and returned to the facility with follow- up care plan for the youth and the staff. The follow-up services for the youth were documented in the chart.

No exceptions were noted.

4.02 Suicide Prevention

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

A review of this policy indicates that it addresses the requirements contained for the Suicide Prevention indicator. The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services. The Program has a Master Plan that details their suicide prevention plan and response procedures, including staff positions, duties, supervisory roles, involvement of licensed professionals, documentation protocols, notification procedures, and referral systems in connection with suicide prevention and response.

There is also a Suicide Prevention plan that includes specific language for staff interacting with youth who are experiencing suicidal thoughts, and detailed instructions and strategies for calming and supervising them.

A review of six (6) files was conducted. In all six (6) files, suicide risk screening was completed during the screening and intake process. In all 6 cases, the youth had a "yes" response to the identified questions and proper procedures were followed. For the residential cases this included being placed on Sight and Sound (S&S) supervision until an additional Suicide Assessment could be conducted by a clinician supervised by a licensed professional. In these cases, the youth was removed from S&S supervision only after the case was staffed with the licensed professional. Six (6) files were reviewed out of the six (6) files reviewed four (4) files had all contained documentation for suicide prevention. One (1) files had missing initials on the sight and sound observation log and One (1) files had missing times, observations and initials on the sight and sound observation log.

Some exceptions were noted. One (1) files had missing initials on the sight and sound observation log. An additional file had missing times, observations and initals on the sight and sound observation log.

4.03 Medications

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The CCYS agency has a detailed Medication Policy that includes a detailed explanation how the agency will address the use of medications in the residential facility. The current medication policy addresses secure storage, access, inventory, disposal and distribution of medication in accordance with the DJJ Health Services Manual. Further review on the agency policy revealed that the agency has successfully updated the policy manual to include the Verification of Medication of all youth admitted to the program. A selection of eight (8) resident files (five open and 3 closed) of youth on medication was conducted during the program review.

The agency is now using a Medication Overview sheet. The sheet is pink in color to highlight the actual time of day when medication is scheduled to be given. The sheet displays five (5) areas of time that medication can be given. Sheet captures times including morning, mid-day, evening, bedtime, As Needed Only periods when a medication can be given. The sheet also lists special instructions and dosage amounts. The sheet also includes any applicable alerts.

The agency utilizes the Medication Oversight and Inventory Record that has been to include the staff member that initial completes the document and another area that includes a person that completes secondary review of this document for accuracy and completion.

A selection of eight (8) resident files (five open and 3 closed) of youth on medication was conducted. Of these files, seven out of eight contained evidence that the agency had completed the steps necessary to confirm verification of each youth's medication in order to meet this requirement.

The agency provided a list of all staff members that have received training that are designated to have access to secured medications, Over the Counter medications and Controlled Substances. At the time of this onsite program review, there were a total of thirty-four (34) staff members listed as training and approved to assist in the delivery of medications.

All medications in the shelter are stored in a designated separate, secure room that features separate storage cabinet each with double locking cabinets that are inaccessible to youth. The keys to access the double locking cabinet are stored in a locked key box with the pill counting tray and pill counter.

All controlled and prescribed medication are stored in small plastic containers with each youth's first name listed on the outside label. Both oral and topical medications are stored in the plastic containers with the topical enclosed in a plastic baggie. There were no injectable medications on site, or identified as needed for any youth during the time of the review. The shelter has a system in place for refrigeration of medication if needed, however there was no medication that required refrigeration during the time of review.

The agency has a plastic bio-hazard waste disposal bin to collect all discarded razors and needles. The reviewer found plastic shavers in the trash bin and not in the bio hazard waste disposal bin. The agency is not ensuring that all bio-hazard waste is disposed in the waste bins designated for razors, shavers, needles, etc.

A review of the Central Communication Center (CCC) reports indicated a total of five (5) medication errors within the last six (6) months. Four (4) out of the 5 incidents were reported to the CCC in March of 2013 related to the youth not receiving the medication dose when required. All 4 of these reported in March were involved staff members that missed distributing medications to the youth at the scheduled time. Agency reporting to the DJJ CCC indicates that the agency informed the DJJ CCC that staff involved in incidents received corrective actions. Follow up in reports indicate that staff cited in DJJ CCC do not all have follow up corrective actions documented in their specific employees files. This indicates that the agency is inconsistent in follow up related to medication error incidents. In general, medication errors appear to be a function of staff members transcribing instructions incorrectly and missing actual times to distribute medication.

Agency sharps are maintained on the right side of the double locking metal cabinet and a pill cutter is located in the locked medication key box. Sharps are counted once per day on the overnight work shift on a designated sharps form. Sharps counts were reviewed from March 2013 through the onsite review date and indicate that counts are consistent and well documented. The agency disposes of sharps in a dedicated wasted bio hazard wasted bin. However, at the time of this onsite review, not all sharps are being disposed of in the dedicated bio hazard waste bin.

The agency provided over the counter (OTC) medication to clients on an as needed basis. The agency provides general OTC medication to residents during their shelter stay on an as needed basis. The agency requires that counts be conducted once per day on the overnight work shift. A review of the OTC medication inventory counts and distribution records from March 2013 to April 2013 were conducted. All counts are documented on the OTC Medication Oversight and Inventory Record for counts and distribution. All counts and distribution documentation is generally consistent. The reviewer found a minor discrepancy with distribution documentation from September 2013.

Some exceptions were noted. One (1) out of eight (8) files did not complete the verification of medication within reasonable time frame. The case did not have documented evidence of medication verification for 3 days after admission to the program. The name of a youth that received an OTC medication on the early AM work shift was not documented on 09/10/2013.

A total of six (6) incidents were reported over the last six (6) months. Of these 6 incident, five (5) were related to medication distribution errors. Of the 5 medication incidents, only three (3) out of the 5 had documented administrative performance action forms written in the file of the staff that committed to the medication error. To better support the effort that a verbal intervention was conducted, its recommended that the agency document all verbal, counseling, suspension and termination related workplace interventions in writing.

Medication inventory counts reviewed in one client's file were not documented on 2 occasions for 1 client served by the agency during April 19 and 20, 2013.

At the time of this on site review, the reviewer found that that agency is not disposing of used biohazard materials (razors) in an approved waste disposal bin. Agency is currently disposing of used razors in a general trash bin. The agency should consider othe disposal methods such as using a private sector vendor, or seeking assistance from their local hospital or fire and health departments.

4.04 Medical/Mental Health Alert Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy to address medical and mental health alert process that meets the requirements of this indicator. The staff reported that they used to have a large dry erase board with appropriate color coded dots to identify various medical/mental health conditions, but do to confidentiality reason they have since done away with placing any alerts on the dry erase board. The shelter now maintains a CCYS Residential Alert System form that is located at the front desk in the shelter that the entire staff is able to access. This legend is coded by color as a guide for the various conditions to maintain the youth's privacy and confidentiality. The Green dot indicates youth with Mental Health and Behavioral conditions; Blue dot indicates youth with Non-Controlled Medications (prescription and over-the-counter), Yellow dot indicates allergies (non-food allergies, medication allergies, food allergies); Orange dot indicates youth with Sexual Behavior Concerns (perpetrator or victim); Pink dots indicates youth on Controlled Medications; Red dot indicates youth with major health issues (seizures, heart problems, Asthma, any other major health/medical issues).

A review of 6 charts (3 open and 3 closed) was conducted to assess the agency's adherence to the requirements of this indicator. All open files contained the appropriate color coded dots which were documented on the binder of each chart as well as on the intake and assessment form, the contact authorization form. Shift Exchange Information entries and log book entries were reviewed to indicate staff members were provided sufficient information and instructions regarding the youth's medical conditions, allergies and information to allow them to recognize and respond to the need for emergency care and treatment. The log book indicated that each person on shift reviewed the information with a signature and date of the review of the information.

A review of 6 charts (3 open and 3 closed) was conducted to assess the agency's adherence to the requirements of this indicator. All open files contained the appropriate color coded dots which were documented on the binder of each chart as well as on the intake and assessment form, and the contact authorization form. Shift Exchange Information entries and log book entries were reviewed to indicate staff members were provided sufficient information and instructions regarding the youth's medical conditions, allergies and information to allow them to recognize and respond to the need for emergency care and treatment.

No exceptions were noted for this indicator.

4.05 Episodic/Emergency Care

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The Program has a policy regarding episodic/emergency care and was able to clearly demonstrate that program staff are trained on emergency medical procedures within employee files. Capital City Youth Services installs a "dot" system for specific medical needs of each youth. In doing so, the CCYS "dot" system helps alert staff to which youth requires special monitoring for health/medical needs. The Program has a coordinated color system for its daily log book to reference the following that include Youth Behavior; Admin/Staff; Medical; Law Enforcement/Baker Act; Safety Issues; and Parent Guardian.

The Program's daily logs appear to be well maintained; clearly describing the events and handwriting was legible within the reports.

The QI Reviewer reviewed the Program's incident reports, CCC reportable incident, and daily logs during the time period March 1, 2013, through July 31, 2013. The QI Reviewer reviewed nine (9) reports during the time period March 1, 2013, through July 31, 2013, and the Program was within compliance set forth by the Department.

The Program, CCYS provided knife-for-life and wire cutters and First Aid Kit/Supplies in the Shelter Building where the youth are located. Furthermore, the Program provided additional First Aid Kit/Supplies in two (2) Program vehicles.

Capital City Youth Services was able to demonstrate under the indicator 4.05 Episodic/Emergency Care the staff received proper training, clearly define policy, and followed the Program's protocols within the Program's policy for episodic/emergency care. Therefore, CCYS meets the requirements set forth by the Department and given a satisfactory rating for 4.05 Episodic/Emergency indicator.