



# **Florida Network of Youth and Family Services Quality Improvement Program Report**

Review of CHS - WaveCREST  
Residential Program

May 8 - 9, 2019

**Compliance Monitoring Services Provided by**

 **FOREFRONT**



## Quality Improvement Review

CHS – WaveCREST – May 8 – 9, 2019

Lead Reviewer: Ashley Davies

### 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
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 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 & Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petition Process	Satisfactory
2.07 Youth Records	Satisfactory
2.08 Sexual Orientation, Gender Identity, Gender Expression	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 & Special Populations

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

**Percent of indicators rated Satisfactory: 87.5%**

**Percent of indicators rated Limited: 12.5%**

**Percent of indicators rated Failed: 0.00%**

#### Standard 4: Mental Health /Health Services

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

**Percent of indicators rated Satisfactory: 100.00%**

**Percent of indicators rated Limited: 0.00%**

**Percent of indicators rated Failed: 0.00%**

#### Overall Rating Summary

**Percent of indicators rated Satisfactory: 96.43%**

**Percent of indicators rated Limited: 3.57%**

**Percent of indicators rated Failed: 0.00%**

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### 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.
Not Applicable	Does not apply.

### Reviewer

#### Members

Ashley Davies, Consultant-Forefront LLC, Florida Network of Youth and Family Services

Shakela Minns, Regional Monitor, Department of Juvenile Justice

Ashton Crawford, Clinical Supervisor, Youth Crisis Center

Andrea Dean, Director of Programs, Mount Bethel



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### Methodology

This review was conducted in accordance with FDJJ-1720 (Quality Assurance Policy and Procedures), and focused on the areas of (1) Management Accountability, (2) Intervention and Case Management, and (3) Shelter Care/Health Services, which are included in the Children/Families in Need of Services (CINS/FINS) Standards (July 2018).

#### Persons Interviewed

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Chief Executive Officer<br><input type="checkbox"/> Chief Financial Officer<br><input type="checkbox"/> Program Coordinator<br><input type="checkbox"/> Direct – Part time<br><input type="checkbox"/> Volunteer<br><input checked="" type="checkbox"/> Clinical Director<br><input type="checkbox"/> Counselor Non-Licensed<br><input type="checkbox"/> Advocate<br><input type="checkbox"/> Nurse – Full time | <input type="checkbox"/> Executive Director<br><input checked="" type="checkbox"/> Program Director<br><input checked="" type="checkbox"/> Direct – Care Full time<br><input type="checkbox"/> Direct – Care On-Call<br><input type="checkbox"/> Intern<br><input checked="" type="checkbox"/> Counselor Licensed<br><input checked="" type="checkbox"/> Case Manager<br><input checked="" type="checkbox"/> Human Resources<br><input checked="" type="checkbox"/> Nurse – Part time | <input type="checkbox"/> Chief Operating Officer<br><input checked="" type="checkbox"/> Program Manager<br><b>1</b> # Case Managers<br><b>1</b> # Program Supervisors<br>_____ # Food Service Personnel<br><b>1</b> # Healthcare Staff<br>_____ # Maintenance Personnel<br>_____ # Other (listed by title): _____ |
|--|---|---|

#### Documents Reviewed

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Accreditation Reports<br><input checked="" type="checkbox"/> Affidavit of Good Moral Character<br><input checked="" type="checkbox"/> CCC Reports<br><input checked="" type="checkbox"/> Logbooks<br><input type="checkbox"/> Continuity of Operation Plan<br><input type="checkbox"/> Contract Monitoring Reports<br><input type="checkbox"/> Contract Scope of Services<br><input checked="" type="checkbox"/> Egress Plans<br><input checked="" type="checkbox"/> Fire Inspection Report<br><input type="checkbox"/> Exposure Control Plan | <input checked="" type="checkbox"/> Table of Organization<br><input checked="" type="checkbox"/> Fire Prevention Plan<br><input checked="" type="checkbox"/> Grievance Process/Records<br><input type="checkbox"/> Key Control Log<br><input checked="" type="checkbox"/> Fire Drill Log<br><input checked="" type="checkbox"/> Medical and Mental Health Alerts<br><input checked="" type="checkbox"/> Precautionary Observation Logs<br><input checked="" type="checkbox"/> Program Schedules<br><input type="checkbox"/> Supplemental Contracts<br><input type="checkbox"/> Telephone Logs | <input checked="" type="checkbox"/> Vehicle Inspection Reports<br><input type="checkbox"/> Visitation Logs<br><input checked="" type="checkbox"/> Youth Handbook<br><b>4</b> # Health Records<br><b>4</b> # MH/SA Records<br><b>11</b> # Personnel /Volunteer Records<br><b>6</b> # Training Records<br><b>5</b> # Youth Records (Closed)<br><b>5</b> # Youth Records (Open)<br>_____ # Other: _____ |
|--|---|--|

#### Surveys

**4** # Youth                                      **4** # Direct Care Staff                                      **0** # Other: \_\_\_\_\_

#### Observations During Review

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Intake<br><input type="checkbox"/> Program Activities<br><input type="checkbox"/> Recreation<br><input type="checkbox"/> Searches<br><input checked="" type="checkbox"/> Security Video Tapes<br><input checked="" type="checkbox"/> Social Skill Modeling by Staff<br><input type="checkbox"/> Medication Administration<br><input checked="" type="checkbox"/> Census Board | <input checked="" type="checkbox"/> Posting of Abuse Hotline<br><input type="checkbox"/> Tool Inventory and Storage<br><input checked="" type="checkbox"/> Toxic Item Inventory and Storage<br><input type="checkbox"/> Discharge<br><input type="checkbox"/> Treatment Team Meetings<br><input type="checkbox"/> Youth Movement and Counts<br><input checked="" type="checkbox"/> Staff Interactions with Youth | <input checked="" type="checkbox"/> Staff Supervision of Youth<br><input checked="" type="checkbox"/> Facility and Grounds<br><input checked="" type="checkbox"/> First Aid Kit(s)<br><input type="checkbox"/> Group<br><input type="checkbox"/> Meals<br><input checked="" type="checkbox"/> Signage that all youth welcome |
|--|--|--|

#### Comments

Additional Comments regarding observations, other important findings of interest, etc.



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### Strengths and Innovative Approaches

The Registered Nurse (RN) involved the youth in planting a natural layered garden. The RN and Food Service Manager assists in continuous teaching of nutrition through life skills groups. The produce grown also aids youth in expanding their knowledge of foods. The produce is also used in meals prepared at the shelter.

Children's Home Society has changed management of the shelter to a regional model, to include their sister shelter, Safe Harbor in West Palm Beach. The decision to do so maximizes the agency's resources and aids in carrying over best practices to both facilities.

The agency strengthened the process of one of their service providers to respond to the gap in attaining services for youth and their families. When appropriate, Drug Abuse Treatment Associates (DATA) provides services while youth are still in the shelter removing barriers to on-going services. This includes drug testing and a full Substance Abuse Assessment at no cost to the youth and family.

## Standard 1: Management Accountability

### Overview

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 a Non-Residential Supervisor. Shelter staff includes: a Data Specialist, Group Living Manager, and seven fulltime Youth Care Staff (YCS). 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 of Employees/Volunteers

Satisfactory

Limited

Failed

The provider maintains a written policy and procedures which outlines the background screening requirements of all employees, volunteers, mentors, and interns. The background screening policy number CHS/7101 was last updated on January 21, 2019.

The provider's policy requires all employees, volunteers, mentors, and interns to undergo a Level Two Employment Screening pursuant to Rule 65C-14.023 and Florida Statutes. All staff must successfully complete the background screening prior to obtaining employment with the provider. Additionally, the provider conducts a background check with the Division of Motor Vehicles prior to hiring staff and a review is conducted yearly. The policy also requires the program's Human Resource Department to review all staff personnel records to determine which employees will be subject to a



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five-year rescreening based upon the staff's anniversary date. All staff upon being hired signs an Affidavit of Good Moral Character annually in the month of January. The report is then submitted to the Department of Juvenile Justice (DJJ) Background Screening Unit by January 31st.

During the review period, nine staff and one intern was applicable and required a background screening. All applicable staff background screenings were completed prior to the staff hire date. All staff received an eligible rating from the background screening unit. Each applicable staff completed an Affidavit of Good Moral Character. One staff was applicable for a five-year rescreening on March 9, 2019. However, the program did not submit the background screening until the first date of the review.

### Exceptions:

One staff five-year rescreening was due March 19, 2019, however, was not completed until the first day of the on-site quality improvement review.

There was no documentation to support any of the newly hired direct care staff completed an approved suitability pre-employment assessment.

### 1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

The provider maintains a written policy and procedures which outlines the provision of an abuse free environment. The policy number CHS/7102 was last updated on August 31, 2018.

The provider's policy outlines an abuse free environment in which youth, staff, and others should feel safe, secure, and not threatened by any form of abuse or harassment. The policy requires all staff to adhere to a code of conduct that prohibits the use of physical abuse, profanity, threat, or intimidation. The policy indicates youth should not be deprived of basic needs, such as food, clothing, shelter, medical care, and security. The policy requires all employees 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. In addition, the provider's policy outlines the procedures and pertinent timeframes for calling the abuse hotline and the Department's Central Communications Center (CCC). The policy outlines who is responsible for taking immediate action to address any incident of physical and/or psychological abuse, verbal intimidation, use of profanity, and/or excessive force

While on site, an observation of the facility found the Florida Abuse Hotline number and other relevant numbers posted throughout the facility. Youth are also informed of these during program orientation. The resident handbook outlines behavioral expectations for

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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 six staff training files reviewed that confirmed this training was received.

The program also maintains a grievance box and forms in the multipurpose room. A review of grievance forms for the past six months found one grievance completed on February 26, 2019 by all the youth requesting more candy. However, the nature of the request was deemed not a grievance on February 27, 2019 by the Program Director and was addressed. All grievance complaint reviews are conducted by the Program Director.

There were four youth surveyed. All four youth reported they knew the Abuse Hotline was available for them to call if they wanted, however, all four stated they have never needed to make a call. All four youth stated staff treat them professionally and they have never heard staff use threats or intimidation on them or any other youth. All four youth felt safe in the shelter.

There were four staff surveyed. All four staff reported they have been trained on abuse reporting and all reported they were aware they needed to report any suspected abuse to the Abuse Hotline. All four staff reported they have never heard a staff deny a youth access to the abuse hotline. All staff reported they have never heard another staff use inappropriate language in front of the youth.

### Exceptions:

No exceptions are noted for this indicator.

### 1.03 Incident Reporting

Satisfactory

Limited

Failed

The provider maintains a written policy and procedures which outlines incident reporting. The agency's policy number CHS/7103 was last reviewed and updated on August 31, 2018.

The provider's policy requires all staff to comply with the Department of Juvenile Justice procedure for reporting Central Communication Center F.A.C 63-F-11, and Children's Home Society for reporting incidents F.A.C 65C-14.016.

The policy requires all staff to notify a manager, supervisor or, on call supervisor of any incident. The staff will also notify the Department's Central Communication Center (CCC) and all other parties requiring notification regarding the occurrence of the incident. In addition, the staff will document the incident in the electronic log book and



an incident report will be taken in the AIRSWEB (CHS's Electronic Database). The Program Director or designee will investigate the incident and implement any appropriate safeguards if until further investigations are completed if applicable.

In the event, of a critical incident staff are required to notify the Executive Director. The Executive Director will then review video footage within twenty-four business hours.

The provider's practice is to maintain information about incident reports in a database system called AirswEB.net. All incident reports are electronically generated, documented, reviewed, and signed online.

A review of the Central Communication Center (CCC) reports were reviewed for the last six months. The provider had four reportable incidents within the last six months. All reviewed incidents were reported within the two-hour time frame. Two required follow-up communication tasks/special instructions and all were completed for each report as required by the CCC. All incidents were documented in the electronic logbook.

The program also maintains internal incident reports in the electronic log book AIRSWEB (CHS's Electronic Database). The program had a total of thirty-three internal incidents for the last six months and eight required follow-ups. Seven out of eight follow-ups were completed by a supervisor. One incident was still within the thirty-day time frame and has not had a followed up completed.

**Exceptions:**

No exceptions are noted for this indicator.

**1.04 Training Requirements**

Satisfactory

Limited

Failed

The agency has a policy titled Training Requirements that addresses the requirements of this indicator. The policy was last reviewed August 31, 2018 by the Director of The policy lists all trainings required within the employee's first 30, 90, and 120 days of hire. Each training is listed in the Program's Employee's Individual Training Log. Employees are charged with the responsibility of participating in planned training, tracking their hours and needs, and maintaining the training logs with Supervisory monitoring and input.

Annual training must include: refresher training in the operation and use of available fire safety equipment and the alarm system, training necessary to maintain current CPR and first aid certification, training to recognize and respond to youth in need of mental health or crisis intervention, training to recognize and respond to youth who need substance abuse interventions, and suicide prevention and protocols.



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Training will be provided either on-site by in-service training, online training through the CHS Learning Management System (LMS), the Florida Network online training, DJJ Skill Pro platform, or outside trainers.

Documentation of training completion will be noted in individual staff's training record. The training file contains the individual training plan and may also include documentation of certifications, re-certifications, practicum's/internships, test results, and documentation of course work.

The Master Training Binder will contain all available syllabi, training outlines, and/or summary of trainings provided in-house or by community trainers when available. The LMS agenda is available online.

There were two staff training files reviewed for new hire training requirements. The first staff documented 119.5 hours of training for the first year of employment. All trainings required during the first 120 days were completed and all additional required trainings were completed within the first year. The second staff had only been with the agency for five months. This staff had already documented 107 hours of training. All trainings required within the first 120 days were completed. All additional required trainings had already been completed as well, except for one, Suicide Prevention Part 2 on DJJ Skill Pro. However, this staff still has seven months left in their training cycle to complete any additional trainings.

There were four staff training files reviewed for annual training requirements. The completed 2018 training cycle was reviewed. All four staff documented over the required 40 hours of annual training with 43, 54.5, 59, and 99 hours of training respectively. One staff documented all required trainings were completed. The other three staff documented all required trainings were completed, except for Suicide Prevention Part 1 and 2 on DJJ Skill Pro. In reviewing training records for these three staff for 2017 and so far in 2019, it was observed all three staff had completed this training during those training cycles. In an interview with the Residential Supervisor it was revealed that DJJ Skill Pro did not notify the staff that this training was due during the 2018 training cycle so the staff did not take the training. Staff have now been instructed to take this training annually regardless if DJJ Skill Pro notifies them it is due or not.

### Exceptions:

No exceptions are noted for this indicator.

### 1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

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The provider maintains a written policy and procedures CHS/7105 for Reporting and Analyzing. The policy was reviewed and updated on August 31, 2018.

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's Quality Management Department oversees the program outputs and outcomes for the quality improvement process. Management is responsible for reviewing findings and sharing the information with all staff and stakeholders.

The provider's Quality Management Specialist is responsible for the execution and oversight of the CQI program. The provider's activities are kept online on the database system called Airsweb.net.

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. This information is 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.

### Exceptions:

No exceptions are noted for this indicator.

### 1.06 Client Transportation

Satisfactory

Limited

Failed

The provider maintains a written policy and procedures which address client transportation. The policy number CHS/7106 was last updated on August 31, 2018.

The policy requires youth to be transported with 3rd party presences when at all possible. The 3rd party may be another direct care staff, volunteer, intern, clinical or administrative staff or other youth. The policy requires two individuals to transport a

suspected victim of human trafficking. The provider's Human Resource Departments conducts a motor vehicle driving check to ensure all staff have a valid Florida driver's license. In the event an employee is placed on "no-drive status" for any reason, the employee would not be permitted to transport any youth. All drivers are approved by administrative personnel. All transporters are required to sign out the vehicle keys and take a first aid kit when transporting youth. Additionally, staff will document in the vehicle binder the name of the driver, date and time, mileage, number of passengers, the purpose of travel, and location. In the event 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.

A review of the providers binder for the last six months confirmed all transporters signed out the keys to the vehicle and takes a first aid kit prior to departing from the agency. The vehicle log listed the driver/staff's name, date and time, mileage, number of passengers, and supervisor's approval space. A review of the vehicle log for the last months found inconsistency in documenting the purpose of travel and location on several occasions.

The vehicle log reflected single client transports were always approved by a supervisor.

Reviewed documentation validated the agency performs annual motor vehicle driving checks with the Florida Division of Motor Vehicles.

The provider maintains a certificate of liability insurance which was issued on 7/1/2018 and will expired 7/1/2019.

**Exceptions:**

No exceptions are noted for this indicator.

**1.07 Outreach Services**

Satisfactory

Limited

Failed

The provider maintains a written policy and procedures for Outreach and Interagency Agreements. The policy number CHS/7107 was last reviewed and signed on August 31, 2018.

Outreach is diligently conducted by the program on an ongoing basis to increase public and community awareness. The provider participates in each of the local county councils and the Department of Juvenile Justice (DJJ) Circuit Advisory Board to ensure prevention programming and CINS/FINS services are represented. The provider also works with youth and families and other community stakeholders to make them aware of CINS/FINS as an effective prevention intervention services.



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

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

A review of the provider's Outreach binder confirmed the agency is well represented in the circuit and in Juvenile Justice Councils and on other boards in various counties. All agendas and minutes were well organized in the provider's Community Meeting Participation binder.

### **Exceptions:**

No exceptions are noted for this indicator.

## Standard 2: Intervention and Case Management

### Overview

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 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

The agency has a written policy consistent with the requirements of the Florida Network of Youth and Family Services Quality Improvement standards. The agency's policy is numbered CHS/7201 and entitled "Screening for Services and Intake Assessment," which has an effective date of July 1, 2011. The policy was last updated August 31, 2018 and was approved by Kristi Walsh, Director of Program Operations.



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The purpose stated in the agency's policy establishes that the agency offers access to services 24/7 services 365 days a year. Screenings are begun within seven calendar days or youth/ family being referred for CINS/ FINS services, by trained personnel. 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 ten files reviewed for this report. Five files reviewed were residential files (two open and three closed) and five files reviewed were non-residential (three open and two closed).

All files reviewed clearly demonstrated evidence of youth meeting the standard for completion of an eligibility screening within seven calendar days from the date of referral.

Each of the files contained evidence, in the form of a completed Netmis intake screening. All forms contained signatures from the recipient(s) 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, the agency's grievance procedure, and that the agency's CINS/FINS Parent Brochure was made available in each case.

### Exceptions:

No exceptions are noted for this indicator.

### 2.02 Needs Assessment

Satisfactory

Limited

Failed

The agency has a written policy consistent with the requirements of the Florida Network of Youth and Family Services Quality Improvement standards. The agency's written policy is numbered CHS/7202 and entitled "Needs Assessment" which has an effective date of July 1, 2011. The policy was last updated on August 31, 2018 and approved by Kristi Walsh, Director of Program Operations.

The purpose stated in the agency's policy indicated that a Needs Assessment shall be completed for all youth receiving services. For residential services the assessment shall be initiated within 72 hours of admission and during the first face-to-face visit (or session) for non-residential services (and completed within three visits/sessions). The agency's policy establishes that assessments more than six months old must be updated.

It is stated in the agency's procedure to the policy that the assessments shall be completed by Bachelor's or Master's level staff and signed by a supervisor indicating supervisory review.

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 ten files reviewed for this report. Five files reviewed were residential files (two open and three closed) and five files reviewed were non-residential (three open and two closed).

All of the youth files reviewed contained fully completed Needs Assessments that were done within the specified time frame for completion from the youth's admission date. Each assessment reviewed, contained the signature of a Bachelor's level or Master's level staff member and completion date. Additionally, in conformance with the agency's policy each Needs Assessment contained the required supervisor's signature and date indicative that a subsequent supervisory review was completed.





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All files reviewed contained completed Evaluation of Imminent Danger of Suicide (EIDS) forms and one of ten youth files reviewed for this indicator was identified with an elevated risk of suicide as a result of the Needs Assessment. The identified file demonstrated evidence of a referral for Assessment of Suicide Risk by or under the direct supervision of a licensed mental health professional.

### Exceptions:

No exceptions are noted for this indicator.

### 2.03 Case/Service Plan

Satisfactory

Limited

Failed

The agency has a written policy consistent with the requirements of the Florida Network of Youth and Family Services Quality Improvement standards. The agency's written policy is numbered CHS/7203 and entitled "Service/Case Plans-Implementation, Review and Revision" which has an effective date of July 1, 2011. The policy was last updated August 31, 2018 and was approved by Kristi Walsh, Director of Program Operations.

The purpose stated under this agency's policy is that the development of a Service Plan, by the agency's Counselor/Case Manager, in conjunction with the youth/family shall be completed within seven working days following the completion of the Needs Assessment. 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



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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 ten files reviewed for this report. Five files reviewed were residential files (two open and three closed) and five files reviewed were non-residential (three open and two closed).

All of the youth case files reviewed contained completed Service Plans dated within the time frame specified in the policy. Each Service Plan contained the required individualized and prioritized needs and goals identified in the Needs Assessment. Each plan detailed: service types, frequency and location; responsible party, and target dates for completion. Some youth case files reviewed did not indicate an actual completion date for the identified goals because they were still active and working toward them.

All files contained the required signatures of the youth and/ or verbal consent on behalf of the parent/guardian. As permitted in the agency's policy, the Counselor/Case Manager clearly noted instances where the parent/guardian's verbal consent was acquired via telephone. The parent/ guardian would sign at a later date when the party was available to come in person and sign the Service Plan.

All residential service plan reviews indicated that they were performed timely, at the seven-day interval in all files and subsequently at twenty-one days when applicable.

All non-residential service plan reviews indicated that they were performed timely, at the 30/ 60/ 90-day intervals whenever applicable.

### Exceptions:

No exceptions are noted for this indicator.

## 2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

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The agency has a written policy consistent with the requirements of the Florida Network of Youth and Family Services Quality Improvement standards. 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 August 31, 2018 and approved by Kristi Walsh, Director of Programs.

The agency establishes that the purpose of this policy is to provide services to youth, their families, legal guardians or other others who are considered to be significant, in the immediate and follow-up care of the youth. Service coordination on behalf of the clients may include, information gathering; supportive linking, advocating, coordination and monitoring of services, case review and termination with appropriate referral when CHS counselor/ case manager’s direct services are no longer needed. 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 ten files reviewed for this report. Five files reviewed were residential files (two open and three closed) and five files reviewed were non-residential (three open and two closed).

In each of the 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-



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going assessments of each youth's/family's problems and needs; coordinated the service plan implementation; monitored the youth's/family's progress; and provided necessary supports.

All files reflected that their respective Counselor/Case Manager referred the youth/family for additional services. All of the closed files reviewed contained documentation of the Counselor/Case Manager's case discharge summary/termination notes.

Five of five closed case files reviewed were subject to the required thirty-day post exit follow-up and that was documented appropriately. Three of five closed files were subject to the sixty-day post exit follow-up, which was also properly documented. The open files reviewed are not subject to post-exit follow up at this time.

### Exceptions:

No exceptions are noted for this indicator.

## 2.05 Counseling Services

Satisfactory

Limited

Failed

The agency has a written policy consistent with the requirements of the Florida Network of Youth and Family Services Quality Improvement standards. 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 August 31, 2018 and approved by Kristi Walsh, Director of Program Operations.

As set forth in the policy of this agency, 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.

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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 ten files reviewed for this report. Five files reviewed were residential files (two open and three closed) and five files reviewed were non-residential (three open and two closed).

Each file 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. Chronological documentation was significantly reflected in respective Service Plan. Signatures of the Counselor/Case Manager's supervisor were present at regular intervals to reflect the on-going internal clinical review of the case records and staff performance. Additionally, evidence of youth and families receiving counseling services in accordance with their respective Service Plans was present in the case notes.

The agency maintains a separate binder documenting residential group sessions. The appropriate content includes: Dates, topics, participants, facilitator, and time of each group counseling session over the past year and a half. Names of all youth in



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residential were identified as having participated in group counseling at least five times a week during their time in the residential program.

### Exceptions:

No exceptions are noted for this indicator.

## 2.06 Adjudication / Petition Process

Satisfactory

Limited

Failed

The agency has a written policy consistent with the requirements of the Florida Network of Youth and Family Services Quality Improvement standards. 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 August 31, 2018 and was approved by Kristi Walsh, Director of Program Operations.

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 working 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/arraignment and issues a summons along with a copy of

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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.

There were three case staffing files reviewed for this report. None of the files reviewed were initiated by the parents/guardians, all files reviewed were referred to case staffing by school district officials due to truancy issues. Evidence of notification sent to the parents no less than five working days prior to the staffing was present in each of the files reviewed. Notification to committee members no less than five working days prior to the staffing was indicated in the case notes. All three files documented individuals present at case staffing to include: local school representative and DJJ rep or CINS/FINS provider.

Case notes in each file indicated that copies of the results of the case staffing committee meeting were provided to the youth and family with included recommendations and reasons behind the recommendations.

### Exceptions:

No exceptions are noted for this indicator.

## 2.07 Youth Records

Satisfactory

Limited

Failed

The agency has a written policy consistent with the requirements of the Florida Network of Youth and Family Services Quality Improvement standards. 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 August 31, 2018 and was approved by Kristi Walsh, Director of Program Operations.

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.



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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 ten files reviewed for this report. Five files reviewed were residential files (two open and three closed) and five files reviewed were non-residential (three open and two closed).

Each of the files reviewed were marked "Confidential" as required by the agency's policy and the Florida Network's Indicator. The agency stores files in an office which is locked when not occupied. The reviewer observed that file cabinets where files are maintained could all be locked and that each was prominently labeled "Confidential." Upon inquiry, the reviewer was shown the solid black, opaque travel bag the agency uses to transport youth case files and it too is prominently labeled "Confidential" with a combination lock.

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.

### Exceptions:

No exceptions are noted for this indicator.

### 2.08 Sexual Orientation, Gender Identity, Gender Expression

Satisfactory

Limited

Failed

The agency has a policy titled Sexual Orientation, Gender Identity, Gender Expression (SOGIGE) that addresses the requirements of the indicator. The policy was last reviewed July 1, 2018 by the Director of Program Operations.

Youth are addressed by their preferred name and gender pronouns. All staff, service providers, and volunteers are prohibited from engaging in any form of discrimination or harassment of the youth based upon their actual or perceived sexual orientation, gender identity, or gender expression. All staff, service providers, and volunteers who have



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contact with youth will be aware of the terms utilized with this policy. The program will have signage placed in common areas indicating that all youth are welcome regardless sexual orientation, gender identity, and gender expression. Youth will be identified in the logbook, on all outward-facing documents, and census boards by their preferred name and gender pronouns. Youth preference is considered and documented for room assignments. Youth will be provided with hygiene products, undergarments, and clothing that affirms their gender identity or gender expression. Staff is prohibited from discussing youth's sexual orientation, gender identity, or gender expression with other youth in shelter without the documented consent from the youth.

The shelter has signage located throughout the building including in the boy's hallway, the girl's hallway, the staff office, the dayroom, the kitchen, the counselor's office, and the lobby indicating that all youth are welcome regardless of sexual orientation, gender identity, and gender expression. The SOGIGE policy is posted in the lobby of the facility where all visitors and volunteers must enter the building. The policy is located next to the sign-in log for review prior to entering the facility.

The program's screening form used at intake has been updated to ask the youth which gender they identify with and their LGBTQ youth pronoun preference.

A review of staff training files confirmed all current staff in the shelter have received training on the new SOGIGE policy. Now all staff hired by the program receive this training as part of their new hire training. The agency's 2018-2019 Training Plan list this training as a required training during the staff's first 120 days of employment. A review of two training files of recently hired staff confirmed staff received this training shortly after being hired, well within the first 120 days of employment.

### **Exceptions:**

No exceptions are noted for this indicator.

### Standard 3: Shelter Care and Special Populations

#### Overview

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, bedcoverings 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 air conditioning unit, insulation, and state of the art exercise equipment.

#### 3.01 Screening and Intake

Satisfactory

Limited

Failed

The agency has a written policy and procedure that addresses all of the key elements of this indicator. Policy # 3.01 Shelter Environment states that the shelter program will maintain a facility and its grounds in an orderly, clean, and safe, fully functioning condition. The shelter also provides a structured program schedule for youth engagement that fosters healthy social, emotional, and physical development.

The provider's procedure includes facility site inspections, which inspect sleeping quarters, to ensure adequate lighting, clean linens, and clear vents, daily room checks, proper cleaning of kitchen, bathrooms, shower facilities, and dining room area. Building inspections are conducted weekly and any needed repairs are documented in the logbook to be addressed by maintenance and emergency repairs are addressed immediately by notifying a supervisor. Graffiti is removed as soon as it is discovered; grounds are to be landscaped and well-maintained and the shelter maintains a contract with an exterminator to ensure the facility is free of insects. Annual fire safety inspections are completed, and the agency completes a minimum of one fire drill per month as well as one mock emergency drill per shift per quarter. These episodic drills are documented and logged. The agency posts food menus that are current and signed

annually by a licensed dietitian. All cold food is properly stored, marked and labeled and dry storage/pantry area is clean, and food is properly stored. Refrigerators and freezers are clean and functional and within required temperatures. All appliances are operable and clean.

For youth engagement the shelter provides programming that fosters healthy, social, intellectual, and physical development. Youth are engaged in meaningful, structured activities seven days a week and idle time is minimal. At least one hour of physical activity is provided daily and youth are encouraged to participate in offered activities. The supervisor develops daily activity schedules which are approved by the director of program operations and is then posted in accessible areas to the youth. Faith-based services are offered by volunteers from the community in which participation by youth is voluntarily.

For this indicator, this reviewer completed a tour of the facility, including looking at dorm rooms, youth bathrooms, showers, sinks, the kitchen area, all appliances, and the outside grounds. Also reviewed were the fire safety/episodic drills emergency care log, the house keeping maintenance binder, and activity schedule binder for the past 6 months.

Upon review, the facility furnishings were in good repair, the facility is free of insect infestation, and grounds are landscaped and well maintained. The bathrooms, shower areas, appliances and kitchen areas are clean and functional. There was no identified graffiti and lighting is adequate for performing tasks. No hazards or debris were observed, and the cold food was properly stored with posted logs of temperature checks.

Drills were completed as stated in the policy and the last fire inspection on 1/31/19 was satisfactory. The two most recent health safety inspection reports were on 12/4/18 and 1/8/19, both of which were satisfactory.

For youth engagement, a daily/monthly activity schedule is very clearly posted for youth to see and are encouraged to participate in. Activities include reading time, off-site activities, letter writing, game nights, holiday activities, physical activity, and optional faith-based activities. The facility has an-site fitness room with well-maintained fitness equipment that is enclosed and air-conditioned. Study time is also built into the activity schedule to allow time for youth to complete homework and there are age-appropriate books located throughout the common area easily accessible to the youth. Youth are provided the opportunity to participate in a variety of faith-based activities and if they choose not to participate, they are offered another activity instead. Idle time is very minimal.

**Exceptions:**

No exceptions are noted for this indicator.

### 3.02 Program Orientation

Satisfactory

Limited

Failed

The agency has a written policy and procedure that addresses all of the key elements of this indicator. Policy # 3.02 Program Orientation states that the program provides an opportunity to youth to learn about the program and its expectations through a positive orientation process within 24 hours of admission. This includes the program philosophy, goals, and services.

Staff will provide all youth with a Resident Handbook that includes information on program goals, expectations, rules, and philosophy. It also includes introduction to staff, description of forms, explanations of services, and the program descriptions. Other information that will be included regards access to medical, mental health and dental services, visitor, mail, and telephone privileges, school/work information, spiritual activity, male/female contact, theft, hygiene, a contraband list, the behavior management plan, dress code, the grievance policy, information regarding the abuse hotline, supervised outings, workout guidelines, and computer lab rules. Staff will review all items listed in the Youth Orientation Checklist and obtain youth's initials next to each item and signature at the bottom of the page. Staff will also sign and date the form. Items to be covered in this checklist include receipt of handbook, review daily program schedule/services, review of the program rules, and a review of the consequences if a youth violates those rules.

For this indicator, the Resident Handbook was reviewed, as well as five open residential client files. The handbook included all the necessary information including the residential program overview, staff roles, information about counseling, client responsibilities, disciplinary action for rules not followed, the grievance policy, rules regarding contraband and a list of what is considered contraband, the abuse hotline number, the shelter daily schedule, the behavior management plan, and rules regarding appropriate and inappropriate behaviors.

All five reviewed files had the Youth Orientation Checklist and the Receipt of client information/handbook form present. All five files had all required signatures/initials from clients, staff, and guardians within 24 hours of admission. The Checklist also indicates that the emergency/disaster procedures and the youth's room assignment are discussed during orientation. Lastly, each file had the client safety agreement formed signed by staff and youth, which discussed client safety and alerting staff if youth feel they want to harm themselves or if they become aware that someone else wants to harm themselves.

#### Exceptions:

No exceptions are noted for this indicator.

### 3.03 Room Assignment

Satisfactory

Limited

Failed

The agency has a written policy and procedure that addresses all of the key elements of this indicator. Policy # 3.03 Youth Room Assignment/Classification states the program demonstrates the goal to protect youth through a classification system that ensures the most appropriate unit assignment and sleeping room assignments.

The provider's procedure ensures that all youth are interviewed upon admission to determine the most appropriate sleeping arrangements. The provider considers all of the following in placement of a youth in a multi-occupancy room: pre-admission review of available information regarding youth's history, status, and exposure to trauma, which includes the CINS/FINS Youth Screenings; collateral information; physical characteristics such as age, sex, height, weight, physical stature; perceived level of maturity and developmental level; any gang affiliation; aggression/violence allegations and prior delinquent history; attitude upon admission; sexual misconduct; suicide risk; and presence of medical, mental health, or physical disabilities. Alerts are immediately entered into the program alert system when a youth is admitted with special needs and risks such as suicide, mental health, substance abuse and physical health or security risks. Staff will complete the screening form and admission form which includes a physical health screening and the intake assessment form which includes the above-mentioned information. These forms are completed prior to making a room assignment. For any youth identified as LGBTQ, the SOGIE policy will be followed. These forms are reviewed by the residential supervisor for additional concerns. Room assignment will be recorded on the CINS FINS Intake Assessment Form.

For this indicator, five open residential client files were reviewed. In all five files, the CINS/FINS screening form and intake forms were present, and all five files indicated the youth's room placement. All five files notated review of youth's history, status and exposure to trauma, age, gender, preferred pronouns, history of violence, physical disabilities, physical size and strength, suicide risk, sexually aggressive or reactive behavior, gender identification, initial interactions and observations, and collateral contacts. All five files also had the client's alerts documented and communicated to the appropriate individuals. A check mark is placed next to the client's name on the census board if any alerts are indicated at admission. This alerts the therapists to review their file immediately for what the particular alert is. Any and all alerts are notated in the file on the General Alert form which is printed on yellow paper. It is reviewed and signed by the supervisor or counselor and signed by the staff completing the intake. It was also noticed by this reviewer that the on-site nurse reviewed and signed off on all five files reviewed, for medical concerns.

#### Exceptions:

No exceptions are noted for this indicator.

### 3.04 Log Books

Satisfactory

Limited

Failed

The agency has a written policy and procedure that addresses all of the key elements of this indicator. Policy # 3.04 Logbooks/Electronic Logbooks states a shelter logbook will be maintained to document all routine information, emergency situations, incidents, and pertinent shelter activities. Entries which impact the security or safety of the youth and/or program are highlighted in either the paper or electronic logbook.

The provider's procedure includes a paper or electronic logbook to be kept in the youth care staff area. It will include all documentation of activities which have taken place in the facility. A paper logbook will be bound with sequential numbered pages. All entries will include the date, time, a clear concise statement of what, where, who and how, and will be signed and dated by the staff member making the entry. All youth care staff and nurses will utilize the logbook for sign in and out. Examples of entries to be included are specific activities, visitations, youth entering or leaving facility, incidents, and pertinent phone calls. Youth care staff and shift supervisor will review the log at the beginning of shift for the previous two shifts and will make an entry that the review was conducted. All major incidents will be highlighted. The supervisor or designee will review the log on a weekly basis to ensure compliance and indicate review by making an entry stating such and signing and dating in red ink/font color. Youth care staff will keep electronic logbooks charged at all times and take precautions utilizing the equipment. Paper logbooks will be retained for a period of three years and an emergency paper logbook will be easily accessible for staff to utilize if connectivity is lost or the electronic logbooks are non-functional.

For this review period, the provider utilized an electronic logbook that is made available on a tablet which staff utilize while on duty. In the event of a non-functional electronic logbook or power outage, the staff use a paper logbook that is easily accessible to them. This reviewer notated where safety and security issues were documented; all entries were brief and clear; any incidents were documented with the youth and staff name involved, and entry of what took place, the date, time, and signatures; one error was notated in which one line was used to strike through with the staff signature and date. Supervisor reviews are conducted weekly, with an entry notated as such along with their signature and date. It was found that during the weekly reviews the supervisor will make notes in the entry as to what needs to be corrected for all staff to see. It was noted that all staff and the nurse sign in and out and review the log entries from the past two shifts. Supervision and resident counts were also notated along with any visitation or home visits.

**Exceptions:**

No exceptions are noted for this indicator.

### 3.05 Behavior Management Strategies

Satisfactory

Limited

Failed

The agency has a written policy and procedure that addresses all of the key elements of this indicator. Policy # 3.05 Behavior Management Strategies/Interventions states that the behavior management system/intervention is designed to foster accountability and compliance with the program rules and expectations. It includes consequences connected to the behavior that serve as incentive to improve youth choices; it provides on-going feedback to youth concerning their behavior; and it is described in the client orientation handbook with the overall goal of influencing the youth to make positive choices and increase personal accountability and social responsibility.

The agency provides the resident handbook to the youth upon admission which describes the behavior management system. This system is also reviewed during the orientation process and the youth initials confirmation that it was reviewed and sign off on their understanding of the system. Inappropriate behaviors and consequences are visibly posted in the living room of the shelter and in each bedroom along with the resident handbook. Weekly, during re-orientation, the BMS is reviewed with youth and all consequences are directly related to exhibited behaviors. Youth earn positive or negative points based on rule compliance, attitude, peer/staff interaction, participation in therapeutic activities, and school behavior. Staff who have been trained in the theory and practice of rewards and consequences score the youth's behavior point sheet before the daily house meeting. When youth have exhibited negative/positive behaviors, they are taken aside by staff to discuss the inappropriate/appropriate behaviors, the relevant consequences or praise and document such on the point sheet and behavior notes. Daily, the youth care staff review with the youth their point sheets and discuss the quality of their behavior during the service plan goal conference. Youth may turn in their points at the shelter store throughout the week and at time of discharge. Before negative points are applied the youth is re-directed, a reason why the behavior is unacceptable is given, and alternative behaviors are offered. Positive reinforcement for appropriate behavior, redirection and verbal intervention are the primary behavioral management tools used. Negative consequences are limited to negative points, or restriction from and outing or privilege, which is outlined in the resident handbook. Separation of a youth from the group will be conducted only with a staff member consistently present. If behavior is disruptive to the program, crisis counseling, separation, verbal de-escalation, and individual counseling may be implemented. Youth are informed that behaviors such as drug use, violent behavior, sexual misconduct, and possession of a weapon will result in the youth's expulsion from the program. All major disciplinary actions require supervisory review.

Upon review, it was noted that the behavior management system (BMS) is clearly detailed in the resident handbook and initialed/signed in multiple places that the youth has been explained this system and acknowledges understanding of it. The reviewer also noticed where the BMS is posted in the youth rooms as well as the common living space. It is also documented in client files that the BMS is explained to the youth during their orientation. It was also noted that, if needed, the orientation status of the BMS can be extended to allow the youth more time to become acclimated to the program. The system is designed to gain compliance with program rules, influence positive behavior, and increase youth accountability. The agency uses a point store as part of the BMS incentives to encourage appropriate behavior and participation in the program. The point store includes age appropriate items, as well as items for all genders. Appropriate consequences to negative behaviors are used in the system. These consequences are clearly detailed in the resident handbook; also, any behaviors requiring expulsion are clearly explained to the youth upon admission and during re-orientation groups. Positive and negative points are based solely on the youth's behavior. The number of points associated with each positive or negative behavior are clearly outlined in the handbook and posted throughout the shelter. Discipline behaviors are categorized by minor, major, and maximum with specific consequences for each category, which are appropriate. The BMS promotes constructive discipline by re-directing the youth's negative behaviors and clearly explaining to the youth why that behavior is inappropriate prior to the negative points given. Constructive dialogue and peaceful resolution is provided during the daily service plan goal conferences. These conferences allow the youth to discuss the assessment and deduction (if any) of points and to expose any miscalculations by staff. These conferences also highlight positive behaviors as well as three target skills that the client needs to improve on. Additional positive points are earned for completing target behaviors. Staff are properly trained in the use and implementation of the BMS and this is logged in their training files. Feedback is provided to staff by the supervisor at every meeting as well as by the supervisor reviewing the video surveillance system to ensure compliance by staff with proper use of the BMS with youth.

**Exceptions:**

No exceptions are noted for this indicator.

**3.06 Staffing and Youth Supervision**

Satisfactory

Limited

Failed

The agency has a policy in place titled Staffing and Youth Supervision that addresses all requirements of this indicator. The policy was last reviewed on August 31, 2018 by the Director of Program Operations.



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CHS – WaveCREST – May 8 – 9, 2019

Lead Reviewer: Ashley Davies

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. A staff roster with home telephone numbers is available when additional coverage is needed. Staff are to observe youth every ten to fifteen minutes while they are in their sleeping room at all times and document in the logbook.

Staff schedules were reviewed for the last six months. The shelter has had issues hiring male staff members and over the past six months has only had one or two male staff members employed at a time. This has resulted in many shifts each month having only female staff on duty. From November 2018 until April 2019 there were between 45 to 83 shifts each month with no male staff on duty. The shelter is licensed for twelve beds so staff to youth ratio requirements are always met on the first shift Monday thru Friday as the Residential Supervisor is on duty with at least one youth care worker. Over the last six months staff to youth ratios were consistently met on the second and third shifts as well. During the last six months there were between fifteen and thirty overnight shifts each month with only one staff member on duty. While the staff to youth ratio was met during this time, the minimum of two staff on duty during the overnight shift requirement was not met. The Residential Supervisor provided documentation of attempts to hire staff, especially male staff over the past year. Each applicant was logged in a chart documenting their name, interview date, date paperwork sent to background screening, and if they were hired, the hire date or reason they were not hired. There have been numerous applicants interviewed over the past several months. Some applicants were not appropriate for the position, some declined an interview due to the pay rate, and a couple were hired and quit or let go. The agency is also having problems with background screenings taking a long time to come back, which delays the hiring process. By the time the screening would come back clear, and the applicant was called and offered a position, they would decline due to finding another job while waiting. The background screenings were taking a month to three months in some cases to come back.

Staff observe youth at least every fifteen minutes while they are in the sleeping rooms, during the overnight hours. Observations were usually every ten minutes but no more than fifteen minutes apart. Observations were documented in the electronic logbook. Video surveillance was reviewed for three random nights, over the past thirty days, and a random two-hour time frame each night was reviewed. Staff completed all observations, during the periods reviewed, at least every fifteen minutes. Observations observed on the video correspond to documentation in the electronic logbook. The Residential Supervisor reviews video surveillance of overnight room checks usually at least every two weeks and documents this review on a log and in the electronic logbook.

### Exceptions:

From November 2018 until April 2019 there were between 45 to 83 shifts each month with no male staff on duty.

During the last six months there were between fifteen and thirty overnight shifts each month with only one staff member on duty.

### 3.07 Special Populations

Satisfactory

Limited

Failed

The agency has a written policy and procedure that addresses all of the key elements of this indicator. Policy # 3.07 special populations states that special populations will be addressed according to the needs of the youth and contract compliance. Domestic Violence Respite services, Probation Respite, Staff Secure, and Domestic Minor Sex Trafficking will meet the requirements of the Florida Network.

For the Domestic Violence Special Population, these youth will have a pending DV charge. These youth will be screened by the local detention screening unit and will not meet criteria for secure detention. All calls from the screening unit will be logged with the screener's information, youth's information, and the staff taking the calls. The youth length of stay will be up to 21 days with the planned expectation of reunification. If needed, youths' files will include documentation of transitioning to CINS/FINS or Probation Respite. The youth's file will include a service plan that reflects goals for aggression/anger management, family coping skills, or other interventions designed to reduce the likelihood for violence in the home.

For the probation respite special population, these youth will have a referral from DJJ probation. The youth must be on probation and may be accepted regardless of adjudication status. The program will verify in JJIS that the youth is on probation before accepting. Approval of admission will be gained from the Florida Network respite coordinator through the Probation Respite Referralator. The length of stay will be determined at admission with expected length of 14-30 days. Placement beyond 30 days will require the approval of the JPO, CPO, and the Florida Network.

For the staff secure special population, these youth will be assigned by the court for services and will include the assignment of one staff to one youth. An in depth orientation will be conducted upon admission to promote the youth's success in placement. Assessment and service planning will be reflective of the youth's needs and sanctions outlined in the court order. Parental involvement is expected and required for success of the youth while in the shelter. For continued success, ongoing communication and collaboration with the non-residential counselor assigned to the

youth will take place both during and after youth's shelter stay. The program will only accept youth that meet the legal requirements outlined in chapter 94 F.S. for being formally court ordered into staff secure services. Documentation of the assigned staff to the youth will be documented in a variety of places, identifying youth and staff to other employees.

For the DMST Special Populations, services are designed for these youth who may exhibit behaviors which require additional supervision for the safety of the youth or the program. All requests may be approved for a maximum of seven days with extensions needing approval. Staff assigned to these youth are to enhance the regular services available through direct engagement with the youth in positive activities designed to encourage the youth to remain in the shelter.

The for the Family/Youth Respite Aftercare Services (FYRAC) special population, youth must be referred by DJJ, all intake and case files must adhere to the Florida Network policy requirements, and deliverables can be verified by one or more of the following: intake and initial assessment session, life management sessions, individual sessions, group sessions.

The services provided to these youth will be consistent with all other CINS/FINS requirements.

During this review period, the provider had no cases for the special populations of DMST, FYRAC, or Staff Secure. There were cases for DV and PR. Files reviewed included three closed DV files, one closed PR file, and one open PR file.

All three DV clients had a pending DV charge and the files had evidence that the clients were screened at detention and did not meet criteria for secure detention. All three youth did not have a length of stay in DV respite exceeding 21 days (one was 7 days and the other two were 20 days). They were discharged therefore did not need to be switched to CINS FINS or PR. All three case plans reflected goals focusing on aggression/anger management and/or family coping skills. All other services provided to these youth were consistent with all other general CINS FINS program requirements. Although the services plans reflected appropriate goals, it is important to notate that two of the plans were not filled out in their entirety. One was missing one of the identified issue/need, type of service and frequency, location of services, and person responsible. The second was also missing the same information in addition to the appropriateness of services to be provided.

Both PR files had a PR referral present in the file from DJJ and both did not exceed 30 days for length of stay. There was evidence that all case management and counseling needs were considered and addressed and all other services provided were consistent with all other general CINS FINS program requirements.

**Exceptions:**

No exceptions are noted for this indicator.

### 3.08 Video Surveillance System

Satisfactory

Limited

Failed

The agency has a written policy and procedure that addresses all of the key elements of this indicator. Policy # 3.08 video surveillance system states that the system is in operation 24 hours a day, 7 days a week. The purpose of the system is to guarantee personnel accountability while capturing the agency happenings to ensure the safety of all youth, staff, and visitors. The system shall be a means to deter any misconduct and provide video surveillance evidence to any situation that involves allegations.

The provider's system captures and retains video photographic images which are stored for a minimum of 30 days. It records date, time, and location as well as maintains resolution that enables facial recognition and some details of vehicles entering and exiting the property. It has back-up capabilities allowing the cameras to operate during a power outage. Cameras are placed in interior and exterior locations which cover general locations, including hallways of sleeping rooms, common areas where youth and staff congregate, and where visitors enter and exit. Cameras are also located capturing the PYXIS Medication cart and the intake room. Cameras are not placed in the bathrooms or sleeping quarters. The system is only accessible to designated personnel and is only viewed onsite. Supervisory review is conducted at least bi-weekly or more often, documented on a review log and noted in the logbook. The reviews assess the activities of the facility and include a review of a random sample of overnight shifts. All cameras are visible to persons in the area and written notice is conspicuously posted at both entrances of the shelter.

Upon review, it was noticed that there are conspicuous postings on the premises stating the facility is under video surveillance. All cameras are visible and none were noted in the bathrooms or bedrooms. Cameras are located at both entrances/exits, overlooking the medication cart, the intake room, the hallways of the sleeping quarters, as well as the common living area where youth and staff congregate. The system can capture and retain video photographic images including facial recognition and can record date, time, and location. Video can be stored for 30 days, which is the minimum requirement. The cameras can operate during a power outage by use of a backup battery for 30 minutes. Only one employee is designated who has access to the system. A supervisory review is conducted a minimum of every 14 days (at times it was reviewed more often). These reviews are notated in the electronic logbook as well as a separate log labeled the video surveillance log review. During these reviews, the supervisor assesses the activities of the facility, ensures compliance with the behavior management system by staff and reviews a random sample of overnight shifts.

**Exceptions:**



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Lead Reviewer: Ashley Davies

No exceptions are noted for this indicator.

## Standard 4: Mental Health/Health Services

### Overview

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

The agency has a policy in place titled Healthcare Admission Screening that addresses the requirements of the indicator. The policy was last reviewed November 19, 2018 by the Director of Program Operations.

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 one of the files reviewed the youth was taking medications and those were documented on the Intake Assessment Form. One of the youths had two food allergies documented, fish and guacamole. The mother reported the youth is highly allergic to these two items. The Registered Nurse (RN) made a chronological note in the medical section of the file stating there will be no fish or guacamole served in the facility while the youth is there. Four of the five files documented the RN reviewed and signed the CINS/FINS Intake Assessment the day after admission. The remaining file documented a review two days after admission. The RN also completes a Physical and Health Screening Form with each youth, which includes a body chart, and documents an intake note, in the medical section of the file, documenting a review of all intake paperwork.

**Exceptions:**

No exceptions are noted for this indicator.

**4.02 Suicide Prevention**

Satisfactory

Limited

Failed

The shelter has a policy in place titled Identification of Suicide Risk in Shelter/Prevention that addresses the requirements of the indicator. The policy was last reviewed November 19, 2018 by the Director of Program Operations.

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 four files of youth placed on suicide precautions that were reviewed. 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 four files. All four files also documented notification to the youth's parent, on the EIDS, of the positive screening results. All four youth were seen and assessed by the Licensed Clinical Social Worker (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 all four 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 and LCSW. The shelter has a daybed in the dayroom that youth must sleep on when on suicide precautions during the overnight hours. All four 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. All four 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.



### Exceptions:

No exceptions are noted for this indicator.

### 4.03 Medications

Satisfactory

Limited

Failed

The agency has a policy titled Medications that addresses the requirements of this indicator. The policy was last reviewed November 19, 2018 by the Director of Program Operations.

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 agency has a policy titled Medications that addresses the requirements of this indicator. The policy was last reviewed November 19, 2018 by the Director of Program Operations.

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 two Registered Nurse's (RN). There is one RN on-site six days a week after 5:00pm for approximately two hours. One RN works Sunday thru Tuesday and the other RN works Wednesday thru Friday. Both RN's and the Residential Supervisor are listed as the Super Users for the Pyxis Med-Station. There were eight 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 drawer two is prescription medications. Drawers three, four, and five are normally empty. 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 time they are given. 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 three 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 was one youth in the shelter currently on medication. This file as well as three additional closed files were reviewed for administration of medication. All four 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 time the medication was given. The RN dispenses evening medications and the staff dispense morning and afternoon medications.

The RN runs monthly reports from the knowledge portal. A Discrepancy Report, a Summary by Transaction Type report, an Override report, and a User Summary report is reviewed each month by the RN. These reports are maintained in a binder. Staff average one to four discrepancies per month. Staff are aware discrepancies need to be cleared out by the end of their shift and generally they are with a few exceptions. There was one open discrepancy at the time of the review that had not been closed out from a previous shift.

#### **Exceptions:**

No exceptions are noted for this indicator.

#### **4.04 Medical/Mental Health Alert Process**

Satisfactory

Limited

Failed

The agency has a policy in place titled Medical and Mental Health Alert Process that addresses the requirements of this indicator. The policy was last reviewed on November 19, 2018 by the Director of Program Operations.

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 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.

**Exceptions:**

No exceptions are noted for this indicator.

**4.05 Episodic/Emergency Care**

Satisfactory

Limited

Failed

The agency has a policy in place titled Episodic/Emergency Care that addresses all the requirements of this indicator. The policy was last reviewed on November 19, 2018 by the Director of Program Operations.

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

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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 site emergency room care/visits.

The shelter has an Episodic/Emergency Care Daily Log to log all emergency medical care needed. A review of this log and CCC reports confirmed there have been no instances of off-site emergency medical care since the last on-site review.

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 a spider bit, a food allergy, ingesting a toxic substance, and a burn. The drills included a description, a staff response, debriefing notes, supervisory review, a corrective action plan, and staff involved.

The shelter has four first aid kits, two located inside the shelter and two 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. All staff employed at the shelter have a current CPR and First Aid certification.

### **Exceptions:**

No exceptions are noted for this indicator.