



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of CHS Treasure Coast, WaveCREST

on 05/02/2018

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Standard 3: Shelter Care

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

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

Standard 2: Intervention and Case Management

2.01 Screening and Intake	Satisfactory
2.02 Needs Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management and Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/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%

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

Rating Definitions

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

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

Review Team

Members

- Ashley Davies, Lead Reviewer/Consultant, Forefront LLC
- Gregg Miller, Director of Programs, LSF SE Lippman
- Baldwin Davis, Chief Administrative and Compliance Officer, Miami Bridge
- Susan Yang, Shelter Supervisor, Boys Town
- Raylene Coe, Street Outreach Coordinator, Crosswinds

Persons Interviewed

- | | | |
|--|--|---|
| <input type="checkbox"/> Chief Executive Officer | <input type="checkbox"/> Executive Director | <input type="checkbox"/> Chief Operating Officer |
| <input type="checkbox"/> Chief Financial Officer | <input checked="" type="checkbox"/> Program Director | <input checked="" type="checkbox"/> Program Manager |
| <input checked="" type="checkbox"/> Program Coordinator | <input checked="" type="checkbox"/> Direct- Care Full time | <input checked="" type="checkbox"/> Direct-Care Part Time |
| <input checked="" type="checkbox"/> Direct-Care On- Call | <input type="checkbox"/> Volunteer | <input type="checkbox"/> Intern |
| <input checked="" type="checkbox"/> Clinical Director | <input checked="" type="checkbox"/> Counselor Licensed | <input checked="" type="checkbox"/> Counselor Non- Licensed |
| <input checked="" type="checkbox"/> Case Manager | <input type="checkbox"/> Advocate | <input checked="" type="checkbox"/> Human Resources |
| <input checked="" type="checkbox"/> Nurse | | |
| 1 Case Managers | 0 Maintenance Personnel | 2 Clinical Staff |
| 1 Program Supervisors | 0 Food Service Personnel | 0 Other |
| 1 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 checked="" type="checkbox"/> Logbooks | <input checked="" type="checkbox"/> Fire Drill Log | 5 # Health Records |
| <input checked="" type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 3 # MH/SA Records |
| <input type="checkbox"/> Contract Monitoring Reports | <input checked="" type="checkbox"/> Table of Organization | 5 # Personnel Records |
| <input type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 3 # Training Records |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 4 # Youth Records (Closed) |
| <input checked="" type="checkbox"/> Fire Inspection Report | <input type="checkbox"/> Telephone Logs | 4 # Youth Records (Open) |
| <input type="checkbox"/> Exposure Control Plan | <input type="checkbox"/> Supplemental Contracts | 0 # Other |

Surveys

4 Youth 4 Direct Care Staff

Observations During Review

- | | | |
|--|--|--|
| <input type="checkbox"/> Intake | <input checked="" type="checkbox"/> Posting of Abuse Hotline | <input checked="" type="checkbox"/> Staff Supervision of Youth |
| <input checked="" type="checkbox"/> Program Activities | <input type="checkbox"/> Tool Inventory and Storage | <input checked="" type="checkbox"/> Facility and Grounds |
| <input checked="" type="checkbox"/> Recreation | <input checked="" type="checkbox"/> Toxic Item Inventory and Storage | <input checked="" type="checkbox"/> First Aid Kit(s) |
| <input type="checkbox"/> Searches | <input type="checkbox"/> Discharge | <input type="checkbox"/> Group |
| <input checked="" type="checkbox"/> Security Video Tapes | <input type="checkbox"/> Treatment Team Meetings | <input type="checkbox"/> Meals |
| <input checked="" 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

WaveCREST is contracted with the Florida Network of Youth and Families to provide both shelter and non-residential CINS/FINS services for youth and their families in Martin, Okeechobee, Indian River, and St. Lucie Counties. Since the last quality improvement review:

Facility Improvements

The shelter recently received new, upgraded computers and an upgraded technology infrastructure.

The interior dorm rooms were recently painted, as well as, the exterior picnic tables under the pavilion.

Publix donated a "Day of Service" to the shelter and did landscaping and tree trimming work around the outside of the shelter.

Programming Improvements

The agency strengthened their services by now using two different service providers to respond to the gaps in attaining services for the youth and their families. When appropriate, Drug Abuse Treatment Associates (DATA) and Sun Coast Mental Health provide services while youth are still in the shelter, removing barriers to on-going services.

The shelter added the position of Food Service Manager since the last review.

The current Program Director is transitioning to shared management with the agency's other shelter CHS West Palm Beach. The Program Director of CHS WaveCREST is now the Director of Program Operations overseeing CHS West Palm Beach CINS/FINS and shelter.

Challenges

The hiring of Youth Care Staff continues to be a challenge. Delays in the background screening process are resulting in applicants finding other jobs while waiting.

The Non-Residential program was down to one counselor for the entire circuit, there were three vacancies. The agency has recently hired two counselors, one counselor has started taking some cases and the other counselor does not have any cases yet. The Non-Residential Program now has one vacancy.

There were some inconsistencies in the process of referring youth. Quality Management conducted retraining with staff to clarify and improve the process.

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 is located at 4520 Selvitz Road in Ft. Pierce, Florida and is under the leadership of the Director of Program Operations. In addition, other staff include: a Residential Supervisor, a licensed Clinical staff, an Administrative Secretary, Residential Counselor and an Outreach Counselor. Shelter staff includes: a Data Specialist, Group Living Manager, six fulltime Youth Care Staff (YCS), and two part time/relief Youth Care Staff. There was one full-time YCS position vacant and two relief YCS positions vacant.

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 Employees' 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.

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, last updated September 26, 2017. Policy number CHS 7101 addresses the requirements of the indicator for background screening of employees and volunteers.

The policy reviewed onsite requires all potential employees, volunteers who work alone with youth, 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 these individuals to undergo a Level 2 Employment Screening pursuant to Rule 65C-14.023 and Florida Statutes. Additionally, the provider conducts a background check with the Division of Motor Vehicles prior to hiring staff and a review is conducted annually. Every January, staff will complete an Affidavit of Good Moral Character. The report is submitted to the DJJ Background Screening Unit by January 31st.

A total of five background screening files were reviewed for five new hires. There were no employee's who were eligible for a 5-year background screening during the review period. The five new personnel had timely background screenings completed prior to their hire dates. All screenings were rated as eligible.

The program provided a copy of its Annual Affidavit of Compliance with Level 2 Screening Standards and evidence that it was submitted to the BSU on November 1, 2017.

There were no exceptions to this indicator.

1.02 Provision of an Abuse Free Environment

Satisfactory

 Limited

 Failed

Rating Narrative

The agency has policy CHS/7102 in place for the provision of an abuse free environment updated on 9/26/2017 and approved by the Program Director.

CHS's policy outlines it's expectations that youth, staff and others feel safe, secure, and not threatened by any form of abuse or harassment. Their policy requires that all employees are to report abuse, neglect, and abandonment to the Florida Abuse Hotline and the procedure is in public view and all youth have unimpeded access to report abuse.

The CHS employee handbook outlines clear prohibitions against using physical abuse, intimidation of any kind, profanity, threats and or excessive use of force. In addition the youth will not be deprived of their basic needs such as food, clothing, medical care, and/or security.

Policy dictates when the abuse hotline is to be called or the Central Communications Center and within what time frames. It also indicates who

is to begin the internal investigation.

During the tour of the facility it was observed that the Florida Abuse Hotline number and other relevant numbers are posted in the male and female rooms. Youth are also informed of these during program orientation. The resident handbook outlines behavioral expectations for youth which promotes a safe and abuse free environment towards their peers.

Upon hire, staff receive and sign receipt of the Agency's Code of Conduct which is included in the Employee Handbook. Employees are required to report all known or suspected cases of abuse and are trained on child abuse reporting. There were five staff training files reviewed that confirmed this training was received.

There is a grievance box and forms located in the day room. The box is locked and the supervisor has the key to check it daily. There have been three grievances in the last six months. All three grievances were reviewed. Each grievance was appropriately handled and the youth indicated they were comfortable with the resolution.

There were no exceptions to this indicator.

1.03 Incident Reporting

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy CHS/7103 outlining the Incident Reporting procedure. It was updated on 9/26/2017 and approved by the Program Director.

The policy requires staff to comply with DJJ/Florida Network incident reporting procedures.

All staff are to notify the supervisor on call in the event of any incident. Staff will then contact the CCC and other parties needing notification regarding the occurrence of an incident. A note will be taken in the electronic log book and an incident report will be taken in the AIRSWEB (CHS's Electronic Database).

The Executive Director is to be notified of any critical incident within twenty-four hours.

The program maintains information about incident reports in a paperless computer database system called Airswab.net. All incident reports are electronically generated, documented, reviewed, and signed online.

A list of incidents was provided for the last six months. There were seven incidents reported to the CCC between 11/1/17 and 5/1/18. Each of these incidents were reviewed. All seven incidents were reported within the two hour time frame. There was follow-up communication tasks/special instructions as completed for each report as required by the CCC. All incidents were documented in the electronic logbook.

There were no exceptions to this indicator.

1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy for Training Requirements that was last updated on July 1, 2017. The policy number is CHS 7104. In addition to its policy and procedures, the provider has an annual Training Plan for FY 2017-2018 that describes its protocol for complying with the training requirements.

Training is provided through various means including online using the agency's Learning Management System (LMS), the Florida Network, DJJ Skill Pro platform, and external professional trainers. The program director develops an Individual Training Plan with each staff annually and monitors training on a monthly basis to ensure staff receives the required training throughout the year. Monthly training calendars are maintained in a binder along with sign-in sheets and curriculum's for training's conducted each month.

There were three training files reviewed for new hire training completed during the first 120 days of employment. All three staff received all trainings required within the first 120 days, with the exception of one staff who did not receive CPR/First Aid training in the first 120 days. This staff did receive the training; however, it was outside the 120 day time frame. All three staff documented well over the required 80 hours of training.

There were three training files reviewed for annual in-service training requirements. All three staff documented more than the required 40 hours of annual training. All three staff documented all required trainings, as well as, additional trainings were completed.

Exception:

The staff received CPR and First Aid training outside the 120 day time frame.

1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy CHS/7105 for Reporting and Analyzing Data updated on 9/26/17.

The program collects and reviews several sources of information to identify patterns and trends including: monthly outcomes; quarterly case record review reports; monthly review of incidents, accidents and grievances; monthly review of program satisfaction surveys; monthly review of NetMIS data reports. The program has a Quality Management department that oversees the program outputs and outcomes for the quality improvement process. Findings of data collected and reviewed are shared with staff, identifying strengths and weaknesses as well as improvements to be implemented or modified with staff input.

The program has a designated Quality Management Specialist who is responsible for the implementation and oversight of the CQI program. All these activities are kept online on the database system called Airsweb.net.

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Peer Record Reviews are completed quarterly. Each quarter, upon completion of the record review, the QMS aggregates the results and enters data into the database system. The same process is done with incidents, accidents, and grievances. This information is shared with the Children's Home Society's Executive Team and reviewed by the Board of Directors. These reports are reviewed with the Program Director who then shares the information with all staff during a staff meeting.

Consumer Satisfaction and Outcome Data are administered on an ongoing basis and collected by QMS and entered into the database then submitted to the program supervisor for review.

A binder with Staff Monthly Minutes was provided for review. There was documentation in these minutes that all staff reviews training, incident & accidents, NetMIS data, record reviews, and satisfaction surveys. There was also documentation in these minutes that staff are using the data to identify strengths and weaknesses, and improvements are implemented or modified throughout the process when needed.

There were no exceptions to this indicator.

1.06 Client Transportation

Satisfactory

Limited

Failed

Rating Narrative

Agency has a transportation policy CHS/7106 that was last reviewed and approved by the Program Director in September 2017.

Youth will be transported with a third party present in the vehicle when at all possible. The third party may be another direct care staff, volunteer, intern, administrative staff or other youth. The HR department performs motor vehicle driving checks to ensure that staff have a valid Florida driver's license. If an employee is placed on "no-drive status" for any reason, the employee would not be permitted to transport youth. Each driver will log out the keys and take with them a first aid kit when transporting youth. Staff will log in vehicle binder the name of the driver, date and time, mileage, number of passengers, the purpose of travel, and location. If a third party cannot be obtained for transport, the client's history, evaluation, and recent behavior are considered as well as the transporting staff's history before management permits to transportation arrangements. The cameras installed in each vehicle will be utilized in the absence of the third party.

All drivers are approved by administrative personnel. Each driver of a vehicle will log out the keys to the vehicle and also takes a first aid kit. The driver's log is maintained in a binder in the vehicle and consists of driver/staff's name, date and time, mileage, purpose of travel and location, number of passengers, and supervisor's approval space. These logs were reviewed for the last six months and were consistently completed and filled out.

There were several cases reviewed of single client transports. All were approved by the supervisor, documented in the space provided on the driver's log, and documented a review of the client's history and recent behavior.

The agency performs annual motor vehicle driving checks with the Florida Division of Motor Vehicles. All employees must pass the vehicle driving checks to be allowed to transport youth. The agency has a certificate of liability insurance which was issued on 3/7/2018.

There were no exceptions to this indicator.

1.07 Outreach Services

Satisfactory

Limited

Failed

Rating Narrative

The Agency has an Outreach and Interagency Agreement policy CHS/7107 that was updated on 9/26/17.

Outreach is diligently conducted by the program on an ongoing basis to increase public and community awareness. Outreach strategy includes the implementation of school and community presentations and a direct media campaign to target and educate youth. The program utilizes Interagency Agreements to build strong community partnerships and collaborations to address the needs of the youth in the 17th Judicial Circuit.

The agency keeps and maintains a wide variety of Interagency Agreements and documents updates with the agencies yearly.

Outreach Events that staff participate in on are recorded on NetMIS. The program maintains a binder with information from weekly conference calls for detention hearing meetings.

The agency is well represented in the circuit and in Juvenile Justice Councils. The Program Director is the Chair of Okeechobee's Juvenile Justice Council and the licensed Counselor at the program is the past Chair of Martin County's Juvenile Justice Council. Both are representatives on the Circuit 19 Juvenile Justice Board. All agendas and minutes, from these meetings, are kept in a Community Meeting Participation binder.

There were no exceptions to this indicator.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

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. Direct Care staff are responsible for completing all applicable admission paperwork, orientating youth to the shelter/program, 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 and 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 counseling positions and a supervisor. One of those four counseling positions was vacant. The counselors are responsible for completing assessments, developing case plans, providing case management services, and linking youth and families to community services.

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 agency has a written policy numbered CHS/7201, entitled "Screening for Services and Intake Assessment," which has an effective date of July 1, 2011. The policy was last updated September 26, 2017 and was approved by the Program Director.

The policy establishes that the agency provides 24/7 services 365 days a year and that screenings by trained personnel are initiated within seven calendar days of a youth/family being referred. The policy also specifies that the agency's Centralized Intake services include: screening for eligibility, crisis counseling and information, and referral. The policy specifically designates the Florida Network NetMIS intake screening form as the document approved by the agency for determining eligibility for services.

Upon intake, the procedures outlined in the agency's policy require youth and their parent(s) or guardians to receive written information about the available service options, grievance procedures, their rights and responsibilities pertaining to participation in the program, and possible actions that could occur as a result. The policy also specifies that parents or guardians should receive the CINS/FINS program brochure.

The agency's policy also sets forth that certain forms must be completed during the intake process to include the NetMIS Screening form, Consent for Services form, CINS/FINS Intake form, Risk Factor form, and a Suicide Risk Screening (EIDS).

There were a total of eight files reviewed, four Residential (two open and two closed) and four Non-Residential (two open and two closed).

All but one of the eight files reviewed clearly evidenced meeting the standard for completion of an eligibility screening within seven calendar days from the date of referral. One open, Non-Residential file lacked an entry date on the NetMIS Screening form. However, upon further inquiry, the reviewer learned that the school district making the referral had completed that particular screening and supplied it concurrently with the referral. The reviewer accepted this as a timely screening where the agency could not accomplish contact with the family referred until nine days after its receipt of the school's facsimile referral since the school district staff is well-versed in the agency's eligibility criteria.

Each of the eight files contained evidence, in the form of acknowledgment signatures, indicating receipt of written information about available service options and the rights and responsibilities of youth and parents. The acknowledgement form also establishes that the youth and parents/guardians in each case file reviewed were provided information on potential actions resulting from involvement with the CINS/FINS program, grievance procedures, and that the agency's CINS/FINS Parent Brochure was made available.

There were no exceptions to this indicator.

2.02 Needs Assessment

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy numbered CHS/7202, entitled "Needs Assessment" which has an effective date of July 1, 2011. The policy was last updated on September 26, 2017 and was approved by the Program Director.

The agency requires a Needs Assessment to be completed for all youth receiving services. The policy specifies that it be started within 72 hours of admission for residential services and during the first face-to-face visit (or session) for non-residential services (and completed within three visits/sessions). The agency also conforms to the indicator in requiring assessments to be completed by Bachelor's or Master's level staff. These must be signed by their respective supervisors upon completion as evidence of supervisory review. The agency's policy establishes that assessments more than six months old must be updated.

As required by the Indicator and Florida Network Policies and Procedures, the agency's policy is that a youth identified with suicide risk factors must be referred for a suicide risk assessment by a Licensed Mental Health Professional.

The agency's procedures under its Needs Assessment policy, specifies exactly what information must be included in the Needs Assessment: demographic information; date(s) of assessment; who was present for the assessment; reason for referral – presenting problem; youth and family assessment – what they want to change; psychiatric and counseling history; mental, physical and emotional status; educational history; family, home constellation and assessment; family history and involvement; youth residential history; developmental history; medical history; legal history (DJJ/DCF); financial/employment history; drug and alcohol history; peer relationships; potential for violence/abuse; history or violence/abuse; youth and family strengths, weaknesses and interests; staff impressions, comments, summary; staff signature and completion date; supervisor's signature and completion date.

There were a total of eight files reviewed, four Residential (two open and two closed) and four Non-Residential (two open and two closed).

All of the youth case files from both the Residential and Non-Residential Program contained fully completed Need Assessments that were done the same day as the youth's intake/admission into the program. Each reflected that a Bachelor's level or Master's level staff member had conducted the assessment in conformance with the agency's policy and each contained the required supervisor's review signature.

None of the youth in the eight files reviewed for this indicator were identified with an elevated risk of suicide as a result of the Needs Assessment; therefore, referral for Assessment of Suicide Risk by or under the direct supervision of a licensed mental health professional was not applicable for this review.

There were no exceptions to this indicator.

2.03 Case/Service Plan

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy numbered CHS/7203, entitled "Service/Case Plans- Implementation, Review and Revision" which has an effective date of July 1, 2011. The policy was last updated on September 26, 2017 and was approved by the Program Director.

Development of a Service Plan in conjunction with the youth/family within seven working days following the completion of the Needs Assessment is required by the agency's Counselor/Case Manager under this policy. It also stipulates that the Service Plan must contain: the specific needs identified in the assessment; realistic time frames for completion; measurable objectives that identify problems or needs; designates responsibilities of the youth and family to complete goals, and lists the responsibilities of the program to assist the youth/family in their goal completion. Agreement to participate with the Service Plan must be denoted by signature(s) of youth/family and the Counselor/Case Manager is responsible for reviewing the progress of the Service Plan at regular intervals under this policy.

The agency's policy sets forth procedures to help ensure that Service Plans are completed within the required 7 working days after completion of the Needs Assessment by the appropriately assigned counselor/case manager and are developed to address the specific needs identified in the initial screening, intake and assessment. Therefore, policy indicates that Service Plans should include: identified needs, goals with measurable objectives, types of services or treatment, frequency of services or treatment, location of service provision, responsible/accountable staff or service provider, realistic time frames/target dates for completion, actual completion dates, signature of the client, parent/guardian, counselor, and supervisor, and the date the Service Plan was initiated. Accommodation is made in the agency's policy for documenting the absence of the youth or parent/guardian and for any other incompleteness in developing the Service Plan. Specific formal reviews to assess progress in achieving goals for Residential Service Plans are to be made at seven days, twenty-one days, and forty-two days from the date of the initial plan and for Non-residential Service Plans these formal reviews are to occur at thirty, sixty, and ninety day intervals at a minimum, and every six months thereafter. Documentation of goal achievement, revisions, progress, and reviews is required under the policy as well.

There were a total of eight files reviewed, four Residential (two open and two closed) and four Non-Residential (two open and two closed).

All of the youth case files reviewed from both the Residential and Non-Residential Programs contained completed Service Plans dated the same date as each youth's Intake and Needs Assessment. Each Service Plan contained the required individualized and prioritized needs and goals identified in the Needs Assessment; service type, frequency and location; responsible party, and target dates for completion. Although not all of the youth case files reviewed indicated an actual completion date for the identified goals because some were still working toward them, nearly all contained the required signatures of the youth and parent/guardian.

As provided in the agency's policy, the Counselor/Case Manager clearly noted that the parent/guardian's verbal agreement with the Service Plan was acquired when the party was unavailable to come in person to sign. However, the signature of the Counselor/Case Manager and the Supervisor along with the date the Service Plan was initiated was evident in all eight of the youth case files reviewed. Furthermore, as set forth in the agency's policy, the Residential case file reviews indicate that they were timely performed at the seven day interval in all three applicable files and subsequent thirty day and sixty day reviews were documented to have occurred in the single applicable closed file. Similarly, all four of the Non-Residential case files clearly reflect applicable Service Plan reviews and revisions (as needed) by the assigned Counselor/Case Manager at thirty and sixty days post initiation.

There were no exceptions to this indicator.

2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy numbered CHS/7204, entitled "Case Management and Service Delivery/Family Involvement" which has an effective date of July 1, 2011. The policy was last updated on September 26, 2017 and was approved by the Program Director.

Through this policy the agency establishes that its purpose is to provide services to youth, their families, legal guardians or other others in the immediate and follow-up care of the youth. Through coordination of services the agency indicates it may fulfill its stated purpose.

The agency's procedures outlined under this policy indicate each client will be assigned Counselor/Case Manager who will follow the youth's case and ensure delivery of services through direct provision or referral. Engagement of the families, guardians and significant others and the youth in all case planning services activities is denoted by acquiring their signature on the Service Plan and all contacts or attempts to contact the family participants is to be documented in the progress notes of the youth's case file by the Counselor/Case Manager. As set forth in this Quality Improvement Indicator and its referenced Florida Network Policies and Procedures, the agency's policy spells out that case management shall include: establishing referral needs and coordinating referrals to services based upon on-going assessment of the youth's/family's problems and needs; coordinating service plan implementation; monitoring youth's/family's progress in services; providing support for families; monitoring out-of-home placement, if necessary; referrals to case staffing committee, as needed to address the problems and needs of the youth/family; recommending and pursuing judicial intervention in selected cases; accompanying youth and parent/guardians to court hearings and related appointments, if applicable; referral to additional services, if needed; continued case monitoring and review of court orders; and case termination with follow-up.

There were a total of eight files reviewed, four Residential (two open and two closed) and four Non-Residential (two open and two closed).

In each of the eight files reviewed a Counselor/Case Manager was immediately assigned to the youth at intake. As reflected by the documentation in each of the case files, the assigned Counselor/Case Manager also completed the Needs Assessment and initiated the Service Plan. Each file reviewed showed that the Counselor/Case Manager established and coordinated applicable referral services as needed and continued on-going assessments of each youth's/family's problems and needs; coordinated the service plan implementation; monitored the youth's/family's progress; provided necessary supports; and, for those youth placed in the Residential Program, monitored the out-of-home placement. Because none of the eight youth cases required referral to case staffing, this reviewer was unable to evaluate the agency's Counselor/Case Manager performance with regard to referrals to case staffing or accompanying youth and parents/guardians to court hearings and related appointments. All five applicable files reflected that their respective Counselor/Case Manager referred the youth/family for additional services. All four of the closed files reviewed contained documentation of the Counselor/Case Manager's case termination notes. Two of the case files reviewed were subject to the required thirty day post exit follow-up and that was documented in the case file appropriately. Only one of the closed files was subject to the sixty day post exit follow-up, which was also properly recorded in the youth's case file.

There were no exceptions to this indicator.

2.05 Counseling Services

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy numbered CHS/7205, entitled "Counseling Services" which has an effective date of July 1, 2011. The policy was last updated on September 26, 2017 and was approved by the Program Director.

As set forth in its policy, youth and families are to receive counseling services in accordance with the youth's Service Plan to address the needs identified during the youth's assessment process. The agency's Residential Program provides both individual and family counseling services. Group counseling sessions are provided at least 5 days per week to youth in the Residential Program and, although not intended to be therapy, these group sessions are structured with a clear leader or facilitator, a relevant topic, provide for youth participation and are at least thirty minutes in duration. The agency's procedures require documentation of groups to include date and time, list of participants, length of time and topic covered.

The agency's Non-residential counselors are to provide therapeutic community-based services designed to provide the intervention necessary to stabilize the family in the event of crisis, keep families intact, minimize out-of-home placement, provide aftercare services for youth returning home from shelter services, and prevent the involvement of youth and families in the delinquency and dependency systems. The agency's policy indicates that non-residential counseling services are provided in the youth's home, community location, or at the agency's facility.

The agency's procedures under this policy require that the counseling services shall: be intensive in nature, according to the needs of the family/youth; reflect all case files for coordination between the presenting problems, Needs Assessment, Service Plans and reviews, case management and follow-up; maintain individual case files on all clients and adhere to all laws regarding confidentiality; maintaining chronological case notes on the youth's progress; and maintain an on-going internal process that ensures clinical review of case records, youth management, staff performance regarding CINS/FINS services. These procedures also specify that the agency offers a multi-dimensional array of counseling/case management services that may include: intensive crisis counseling; parent training; individual, group or family counseling; community mental health services; prevention and diversion services; services provided by voluntary or community agencies; runaway center services; special education, tutorial, or remedial services; vocational, job training, or employment services; recreational services; homemaker or parent aide service and other services as may be appropriate.

There were a total of eight files reviewed, four Residential (two open and two closed) and four Non-Residential (two open and two closed).

All eight files reviewed revealed that each youth's presenting problems, as documented in the initial intake and Needs Assessment, were appropriately addressed in the initial Service Plan, as well as, in the applicable Service Plan reviews. Each file reflected that the Counselor/Case Manager maintained case notes for all counseling services provided and each youths progress was both chronologically documented, as well as, reflected in their respective Service Plans.

Each of the youth case files documented the signature of the Counselor/Case Manager's supervisor at regular intervals to reflect the on-going internal clinical review of the case records and staff performance. Furthermore, each of the youth files showed ample documentation to establish that youth and families are receiving counseling services in accordance with their respective Service Plans. The four Residential files reviewed contained documentation from the group counseling sessions where each youth participant was asked to contribute their written thoughts/ideas on the topic/subject matter addressed. Furthermore, the agency provided its notebook documenting the appropriate content, participants, facilitator, date, time, and duration of each group counseling session over the past year and a half; thus, this reviewer could easily verify that the agency is providing group counseling at least five times a week.

There were no exceptions to this indicator.

2.06 Adjudication/Petition Process

Satisfactory Limited Failed

Rating Narrative

The agency has a written policy numbered CHS/7206, entitled "Adjudication/CINS Petition Process – Case Staffing Committee" which has an effective date of July 1, 2011. The policy was last updated on September 26, 2017 and was approved by the Program Director.

The agency schedules a case staffing to review cases where documentation from the Counselor/Case Manager shows that reasonable and appropriate efforts have been unsuccessful in resolving the problem. Specifically, the agency's procedures set forth that a staffing will be schedule if: the family/child will not participate in the services selected or, the family/youth is not in agreement with the services or treatment offered or, the program receives a written request from the parent/guardian or any other member of the staffing committee. The staffing must convene within seven work days after receipt of a written request from a parent/guardian.

The agency's policy reflects the Florida Network's Policies and Procedures and state statute for this indicator in requiring a representative from

the youth's school district and from the contract provider for CINS/FINS to comprise the case staffing committee and optionally may also include the youth and parent/guardian, a representative from DJJ, the State Attorney's Office, Alternative Sanctions Coordinator, and health, mental health, social services, and substance abuse.

After convening a staffing, the agency's procedures require a written report outlining the basis for the committee's recommendations within seven days. Judicial intervention, if recommended by the case staffing, is coordinated by the Counselor/Case Manager and court documentation is prepared as required by the DJJ Attorneys, who will file the petition and predisposition report with the clerk of court, who in turn schedules the hearing/arrestment and issues a summons along with a copy of the petition. At the arraignment, the child and the parent, guardian or custodian is given the opportunity to admit, deny or consent to the allegations in the petition and, based on the court's findings, an order is issued. The court holds review hearings to check on the child's progress and the Counselor/Case Manager is required to complete a review summary on the child's behavior and progress prior to each of these hearings.

The agency has only had one youth referred for a case staffing since the last review. That file was reviewed.

The parent did not request the case staffing, so the requirement for convening the staffing within seven working days was not applicable for review. However, the case file reflected documentation that the family was provided written notification no less than five working days before the staffing. Furthermore, the staffing committee included a member from the school district and from the agency, as well as, the youth and the parent. There was a revised Service Plan created as a result of the case staffing and the file indicated that a written report was provided to the parent/guardian within seven days that outlined the committee's recommendations and reasoning. The Counselor/Case Manager provided a review and pre-disposition report to the DJJ Attorney for filing with the petition and accompanied the youth and family at the court hearing. The file reflected the Counselor/Case Manager's monitoring of the youth's compliance in review summaries as required by the agency's policy and this indicator.

The agency provided documentation regarding its regular communication with the school district representative and has an established schedule for committee meetings.

There were no exceptions to this indicator.

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy numbered CHS/7207, entitled "Youth Records and Case Management Services" which has an effective date of July 1, 2011. The policy was last updated September 26, 2017 and was approved by the Program Director.

The agency's procedure, as outlined in this policy, requires that a confidential case record be created and maintained on each youth admitted into the agency's program. The file records of both residential and non-residential admitted youth are to be marked "Confidential" and stored in a corresponding locked drawer also marked "Confidential." The agency's policy, which comports with the Florida Network's Policies and Procedures, mandates prominent "Confidential" labeling on an opaque or solid container when youth file records are being transported.

The agency's policy also designates the personnel responsible for maintenance of case file records by program type and/or category of information and requires the files to be systematically numbered and organized according to the agency's file index. The agency's procedures under this written policy also specify the order in which the files are stored after they are closed and specifies that such records must be kept in an accessible manner for seven years after the contract year in which the file was closed.

There were a total of eight files reviewed, four Residential (two open and two closed) and four Non-Residential (two open and two closed).

Each file was marked "Confidential" as required by the agency's policy and the Florida Network's Indicator. The reviewer observed that storage drawers for the youth case files could all be locked and that each was prominently labeled "Confidential." Upon inquiry, the reviewer was shown the solid black, opaque container the agency uses to transport youth case files and it too is prominently labeled "Confidential". The agency stores closed files in the Program Director's office, which is locked when not occupied. Open files are kept in locked, confidential-labeled drawers in their respective case manager's/counselor's offices.

All files reviewed were uniformly organized, neat and orderly. Information was readily accessible. Each file contained various sections separated by tabs, with an indexed header sheet listing the various forms contained under that tab. All files were marked confidential.

There were no exceptions to this indicator.

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 twelve beds. The shelter also admits youth from the Department of Children and Families (DCF) and also for the Basic Center Program. In addition, the provider has a contract to provide residential services for youth referred by DJJ for domestic violence and/or Probation Respite. The shelter is designated by the Florida Network to provide staff secure services for up to ninety days or as court ordered.

The building occupied by the shelter program is over forty years old and is leased by Children's Home Society from St. Lucie County. 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 equipped with an AC unit, insulation, and state of the art exercise equipment.

3.01 Shelter Environment

Satisfactory

Limited

Failed

Rating Narrative

The program has written policies and procedures in place and compliance with the Florida Network contract. The policy CHS 7301 was last reviewed and approved by the Program Director on 9/26/17.

Program Director or designee responds to the need for necessary repairs or maintenance. Emergency repairs will be addressed immediately. The shelter maintains a contract with an exterminator to ensure the facility remains free of insect infestation. The Residential Supervisor designee develops activity schedules designed to provide a structured daily, weekly, and monthly schedule to engage youth in activities that foster healthy social, emotional, intellectual and physical development. Program Director reviews and approves all daily activity schedules before posting. Youth are to be provided an opportunity to participate in faith-based activities and will be voluntary. Youth have the opportunity to participate in non-punitive activities who do not choose to participate in religious activities.

A tour of the facility was conducted. Furnishings were in good repair, and the program was free of insect infestation. Bathrooms and shower areas were clean and functional. There was no graffiti on walls, doors, or windows. Lighting was adequate for tasks performed. Agency's vehicles were equipped with safety equipment including: the fire extinguisher, glass breaker, and seat belt cutter. The agency does not keep the first aid kit in the vans due to items melting during hot weather. However, the agency maintains the first aid kit in the building and staff are required to take the first aid kit, and it is documented.

Detailed map and egress plans of the facility, general client rules, grievance forms, abuse hotline information are posted in youth's rooms and common area. The agency has a current DCF Child Care License. The Department of Children and Families issued a certificate of license on 2/28/2018. Interior regions do not contain contraband and are free from hazardous unauthorized metal/foreign objects. All chemicals area listed, approved for use, inventoried, stored securely, and Material Safety Data Sheets (MSDS) are maintained on each item. Washer and dryer are operational, and general area/lint collectors are clean. Each youth has own individual bed with clean, covered mattress, pillow, sufficient linens, and blanket. Youth have a safe, lockable place to keep personal belongings if requested.

The agency maintains the safe box in the pantry and only approved personnel can access. The fire inspection was last completed on 1/19/18, and no violation was indicated. Agency completes a minimum of one fire drill per month within two minutes or less. All annual fire safety equipment inspections are valid and up-to-date. The provider is scheduled to have sprinkler and alarm system inspections on 5/4/2018. Health Department Group Care inspection report was completed on 2/15/2018. The agency has a current Satisfactory Food Service inspection report posted in the kitchen.

Refrigerators and freezers are clean and maintained. Youth are engaged in meaningful and structured activities. Television time may be included in the leisure activities as part of the behavior management system or for educational purposes. Idle time is minimal. At least one hour of physical activity is provided daily, and the schedule is both visible to youth and staff members. The agency offers voluntary religious program Thursday evenings and Sunday mornings. Youth receives the handbook upon intake which they are informed of their rights to partake in faith-related activities.

There were no exceptions to this indicator.

3.02 Program Orientation

Satisfactory

Limited

Failed

Rating Narrative

The provider has a written policy and procedures in place where youth is given an opportunity to learn about the program and its expectations through orientation process within twenty-four hours of admission. The policy was last reviewed and approved on 9/26/17 by the Program Director.

The provider's procedure requires that all new residents receive an orientation packet within twenty-four hours of admission to the program. The Youth Orientation Packet covers program philosophy, goals, services, expectations, search policy, access to medical, mental health and dental services, spiritual activity, school information, daily program, behavior management strategies, computer lab rules, emergency building evacuation procedures, dress code policy, the review of youth's rights, the grievance procedures, and contraband policy. Staff will review all items listed on the Youth Orientation Checklist and obtain youth's initials for each item to ensure youth complete the orientation process.

There were five, open, residential files reviewed. All youth received a handbook during intake or within twenty-four hours. The Youth Handbook consists of program policies and guidelines, disciplinary action for violation of program rules, grievance procedures, emergency/disaster plans, contraband rules, physical/facility layout map, room assignment, abuse hotline number, dress code, and daily activities. The Youth Handbook describes how disciplinary action would be conducted. Abuse hotline process is explained to both the youth and guardian. All five files had the youth and guardian's signatures.

There were no exceptions to this indicator.

3.03 Youth Room Assignment

Satisfactory

Limited

Failed

Rating Narrative

The agency does have a written policy and procedure to determine a youth's room assignment. The policy number, CHS/7303, was last updated and reviewed on 9/26/2017. The program director approved the policy.

The agency's procedure requires the room assignment to be determined based on the information gathered during intake and initial interactions with and observations of the youth. The room assignment is based on suicide risk, perceived maturity, past involvement in assault or aggressive behavior, physical characteristics, and proclivity for violence, sexual misconduct, gender, age, exposure to trauma, gang affiliation, attitude upon admission, and sexual orientation. For any youth identified as LGBTQ, youth will be made aware of alternative gender neutral sleeping options available. Staff will assign a room, and the Program Director or designee will review the admission packet and room assignment for appropriateness and consider additional factors.

There were five, open, residential files reviewed. All five files had a room assignment based on the information collected during intake. Room assignments and alerts are documented in the youth's file. Youth who are placed on Constant Sight and Sound monitoring is noted during assessment and room arrangement is made. Male and female rooms are assigned in separate wings. Youth Care Worker office is positioned in the middle of these wings. Sight and Sound youth are assigned to sleep in the common area for staff to monitor the youth's movement closely. The agency also has a system in place to indicate "General Alert to Staff" to be aware of particular concerns surrounding the youth's behaviors.

There were no exceptions to this indicator.

3.04 Log Books

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure to ensure that daily activities, guidelines, and entries are appropriately documented in the

electronic log book. This policy was last updated on 9/26/17 and approved by Program Director.

The electronic logbook will include documentation of all activities which have taken place in the facility. Any information pertaining to a child, such as, behavior, a child entering or leaving the program, etc. should be documented in the log. All entries will include the date and time; a clear, concise statement of what, where, when, who, and how and will be signed and dated by the staff member noting the entry. Staff members and shift supervisors will review the log at the beginning of a shift for the previous two shifts to become aware of recent occurrences/problems. If any corrections need to be made in the electronic logbook, the user will make a note of error. Any safety and security issues are documented in the log book. The supervisor or designee will review the log on a weekly basis to ensure all entries are appropriate and indicate the entries have been reviewed. An emergency paper logbook is utilized if connectivity is lost and electronic logbooks are non-operational.

The agency implemented the electronic logbook system the beginning of 2017. All staff are properly trained and receive additional training if needed. The electronic logbook keeps three months of entries. After three months, the record can be found in the backup computer system. Safety concerns such as any contraband, medical, suspected runaway related matters are noted in the logbook. Staff members also note any behavioral concerns of the youth to alert other shift members. Resident counts are documented in the log book. Youth are encouraged to do visitation on campus or go off campus for a few hours and return to the facility. Youth's home visits are documented in the log book and progress notes in youth's file. All recording errors are voided in the electronic logbook with staff initial and date. Youth Care Workers can also make the late entries when needed. A supervisor reviews the logbook and provides feedback in regards to the entries noted by the users.

There were no exceptions to this indicator.

3.05 Behavior Management Strategies

Satisfactory

Limited

Failed

Rating Narrative

The agency has a current Behavior Management Strategies and Interventions Policy. The policy was developed on 07/01/2014 and was last updated by the Program Director on 09/26/2017.

The agency's procedure is implemented into practice from when the intake process begins. It is to be discussed at that initial intake meeting with youth, it provides further explanation in youth handbook and continues as part of the programming process. Staff are aware of the necessity of the BMS and how it is to be implemented for the integrity and fidelity of the program and are to be fully engaged in facilitating the points system for youth in both individual and group sessions. The necessary documents are kept in youth files and fully updated, these will include weekly points and tally sheets.

Upon admission each youth receives a handbook that gives a detailed explanation of the program's behavior management system (BMS). Each reviewed case file indicated a signed acknowledgement that the youth received the shelter handbook. The BMS is reviewed with each youth during orientation to the program and each youth signs to acknowledge their understanding of the BMS. The handbook along with postings in the shelter common area and each bedroom outlines inappropriate behaviors and the related consequences.

Youth earn their points within the BMS for compliance with program rules, attitudes and interactions, school behavior as well as participation in therapeutic activities. Youth's individual point sheets are scored by staff prior to the daily house meeting and target skill meeting, where these target skills can be reviewed and changed if necessary by the youth. The daily target skills sheets are completed throughout each day with the awarding of points for keeping with program rules/activities and behavioral expectations. Points are tallied and youth must receive a minimum daily total of 80 points for youth to earn privileges.

Youth have a points store that is fully stocked with an appropriate array of items for them to purchase during designated daily hours with the points accumulated. An informal interview was conducted with a youth care worker regarding the behavior management system. All five case files reviewed and observations of staff/youth interactions documented the consistent use of the BMS in the program. One youth was interviewed and who explained the use and understanding of the system, he stated that it was explained as part of the program expectation since he was admitted to shelter.

Staff use verbal interventions and de-escalation techniques from Policy and Procedure that prohibit techniques inclusive of isolation, restraints, and verbal threats. Disciplinary methods are not to violate youth's basic rights of food, clothing, sleep, healthcare, school, exercise, family contact/correspondence, etc. The program cannot use room restriction for youth who display inappropriate behavior and although youth separated from the population must be under constant supervision. Individual crisis counseling may be utilized if a youth's behavior is disruptive. Annual crisis intervention training is to be conducted to enhance staff skills. For interventions, the agency uses Florida Network approved MAB curriculum, though that is not stated specifically in their Policy and Procedure manual, the Program Director confirmed that. Also, the agency now has staff on team that is certified to conduct that training.

The agency's BMS system in its entirety is effective as staff are very methodical and consistent in administering it. There were six employee training files reviewed and they all had BMS and MAB training which were completed within the required timelines. Staff were interviewed and

are very versed with BMS system and MAB procedures and how they operate key elements of the program component.

There were no exceptions to this indicator.

3.06 Staffing and Youth Supervision

Satisfactory Limited Failed

Rating Narrative

The program maintains policy and procedure number CHS/7306 to address staffing and youth supervision. The policy was last revised on 9/26/2017 and approved by the Program Director.

The policy requires a minimum staffing ratio of one staff to six youth during awake hours and community activities, and one staff to twelve youth during sleeping hours. The staff schedule is to be posted in a place visible and available to all staff. The program's policy requires staff to holdover until the next shift's relief arrives to replace them. The policy requires the program to make every attempt to ensure the gender of at least one staff on shift is the same gender as the youth in the shelter. The Program Director is responsible for doing the staff schedule and if there are any gender related staffing issues on a particular shift, she has designated to authority to make that decision to ensure that coverage is in ratio.

Youth location is logged utilizing the youth location chart/grip at the beginning and end of each shift, included in the electronic log book, on the manually written day sheet and written in their individual notes for anytime the youth enter or leave the facility, as well as upon admission and discharge. During emergency situations staff must assemble all youth for a head count and at least one staff must remain with the youth for the duration of the emergency. Agency policy requires staff to observe youth at least every ten minutes while they are in their sleeping rooms and to document each observation in the program's communication log book.

Staff schedules were reviewed for the last six months and confirmed that staffing ratios were consistently maintained at all times, on all shifts. The program currently has vacancies for one full-time male staff and two part-time shelter staff positions.

A review of logbooks supported the requirement for staff to conduct ten-minute checks on youth while they were in their sleeping rooms overnight, which exceeds the fifteen-minute requirement. Video footage of bed checks were reviewed for three random nights. All bed checks were completed and coincided with times documented in the logbook.

There were no exceptions to this indicator.

3.07 Special Populations

Satisfactory Limited Failed

Rating Narrative

The program maintains policy and procedure number CHS/7307 to address special populations. The policy was last revised on 9/26/2017 and approved by the Program Director.

The program maintains appropriate policy and procedure that addresses the needs of youth that require services specific to probation respite, domestic violence respite, staff secure, and domestic minor sex trafficking services.

Per its CINS/FINS contract, Domestic Violence Respite service is available to youth with a pending domestic violence charge who do not meet the criteria for placement in secure detention. They will stay up to twenty-one days with a planned expectation of family reunification. Service plan goals must include aggression/anger management, family coping skills to reduce the likelihood of violence in the home. After discharge, follow up is to occur at thirty, sixty and one-hundred-eighty days.

For Probation Respite, referral will come from DJJ Probation with agency verifying youth is in fact on probation before accepting, this is done through the JJIS system. Approval must be gained from the Florida Network Respite Coordinator with a length of stay of fourteen days to thirty days, beyond that will require approval from a Chief JPO. Case management and counselling needs ot be considered as well as all CINS/FINS program requirements.

For Domestic Minor Sexual Trafficking Victims, services are to be approved for a maximum of seven days with any support beyond seven days required to seek approval on a case-by-case basis. Services are to be enhanced through direct engagement of the youth in positive activities to encourage the youth to remain in shelter.

Staff Secure youth are assigned by the court with one staff assigned to youth at all times while in shelter. Youth will receive more thorough orientation with counselling and service plan developed to follow the sanctions outlined in the court order. Assignment of staff to a staff secure youth is to be documented in the log book, youth location tracking form, the census board, and highlighted on the staff schedule.

The agency has adequately trained staff and programming in place to facilitate the needs of these special populations. There were no youth served that met the Staff Secure or Domestic minor Sex Trafficking criteria.

There were seven files reviewed, four files were reviewed for domestic violence respite and three files were reviewed for probation respite.

All four of the domestic violence respite files met the requirements for referral, admissions, and case management processes. There was documentation in all files that all case management and counseling needs were considered and addressed within the case plan. All other services provided were consistent with all other general CINS/FINS program requirements. No youth exceeded the twenty-one day stay requirement.

All three probation respite files contained documentation that all case management and counseling needs were considered and addressed within the case plan. All other services provided were consistent with all other general CINS/FINS program requirements. None of these youth stayed for the length of the agreed and approved stay and discharges were appropriate to each individual circumstance.

There were no exceptions to this indicator.

3.08 Video Surveillance System

Satisfactory

Limited

Failed

Rating Narrative

The program maintains policy and procedure number CHS/7308 to address its video surveillance system. The policy was made effective on 9/26/2017 and approved by the Program Director.

The program is to retain and store video for at least thirty days. Per program policy, the system is to record the date, time and location and must be clear enough to allow facial recognition and detail of vehicles entering and exiting the property. The video surveillance system is required to have a battery back-up to allow cameras to continue operation during a power outage. The shelter is to have cameras visibly placed in general interior and exterior locations, including hallways and common areas where youth and staff congregate as well as where visitors enter and exit the program.

It is a requirement of the program's policy that a camera is to be focused on the Pyxis medication cart and the intake room at all times, that was evidently the case. No cameras are to be placed in the bathrooms or sleeping quarters. Only designated staff are to have access to the video surveillance system and the system is only to be viewed on-site. Supervisory review of video must be conducted weekly and documented on a review log to assess the activities of the facility.

The program places stickers in each program van and on the interior of the front door to the shelter advising that the facility is under video surveillance. Cameras are mounted in visible locations around the facility. No cameras were placed in bathrooms or youth sleeping rooms as they are not required in those locations. The system is able to store video for at least thirty days as required. The program maintains a battery back-up system to allow uninterrupted video recording should a power outage occur.

The Residential Supervisor confirmed that she and the Program Director are the only two staff designated to access the video surveillance system and it is the program's policy and documented practice to review randomly selected video on a weekly basis. The Program Supervisor has created a useful and separate log that she uses to log her reviews of the video surveillance system.

There were no exceptions to this indicator.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

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 Counseling 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. The agency also uses the Evaluation of Suicide Risk (EIDS) on all youth admitted to the shelter. The qualified mental health professional is the only staff person with the authority to determine the suicide risk status of the youth. The clinician completes a full Assessment of Suicide Risk (ASR) on all youth on close observation status.

Youth admitted to the shelter with prescribed or over-the-counter medication will surrender those medication to staff during admission. The shelter uses the Pyxis Med-Station 4000 Med Cabinet for the provision of prescribed medication to youth. All staff in the facility received regular healthcare and mental health trainings. 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 agency has a policy in place for Healthcare Admission Screening. The policy number is CHS 7401 and was last updated on September 26, 2017.

During the admission process, non-health care staff will complete an initial physical health screening form with the youth. If present on premises, the staff nurse will conduct the health screening. Staff doing the intake will review with the youth their past and current medical history. When a nurse comes on shift, new intakes are reviewed within five business days and documentation of such is noted in the youth file.

During the initial physical and mental health screening, youth are screened for serious conditions that may be encountered in the shelter such as diabetes, seizure disorder, cardiac disorders, asthma, tuberculosis, hemophilia, pregnancy, or suicidal ideation/mental health concerns and head injuries occurring during the previous two weeks. For all youth with any of the above conditions there is a referral process in place. The parent/guardian shall be contacted to identify established guidelines for daily medical care and routines. If any chronic conditions are identified that indicate a need for medical follow-up, staff will document discussion of this need with the parent/guardian in the medical section of the youth's file. If a youth has not been treated for a condition, the intake staff will follow-up with the parent/guardian, to have the parent schedule a medical examination as soon as possible and document communication. The youth will be transported by the parent/guardian to any scheduled medical appointments.

There were five youth files reviewed for Healthcare Admission Screening. In all five files the CINS/FINS Intake Assessment Form was completed at admission. In two of the files reviewed the youth were taking medications and those were documented on the Intake Assessment Form. Three of the youth had allergies documented. One youth had an allergy to Penicillin and one youth had an allergy to Benadryl. The remaining youth had numerous allergies including: dogs, cats, grass, oak trees, and peanuts. This youth did have two Epinephrine's at the shelter for emergencies. Two youth were documented as having asthma. One youth did not have an inhaler. Attempts were made by the nurse to get the youth's grandmother to bring the inhaler to the shelter; however, the grandmother refused to stating the youth does not use it. The youth reported not using the inhaler in a very long time. The other youth with asthma did have an inhaler at the shelter.

None of the youth required any type of follow-up medical care. Three of the five files documented the RN reviewed and signed the CINS/FINS Intake Assessment on the day of admission. The remaining two files documented a review the day after admission. The RN also completes a Physical and Health Screening Form with each youth and also documents an intake note, in the medical section of the file, documenting a review of all intake paperwork.

There were no exceptions to this indicator.

4.02 Suicide Prevention

Satisfactory Limited Failed

Rating Narrative

The shelter has a policy in place for Identification of Suicide Risk in Shelter/Prevention. The policy number is CHS 7402 and was last updated

on September 26, 2017.

During the admission process, staff will complete the CINS/FINS Intake Assessment Form. Staff will then complete the Evaluation of Imminent Danger of Suicide (EIDS). If the youth answers a minimum of five "yes" responses on the Risk Factor Criteria Area 2, or one "yes" response on Risk Factor Criteria Area 1, they are immediately placed on suicide precaution status. A full assessment of suicide risk will be completed by a licensed professional within twenty-four hours. Youth awaiting an assessment will be placed on constant sight and sound supervision with behaviors documented at least every ten minutes. Staff will also notify the youth's parent/guardian of any positive scores that require a full assessment.

At any time a youth has made suicide gestures or attempted suicide, the Program Director and Residential Supervisor shall be notified. Parents or guardians of the youth shall be notified and informed of what procedures have been put into place to ensure the youth's protection. In the event that the law enforcement officer does not feel that a Baker Act is justified, the parents or guardians shall be requested to transport the youth to the nearest Baker Act receiving facility.

Staff will indicate on the resident census board in the staff time clock area that an alert is in place for the youth and give a "turn over/shift report" to oncoming staff as to the situation. All staff are trained to review the program log and individual file to obtain information on the nature of the alert upon reporting for duty. All alerts remain in effect until the situation is resolved, either through a modification of the alert status by the Licensed Clinician, or through a Baker Act.

The shelter uses two different levels of supervision. The first level is Constant Sight and Sound Supervision. This level is for youth who are identified as being at risk of suicide but are not expressing current suicidal thoughts or threats. The second level of supervision is One-to-One Supervision. This is the most intense level and will be used while waiting for the removal of the youth from the program by law enforcement or parent/guardian for the purpose of Baker Act assessment.

There were three applicable files of youth placed on suicide precautions since the last on-site review. The CINS/FINS Intake Assessment form and the Evaluation of Suicide Risk Among Adolescents (EIDS) were both completed at admission and documented positive "hits" requiring the youth to be placed on suicide precautions. The CINS/FINS Intake Assessment and EIDS were both reviewed and signed by the supervisor in all three files. All three files also documented notification to the youth's parent, on the EIDS, of the positive screening results. One youth was admitted on a Saturday and the youth was seen and assessed by the LCSW on Monday morning.

The other two youth were seen by the LCSW within twenty-four hours of the screening. The LCSW completed an assessment of suicide risk on the youth and the youth were placed on standard supervision. There were ten-minute observations maintained on both youth until removed from suicide precautions. All observation sheets were filled out in their entirety, with full signatures and initials of all staff documenting observations. All sheets were reviewed by the supervisor. The shelter has a daybed in the dayroom that youth must sleep on when on suicide precautions during the overnight hours. All three instances of suicide precaution were documented in the program's electronic logbook. There was documentation when the youth was placed on suicide precautions and when the youth was removed.

There were no exceptions to this indicator.

4.03 Medications

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place for Medications. The policy number is CHS 7403 and was last updated on September 26, 2017.

The policy has detailed procedures for admission, verification of medication, administration of medication, storage of medication, inventories, documentation, discharge, and disposal of medications. This policy covers the requirements for medication distribution in accordance with Florida Network requirements.

The shelter has one Registered Nurse (RN) and one Nurse Practitioner (NP) that are on-site six days a week after 5:00 pm for approximately two hours. The two rotate days Sunday thru Friday and are on-call on Saturdays and can come in if needed. The RN, the NP, the Residential Supervisor, and the Program Director are listed as the Super Users for the Pyxis Med-Station. There were ten other staff listed as regular users of the Pyxis Med-Station. All staff employed in the shelter are trained to use the Pyxis Med-Station and administer medication. The RN trains all new hires on using the Pyxis-Med Station. Medication administration training is completed through on-line training during the staff's first 90 days of employment.

All medications are stored in the Pyxis Med-Station. Drawer one is over-the-counter medications and drawers two and three are prescription medications. Drawer four is normally empty and drawer five is used for large or odd shaped medications that do not fit in the other drawers. There is a refrigerator with a lock on it located in the pantry in the kitchen for medications requiring refrigeration. At the time of the review there were no medications requiring refrigeration.

Controlled medications are inventoried each shift by two staff members and non-controlled prescription medications are inventoried every day on the overnight shift. Over-the-counter medications are inventoried weekly and documented when given out. The shelter only has three over-the-counter medications that are given out: Tylenol, Motrin, and Calamine Lotion. The only sharps the shelter keeps are disposable razors. At the time of the review there were twelve razors in the box in a locked cabinet. The razors were inventoried weekly for the last six months. There was also a sign in/sign out log which documented every time a razor was used and when it was returned and disposed of.

The shelter uses a Medication Log Record (MLR) for each youth on medication. The MLR documents the youth's name, a picture of the youth, allergies, diagnosis, physician information, date of birth, date started, if it is a controlled medication, the medication, directions, possible side effects, signatures and initials of staff and the youth. There were three youth in the shelter currently on medication. All three of these files were reviewed. In addition, there were three closed files randomly selected of youth who had been on medications to review. All six files reviewed documented the medication was verified at admission by contacting the local pharmacy. All files had MLR's for each medication the youth was taking. The MRL's were filled out completely and documented all medications were given at prescribed times. All controlled medications had shift-to-shift inventories documented and all other medications had an inventory documented each day by the over-night shift. There was also an inventory documented by the RN an NP each time they were on-site. The RN dispenses evening medications and the staff dispense morning and afternoon medications. There is one staff member assigned on the schedule each shift who is responsible for distributing any medications for that shift. The assigned staff member will print out a medication schedule from the Pyxis Med-Station the beginning of the shift to see what youth are on medications and what time they are to be given.

The RN and NP run weekly and monthly reports from the knowledge portal. A Discrepancy Report is automatically emailed to them each week from the knowledge portal. There are also four additional reports the RN and NP print out and review each month. These reports are maintained in a binder. The NP reported there are very few discrepancies, maybe two to three a week. The discrepancies are generally an error putting the beginning or ending count in and are easily fixed. Staff are aware discrepancies need to be cleared out by the end of their shift and generally they are. There were no open discrepancies at the time of the review.

There has been one medical error reported to the CCC in the last six months. The Residential Supervisor discovered, upon reviewing current MLR's, that a youth did not receive their morning medication. The CCC was notified, as well as, a pharmacy. The pharmacy told the program to give the youth the medication immediately. The youth ended up receiving the medication approximately two and half hours late. The staff who missed giving the morning medication did receive a corrective action note and the case was closed successfully with the CCC.

There were no exceptions to this indicator.

4.04 Medical/Mental Health Alert Process

Satisfactory Limited Failed

Rating Narrative

The agency has a policy in place for the Medical and Mental Health Alert Process. The policy number is CHS 7404 and was last updated on September 26, 2017.

All youth are screened on admission for physical, mental health, and substance abuse needs. After identifying a youth as needing special medical/mental health attention, intake staff will place an identifying marker on the youth's name on the room assignment/census board. For those youth with medical/mental health needs, a medical/mental health alert sticker will be placed on the outside of the youth's file. A red general alert form is the first page placed in the youth's file indicating specifics of the alert. Intake staff will make specific highlighted entries in the logbook describing the particular medical conditions, medications, and allergies. Staff will check the census board at the beginning of their shift and review the chart and medication log for those youth identified as having a medical condition in order to become familiar with said conditions and possible emergency situations.

There were five open youth files reviewed. All alerts identified during the screening process were documented on the alert form in the front of the youth's file. All files had a red alert sticker on the front of the file indicating an alert. Alerts were also documented in the electronic log book the day the youth was admitted. There is an alert board located in the staff time clock area. All youth in the shelter are documented on this dry erase board. If the youth have any alerts a red check mark is next to the youth's name in the alert column. This board also documents if the youth has any allergies or is on any medications. Staff review this alert board when coming on to shift and can then find additional information regarding the youth's alert in the youth's file. All youth in the shelter who had alerts were appropriately documented on this board. Any dietary alerts were also documented on a dry erase board in the kitchen. One youth had a peanut allergy and all foods in the shelter containing peanuts in the ingredients were locked up in the Director of Operations office.

There were no exceptions to this indicator.

4.05 Episodic/Emergency Care

Satisfactory Limited Failed

Rating Narrative

The agency has a policy in place for Episodic/Emergency Care. The policy number is CHS 7405 and was last updated on September 26, 2017.

The program shall ensure that a health authority approves all first aid equipment and supplies and that these are available at all times. Any staff that use items from supplies or kits are to document this usage so that the Residential Supervisor or designee can replace the item used. To assure all first aid supplies and equipment are fully stocked, the overnight staff will perform a weekly inventory and record on the inventory list in each kit. All direct care staff are trained and certified in first aid and CPR. Staff will be trained in emergency situations requiring more than first aid and CPR. The AED, knife-for-life and wire cutters, and first aid kits are securely stored in appropriate locations.

Parental notification takes place when any youth is injured, regardless of the severity, providing parents with the option to seek further medical attention elsewhere. All instances of first aid and emergency care are documented in the log book, the youth's file, and on an internal incident report. Upon return to the shelter from seeking outside medical treatment, verification of medical clearance, discharge instructions, and follow-up care will be provided to staff and included in the youth's file. The program has developed and implemented use of a log for purposes of recording emergency care. Program Director or Residential Supervisor or designee will log any emergencies that require off sight emergency room care/visits.

There have been two instances in the last six months of youth being transported off-site for emergency medical care. Both incidents were reported to the CCC and documented on the Emergency Care Log. There was documentation in both cases that the youth's parent was notified and transported the youth to the emergency room. Follow-up instructions were documented in the chronological notes in each file when the youth returned to the shelter. All discharge paperwork was also maintained in the youth's file. Both incidents were documented in the logbook.

The shelter has completed an Episodic/Emergency Drill each month for the last six months. The drills were conducted on varying shifts. Drills consisted of dizziness, a youth convulsing, an eye wound, tooth injury, youth hanging, and a disoriented youth. The drills included a description, a staff response, debriefing notes, supervisory review, and a corrective action plan.

The shelter has four first aid kits, two located inside the shelter and are for the vehicles. The first aid kits are inventoried weekly by the overnight shift. These inventories were reviewed for the last six months. The inventories document what is inside the first aid kit and what needed replenishing. There is a knife-for-life and wire cutters located in a locked box in the mail room of the shelter.

There were no exceptions to this indicator.