Florida Network of Youth and Family Services Quality Improvement Program Report

Review of CDS-Interface East

on 06/22/2017

CINS/FINS Rating Profile

Standard 1: Management Accountability	
1.01 Background Screening of Employees/Volunteers	Satisfactory
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Satisfactory
1.05 Analyzing and Reporting Information	Satisfactory
1.06 Client Transportation	Satisfactory
1.07 Outreach Services	Satisfactory

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

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

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

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

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

Standard 4: Mental Health/Health Services	
4.01 Healthcare Admission Screening	Satisfactory
4.02 Suicide Prevention	Satisfactory
4.03 Medications	Satisfactory
4.04 Medical/Mental Health Alert Process	Satisfactory
4.05 Episodic/Emergency Care	Satisfactory

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

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

Rating Definitions

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

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

Review Team

Members

Keith Carr, Lead Reviewer, FOREFRONT LLC/FNYFS

Susan Yang, Shelter Supervisor, Boys Town of Central Florida

Kevin L. Greaney, Regional Monitor, Department of Juvenile Justice

Philip Whitby, LMHC; Program Manager; Orange County Youth and Family Services

Teresa Clove, Executive Director, Thaise Educational and Exposure Tours

Persons Interviewed

- [ ] Chief Executive Officer
- [ ] Chief Financial Officer
- [x] Program Coordinator
- [ ] Direct-Care On- Call
- [ ] Clinical Director
- [x] Case Manager
- [x] Nurse
- [ ] Executive Director
- [ ] Program Director
- [x] Direct- Care Full time
- [ ] Volunteer
- [ ] Counselor Licensed
- [ ] Advocate
- [x] Chief Operating Officer
- [x] Program Manager
- [ ] Direct-Care Part Time
- [x] Intern
- [x] Counselor Non- Licensed
- [x] Human Resources

1 Case Managers
1 Program Supervisors
0 Health Care Staff

0 Maintenance Personnel
1 Food Service Personnel

0 Clinical Staff
6 Other

Documents Reviewed

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

4 # Health Records
6 # MH/SA Records
5 # Personnel Records
1 # Training Records
3 # Youth Records (Closed)
4 # Youth Records (Open)
6 # Other

Surveys

8 Youth 7 Direct Care Staff

Observations During Review

- [x] Intake
- [x] Program Activities
- [x] Recreation
- [ ] Searches
- [x] Security Video Tapes
- [x] Social Skill Modeling by Staff
- [x] Medication Administration
- [x] Posting of Abuse Hotline
- [x] Tool Inventory and Storage
- [x] Toxic Item Inventory and Storage
- [x] Discharge
- [ ] Treatment Team Meetings
- [x] Youth Movement and Counts
- [x] Staff Interactions with Youth
- [x] Staff Supervision of Youth
- [x] Facility and Grounds
- [x] First Aid Kit(s)
- [x] Group
- [x] Meals

Comments

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

Strengths and Innovative Approaches

Rating Narrative

The CDS Family and Behavioral Health Services in (Interface East), located in the city of Palatka, is a Child in Need of Services and Family in Need of Services (CINS/FINS) program. They are a private 501(c)(3) non-profit social services agency that has provided services in North Central Florida for over 40 years. They seek to fulfill their organization's mission of strengthening communities by building stronger families with several programs. They are contracted by the Florida Network of Youth and Family Services to provide a runaway, homeless and youth crisis shelter; in-home family services; intervention and assessment services; comprehensive behavioral health assessments; counseling services; and prevention services. The program is also a Staff Secure Shelter and is a provider for youth referred through the Juvenile Justice Court System for domestic violence, probation respite, and domestic minor sex trafficking.

CDS East has accomplished many things since the last quality improvement visit. They include:

- being granted a three year renewal of the Basic Center Grant effective 9/30/2016 through 9/29/2019 which funds a Safe Place/Outreach Specialist and Life Skills Instructor;

- receiving funds from the Challenge grant which allowed them to purchase new bed linens, freezer, new pots/pans, patio furniture, recreational items and make much needed improvements to the boy’s bathroom;

- placing a great emphasis on a Trauma Informed environment, they have added therapeutic toys and bean bag chairs in the counselor’s office;

- implemented a new Enhanced Summer Residential program that integrates the Why Try Curriculum. The program incorporates guest speakers from local law enforcement, Department of Juvenile Justice, SEDNET, System of Care- Transitional Youth Program, and other community partners with an inspirational message. It also provides weekly opportunities to locations such as the courthouse, local historical sites, local tech schools (as well as fun trips such as bowling and movie theater) to culminate in a Career Day for the youth, in hopes of helping them understand what careers are available to them and how they can work towards those careers.

Standard 1: Management Accountability

Overview

Narrative

The CDS Family and Behavioral Health Services, Inc. – Interface Youth Program East conducts background screenings prior to hiring and any five-year anniversary of all staff members through their centralized Human Resources offices located in Gainesville, Florida. The program complies with the requirements and procedures outlined in Florida Statute and Department Policy for Child Abuse reporting. Program staff adheres to a code of conduct that prohibits the use of physical abuse, profanity, threats, or intimidation. CDS is committed to maintaining compliance with the incident reporting policies of the Department of Juvenile Justice. The agency conducts outreach throughout their designated service regions to local youth, parents/guardians, local community organizations, partners and stakeholders.

The CDS-East shelter in Palatka, Florida is operated by one Regional Coordinator. The agency assigns the daily operation and direct responsibility of each shelter to the Regional Coordinator. The agency also has Residential Supervisors, Residential and Non-Residential Counselors, Residential Direct Care and Non-Residential staff members. The agency has Centralized Human Resources and fiscal departments that are responsible for all personnel and financial matters respectively. All CDS residential shelters and Non-Residential programs have implemented uniform operating protocols for all three service locations in their respective service areas. Other uniform protocols for all three locations include training and professional development exercises.

1.01 Background Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

CDS meets the requirements of this indicator. CDS policy is that they will comply with regulations and protocols as defined by Florida's Department of Juvenile Justice and the Department of Children and Families.

Five year re-screenings shall be conducted on employees, calculated from the "Retain Prints Expiration Date" posted on the clearing house site and background screening result form.

The Annual Affidavit of Compliance with Good Moral Character Standards is completed and sent to DJJ Background Screening Unit by January 31st of each year.

When an individual is identified as a person not currently employed by CDS as a potential hire or volunteer/intern, the supervisor must facilitate the completion of a background screening packet to determine the applicant's eligibility for hire.

For five year re-screenings, the Human Resource Manager, through the Clearinghouse portal, will initiate a five-year re-submission every five-year anniversary of staff and volunteers by sending the information as required by policy.

This policy and procedure meets the requirement of the DJJ Background Screening Policy. There has been three new staff hired and retained since the last annual review. All three staff members had documentation that their background screening was completed prior to their hire date. All staff were rated "eligible".

There were three staff who were due for a five-year re-screening since the last annual review. All three staff members had their re-screenings completed prior to their anniversary date. The re-screenings were completed less than one year prior to the staff's anniversary of their initial hire date.

The Annual Affidavit of Compliance was completed and submitted to the DJJ Background Screening Unit on January 12, 2017.

There were no exceptions noted for this indicator.

1.02 Provision of an Abuse Free Environment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program complies with the requirements and procedures outlined in the Florida Statute and Department Policy. Program staff adheres to a code of conduct that prohibits the use of physical abuse, profanity, threats, or intimidation. Staff complies with the National Association of Social Workers Code of Ethics to which CDS staff is ethically bound.

CDS maintains Standards of Conduct and orient participants and staff to those standards. The intent of the policy is to set forth the standards of conduct of participants by establishing written rules, advising participant of their rights and responsibilities, and providing guidance for the participant orientation process.

The program has an accessible and responsive grievance process for youth to provide feedback and address complaints.

Management will take immediate action to address incidents of physical and/or psychological abuse, verbal intimidation, use of profanity, and/or excessive use of force.

When an individual participant comes into CDS for the first time their orientation will begin. They will be given an Informed Consent and Participant Agreement form. Need to know telephone numbers and websites are also given to them. Items covered with the participant include program orientation, participant's rights and responsibilities, confidentiality, complaint/grievance procedures, procedure for reporting abuse, neglect or exploitation to the Department of Children and Families, telephone numbers for the state abuse registry, self-help groups, legal referral services, Disability Rights Florida, assessment process, plan of service, satisfaction with services, smoking policy, seclusion and restraint, policy on weapons and illicit or licit drugs, and program services and activities.

There were no allegations of child abuse reported to the CCC since the last review. The abuse registry number is displayed throughout the facility.

Staff receive training on child abuse reporting quarterly.

The program has an accessible and responsive grievance process for the youth to provide feedback and address complaints. The grievance forms are available throughout the facility and not handled by direct care staff. Youth places the completed grievance forms in a lockbox or directly hands it to a supervisor. There have been two grievances filed since the last review, both of the grievances was for the same thing and on the same day. Both were addressed and solved to the youth's satisfaction.

According to the unusual event book, staff has assisted with six abuse registry calls for youth over the last six months.

Eight youth were survey and seven responded that they knew that the abuse hotline was available to them at the shelter. The same eight youth were surveyed and six of the youth knew where to find the abuse registry's phone number. Seven of the eight youth reported that they have never been stopped or delayed in making a call to the abuse hotline. All eight youth reported that they have never attempted to make a call to the abuse hotline. Seven of the eight youth reported that adults are respectful when talking to them and other youth. All eight youth answered that they have never heard adults using profanity when talking to youth, and never heard staff threaten a youth. All eight knew of the grievance process and how to access it.

Seven staff were surveyed and all responded that they have never stopped nor witnessed other staff stop or delay a youth from making a call to the abuse registry. All seven also responded that they have never heard adults using profanity nor witnessed adults threaten a youth at the shelter.

Exceptions:

Eight youth were surveyed and one responded that they did not know that the abuse hotline was available to them at the shelter.

The same eight youth were surveyed and two of the youth did not know where to find the abuse registry's phone number.

One of the eight youth reported that they have been stopped or delayed in making a call to the abuse hotline.

One of the eight youth reported that adults are not respectful when talking to them and other youth.

1.03 Incident Reporting

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Policy is in compliance with the requirements and procedures outlined in Department policy and Florida Administrative Code. CDS's policy is that all incidents shall be reported according to the requirements of the appropriate governing agency. CDS is committed to maintaining compliance with the incident reporting policies of the Department of Juvenile Justice.

Incident reporting procedures common for all participants are legible and through documentation and internal notification of all incidents. The Department of Juvenile Justice's Central Communications Center will be contacted within two hours of any reportable incident or two hours of becoming aware of the incident.

There were three CCC calls since the last annual review. Each of the three incidents were reported to the CCC within two hours of the caller becoming aware of the incident. Two of the three CCC calls were logged in the program's log book.

Staff receive training on CCC reporting quarterly.

The unusual event book did not contain any reportable incidents that were not reported to the CCC. There were several that were refused by the CCC as unreportable.

Exception:

The one call not logged in the log book was for a medication error.

1.04 Training Requirements

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a Training policy called Training Plan. The agency's Training Plan policy is dated for the fiscal year July 1, 2016 – June 30, 2017. The policy's purpose is to describe the agency's approach to providing training and development opportunities for all full and part time that is required by contract and applicable rule, regulations and law. The agency's policy requires that the organization properly train all staff with training to perform their respective job duties. The policy requires that the training plan be developed annually where planning occurs and training needs are assessed. The policy also requires that the agency have staff-training budget, conduct an annual training meeting to establish goals and create and revise an annual staff development and training plan.

The training policy also requires the Regional Coordinator to develop a quarterly training calendar that outlines specific training topics and dates, based employees' needs. The policy requires a individual training file be maintained on each staff member. The primary areas of training that the agency focuses on is Health and Safety; Person and Family Centered Approach; and Cultural Competency. Specific areas of training focus on Universal Infection Control, Blood Borne Pathogen Exposure, Aggression Control, and Supervision.

The agency encourages employees to contribute their ideas for possible training areas and share their experience and expertise. The agency has procedures that require a training plan be developed for each new employee. The agency requires the CDS personnel be trained on the required curriculum. The agency provides training sessions and topics that include Orientation; CINS/FINS Core; Managing Aggressive Behavior (Residential); Suicide Prevention; Signs and Symptoms of Mental Health and Substance Abuse; CPR/First Aid; Behavior Management-Residential; Title IV-E (Residential); In-Service Training; Medication Distribution for Non-Licensed Staff-Residential; Understanding Youth/Adolescent Development; Ethics Civil Rights, EEO, Sexual Harassment; Confidentiality; Child Abuse Reporting; Trauma-Informed Care; Prison Rape Elimination Act; Fire Safety Equipment; Information Security Awareness; Serving LGBTQ Youth; Cultural Humility.

The agency does require specific refresher training of on-going staff in the areas of safety equipment; crisis intervention; CPR/First Aid and suicide prevention. The agency requires that the Regional Coordinator develop a quarterly training calendar, that outlines training topics, dates based on required trainings, as well as their employees' needs. The agency's official training operates from July 1 through June 30 each year.

A random sample of 9 files were reviewed to assess the agency's adherence to the FNYFS Training requirements. Of these files, all were current employees and included samples of recently hired staff members and staff that recently completed their first year and staff that have been employed with the agency for more than 2 or more years. A total of three (3) staff were hired after July 1, 2016. All 3 of these staff members' files had evidence that confirming their completion of the nine (9) required trainings for all first year (full-time, part-time, and on-call staff) direct care staff. There was one (1) staff member (hired in April 2016) that was hired prior to July 1, 2016 that had a total of 143.5 training hours in their first full year of employment. The other 3 first year direct care staff have evidence of completing 134.5, 104, and 171.5 training hours prior to the end of their first year of employment respectively.

A total of five (5) on-training files were reviewed for adherence to the annual forty (40) hour training requirement. All 5 contained evidence of completing the annual 40 hour training requirement. On-going staff members completed 54.5, 40.5, 46, 41, and 52 hours of training respectively. The program provided an individual training file for each staff member, that included a training log designated by the annual training year July 1 – June 30, and all related documentation, such as certificates, sign-in sheets, and agendas for each training attended by the staff person.

No exceptions were noted for staff files involving completion of training hours requirements.

1.05 Analyzing and Reporting Information

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

It is the policy of CDS to formerly and routinely collect and analyze data for the purpose of quality improvement and to ensure compliance with Substance Abuse and Mental Health, Independent Living, and CICS/FINS related Quality Assurance Standards, and applicable licensure and accreditation requirements.

The program collects and reviews several sources of information to identify patterns and trends. This information includes quarterly peer reviewed CINS/FINS case management records, monthly review of incidents, accidents, and grievances, annual review of customer satisfaction, annual review of outcome data, and monthly review of NetMIS data reports.

The agency prepares a very detailed report every month titled “CDS Performance and Risk Management Reports”. This reports includes performance analysis, CINS/FINS program-wide information, CINS/FINS non-residential items, residential lists, satisfaction survey results, an incident report summary for all programs, as well as other miscellaneous information. It is broken down to review all of the admission, discharge and care day information per facility for the agency. This monthly report also includes a data lag report and analysis and projections of contractual requirements from NetMIS.

In addition to those reports there is an analysis of the residential and non-residential admissions, daily populations, average length of stay and bed days for the last 5 fiscal years. The annual report is further detailed and includes satisfaction surveys result data. CDS conducts quarterly peer reviews on the files. The agency also reviews customer satisfaction data during their monthly management team meeting.

No exceptions were noted.

1.06 Client Transportation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

A written policy is in place for transportation of youth. CDS vehicles are to be used for the sole purpose of conducting CDS business. The policy outlines which employees can be approved drivers and what are grounds for exemption to driving. The policy does outline best practice to prevent situations by having a third party present in the vehicle. It states the third party can be an approved volunteer, intern, agency staff, or other participant. In the event a third party cannot be present in the vehicle, there is a policy in place that the youth’s participant history, evaluation, and behaviors are put into consideration. The employee’s work performance, history, and behavior also has to have no indicators of inappropriateness.

Approved agency drivers are agency staff that have been approved by administration and on the approved drivers list. Drivers must possess a valid Florida Driver’s license and adequate automobile insurance. Copies of the employee’s personal automobile insurance shall be maintained in the employee’s personnel file. At the time of employment and annually thereafter the Human Resource Specialist will review the driver records of all drivers.

A mobile phone will be available at all times when participants are being transported for emergency use and other business purposes.

Procedure also includes what are the accident procedures, what to do immediately following use of vehicles, and the vehicle safety inspections.

Keys and proof of insurance covering CDS vehicles and passengers are kept in a secure area.

A sample time frame was reviewed in the personal vehicle logbooks to ensure single client transports were approved. From January 27, 2017 through April 28, 2017 all single transports were documented in the transportation box in the log book and approved by the supervisor.

The van logs documented the use of the CDS passenger van. Documentation included: the date, staff member using the vehicle, if a second staff member was present, destination or purpose of trip, departure and return time, starting and ending mileage, and beginning and ending number of youth transported. The previously sold vehicle used a transportation exceptions approval log. It had a weekly listing of the approved youth, the approved staff driver and was signed by the supervisor. This form is no longer being used. Vans tags are current until the end of the fiscal year. Insurance card expires January 10, 2018.

The program maintains a list of approved drivers. Each of the drivers has a valid Florida Driver’s License.

No exceptions were noted for this indicator.

1.07 Outreach Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The Prevention Outreach program is to be implemented by program staff and is considered the potential responsibilities of all staff. It includes but not limited to information services, educational services, alternative services, community development services, and early intervention services.

CDS will maintain written cooperative agreements with other community partners that include services provided and a comprehensive referral process.

The Prevention Outreach efforts are to be cooperatively developed and implemented in a manner consistent with the program's goals. The Regional Coordinator is responsible for coordinating Prevention Outreach efforts within each region, providing training to the direct care staff regarding documentation procedures. Direct care staff participate in the initiative based on availability and ability.

A written policy is in place for outreach services. The program has very well-organized and detailed documentation of all outreach services they have completed. They have an outreach specialist who focuses mainly on their community partners and provides them with agency materials.

In the last six months, there has been a variety of different DJJ Board and Council Meetings and Putnam County Juvenile Justice Council that were attended by an employee of CDS. Attached to the outreach documentation are the meeting minutes to provide verification of attendance. Each has approved minutes from the previous meeting attached.

The program maintains a variety of community partners (police departments, mental health services, schools/education, DCF, DJJ and various others) through written agreements that are current and up-to-date. The program provides a detailed referral form for their community partners for referrals. They maintain Cooperative Services Agreements with more than sixty agencies and organizations, which are updated every two years.

The Prevention Outreach Program provides the following five types of service: Early Intervention Service, Informational Service, Educational Service, Alternative Service, and Community Development Service.

No exceptions were noted.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

The CDS-East Non-Residential Counseling Program is contracted to provide non-residential services for youth and their families that are primarily in Putnam, Bradford and Union Counties. The program provides centralized intake and screening twenty-four hours per day, seven days per week to status offenders that include runaways, truants, ungovernable and lockout youth. Residential services include individual youth, family and group services. Case management and substance abuse prevention education are also offered.

The non-residential program consists of two Non-Residential Counselor/Case Managers. The program receives requests for services from parents/guardians, system partners and the general community. The agency's screening determines eligibility of CINS/FINS youth and families that are referred to the program to start the intake process. The program has the capability to offer both case management and substance abuse prevention education on an as needed basis.

The shelter does not routinely perform case staffings unless there is a written request by the parent or school. The shelter defers to the school district's truancy petition process reportedly under sections 1003.21 and 1003.24, Florida Statutes. The shelter participates in the school district's Student Intervention Team (SIT) and is named as part of the school district's Truancy Procedure. However, referral is made to the program only if there is a determination by the school's "RTI/Child Study Team" that the student "is in need of services at a higher level of care".

2.01 Screening and Intake

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

CDS Interface East has a written policy and procedure that addresses all the key elements of Policy 201 – Screening and Intake. The policy was updated on 1/20/2016 and was signed by the Chief Operations Officer.

Screenings are received 24 hours a day, 7 days a week at the Shelter in the CDS centralize intake center. During the day, the screenings are received by the counselors and after hours the shelter staff takes the screening by phone or walk-ins.

Four (4) Non-Residential (2 open and 2 closed) and three (3) Residential (2 open and 1 closed) case files were reviewed.

In four (4) of the Non-Residential case files and two (2) of the Residential case files youth and guardian signatures were received on the required forms for the screening, intake process, available service options, rights and responsibilities of the youth and guardian, grievance procedure and the possible actions involved with the CINS/FINS services. One (1) of the Residential case files was missing the parent signature for the above mentioned items. The youth signed the form but the parent form was missing. The counselor stated that the form must have been given to the parent during intake, without making a copy for the file.

CDS gives the youth and the parent a copy of their brochure, Florida Network brochure along with an 11-page pamphlet during intake.

No exceptions were noted for this indicator.

2.02 Needs Assessment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

CDS Interface East has a written policy and procedure that addresses all the key elements of Policy 202 – Needs Assessment. The policy was updated on 1/20/2016 and was signed by the Chief Operations Officer.

Four (4) Non-Residential (2 open and 2 closed) and three (3) Residential (2 open and 1 closed) case files were reviewed.

Every file met all the required documentation. The Needs Assessments were implemented within 72 hours of admission for the Residential cases and the same day for the Non-Residential cases. They were completed and signed by a Bachelor's or Master's level counselor and reviewed by a supervisor. There were no Non-Residential or Residential youth out of the 7 cases that were reviewed that had an elevated risk for suicide.

There were no exceptions noted for this indicator.

2.03 Case/Service Plan

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

CDS Interface East has a written policy and procedure that addresses all the key elements of Policy 203 – Case/ Service Plan. The policy was updated on 1/20/2016 and was signed by the Chief Operations Officer.

Four (4) Non-Residential (2 open and 2 closed) and three (3) Residential (2 open and 1 closed) case files were reviewed.

The seven (7) Case/Service Plans were developed based on the information gathered during the Need Assessment, Screening and Intake. Four (4) of the Non-Residential case plans were developed on the same day of intake and the three (3) Residential case plans were developed in one to 5 days which met the standard that states it must be completed with seven (7) days of completing the Needs Assessment. Each Case/Service Plan had several goals, date that the plan was implemented, addressed the frequency,

location, person responsible, and target date of completion, actual date of completion if completed and had the child, parent, counselor and supervisor's signatures. The average goals on the Service Plans were one (1) to two (2) and the average objectives were two (2) to six (6). One out of two (2) of the Non-Residential cases that were closed completed all the objectives while the other case completed one (1) out of two (2) objectives. The one (1) Residential case that was closed, completed one (1) out of the two (2) objectives.

The seven (7) Non-Residential and Residential case files had the counselor, youth, parent and supervisor signatures on the Case/Service Plan. The Case/Service Plans were reviewed every 30, 60 and 90 days as required when applicable. Some of the clients were discharged before the Case/Service Plan Reviews were needed to be completed.

No exceptions were noted for this indicator.

2.04 Case Management and Service Delivery

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

CDS Interface East has a written policy and procedure that addresses all the key elements of Policy 204 – Case Management and Service Delivery. The policy was updated on 1/20/2016 and was signed by the Chief Operations Officer.

CDS counselors and case managers were assigned to the seven (7) cases that were reviewed, followed the youth's case throughout the delivery of services and made referrals as needed. Two (2) Non-Residential and one (1) Residential closed case files were referred for additional services. The staff reported that additional referrals are made as needed on a case by case basis. Two (2) Non-Residential case files had a referral form completed and given to the family for additional services through an outside agency.

Two (2) Non-Residential cases were truancy cases that were in Truancy Court. The counselors accompanied the family to court and attended the Student Intervention Team Meeting which is held once a month at CDS facilities. The Student Intervention Team Meeting is a group of professionals that meet once a month on the last Monday of the month to review and staff truancy cases. The team is comprised of a school representative, law enforcement, a mental health or other social service provider, CDS staff and the school's attorney.

Two (2) Non-Residential and One (1) Residential cases were closed and only the Residential case was due for a 30-Day Follow-up. The 30-Day Follow-up was completed on time as required and placed in the Follow-Up Book. A copy of the 30-Day Follow-up was given to this reviewer.

No exceptions noted.

2.05 Counseling Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

CDS Interface East has a written policy and procedure that addresses all the key elements of Policy 205 - Counseling Services. The policy was updated on 1/20/2016 and was signed by the Chief Operations Officer. The policy is in adherence to the guidelines specified in the indicator.

Four (4) Non-Residential (2 open and 2 closed) and three (3) Residential (2 open and 1 closed) case files were reviewed.

The youth/family received counseling, case management services, case reviews and supervisor reviews. One (1) Residential case file did not receive a 30-Day Review because the client was discharged before it became due. One (1) Non-Residential case file was missing a 30-Day review signature from the mother. The youth was seen face to face in a session and signed the 30 Day Review during that session. The counselor stated on the signature page that the mother was "not available" but did not show in the progress notes if there was an attempt to contact her by phone, letter or in person. Another Non-Residential case file 30 and 60 Day Reviews were completed with the youth face to face and included his signature. The guardian was unavailable for a face to face review but completed it by phone. The counselor notated it in the case progress notes. The Residential case files indicated that the clients received individual, group and family counseling and case management services.

All case files that were reviewed reflected that the presenting problems were indicated on the screening and on the Needs Assessment form. Then they were addressed in the Service Plan, Service Plan reviews and documented in the progress notes. Each case file was individualized, adhered to the confidentially policy, progress notes were in chronological order and the clinical supervisor reviewed and signed the case files as required.

No exceptions were noted.

2.06 Adjudication/Petitiion Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

CDS Interface East has a written policy and procedure that addresses all the key elements of Policy 206 – Adjudication/Petition Process. The policy was updated on 1/20/2016 and was signed by the Chief Operations Officer. The policy ensures that a Case Staffing will be scheduled or convened in situations where the youth/family is not in agreement with services, the youth/family will not participate in the services, the program receives a written request from the parent/guardian, the school requests a meeting or any other member of the committee requests a meeting. CDS Interface East has a combined group that meets once a month on the last Monday of the month to review Case Staffings for CINS/FINS youth as well as for Truancy (Court Offered) youth. The team is comprised of a representative from the Department of Juvenile Justice; a CINS/FINS provider; a representative from the school district; a representative from the State Attorney's office; a representative from any of the areas of health, mental health and social services; a supervisor from the CINS/FINS provider; the youth, the family or a family representative.

If a Case Staffing is needed for a CINS/FINS Non-Residential or Residential youth, the Regional Coordinators and Supervisors will coordinate the staffing. After receiving a request for a case staffing, the

counselor/case manager will convene a Case Staffing within seven working days of the receipt for a case staffing. The youth, family and committee members will be contacted by the counselor/case manager to confirm the date, time, and location of the schedule meeting. As a result of the Case Staffing, the youth, guardian and committee members would sign that they were present for the Case Staffing Meeting, the committee members would give input in reference to the reason why they are convened, the committee would make a recommendation and put it in writing in the form of a Revised Service Plan, the youth/family will receive a copy of the Revised Service Plan and the counselor/case manager will maintain communication with the youth/family throughout the process. This was written in the policy and verbally verified by a Non-Residential Counselor, Residential Supervisor and Regional Supervisor. The staff reported the above procedures would be followed when they had a request for a CINS/FINS Case Staffing.

Four (4) Non-Residential (2 open and 2 closed) and three (3) Residential (2 open and 1 closed) case files were reviewed. None of the files requested a CINS/FINS Case Staffings but two (2) of the Non-Residential truancy cases (one open and one closed) were staffed for the Truancy Case Staffing through the Student Intervention Team Meeting. The following team members signed that they were present during the Truancy Case Staffing Team meeting: CDS Counselor, CDS Residential Supervisor, Another Community Agency Prevention Coordinator, 2 School Board Representative and a Mental Health Representative.

No exceptions were noted.

2.07 Youth Records

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

CDS Interface East has a written policy and procedure that addresses all the key elements of Policy 207 – Youth Records. The policy was updated on 1/20/2016 and was signed by the Chief Operations Officer.

Four (4) Non-Residential (2 open and 2 closed) and three (3) Residential (2 open and 1 closed) case files were reviewed.

All files were marked confidential and were neat and orderly. The open case files are in a hard cover binder and the closed case files are in a soft vanilla binder. They have three digital lock rolling portable opaque file containers used to transport case files to other locations as needed. The youth files are accessible only to the program staff as reported by the Director, Residential Supervisor and counselors. The files are kept in a lock file cabinet in the CDS office.

No exceptions were noted.

Standard 3: Shelter Care

Overview

Rating Narrative

The CDS Family and Behavioral Health Services-Interface Youth Program East is located in Palatka, Florida. The agency operates twenty four hour a day, seven days a week. The agency provides the services to the Department of Children and Families (DCF) and Children In Needs of Services (CINS) youth. The program consists of the following residential staff: Regional Coordinator, Residential Supervisor, Senior Youth Care Worker, Administrative Assistant, two part-time Registered Nurse, Community Outreach Specialist, Life Skills Educator, and a House Manager. A Program Supervisor oversees whether the Youth Care Workers are orienting the new youth and introduce of their Behavioral Management Strategies-FACE (Facilitating Activity & Communication Effectively). In the absence of supervisor on duty, a shift lead oversees and maintains the shift.

The program also utilizes the point sheets to enhance the youth's personal accountability and social responsibility. At the time of the Quality Improvement Review, youth were not in school. However, the specific schedule of each day of the week was posted for youth to be engaged. The program promotes youth to be active during the summer. Therefore, CDS developed a 2017 IYP-E Enhanced Summer Residential Program. Youth are offered to participate with a variety of activities such as gardening, baking, journaling, painting, and attend to guest speakers. The youth's sleeping arrangement was made based on gender, age, history of aggression, mental health, suicide risk, etc. The youth information such as his/her referral behaviors, alerts, allergies, monitoring status, medications could be found in the files, alert board, and the log book.

3.01 Shelter Envonment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The Program has a Policy & Procedure (P&P) in place which indicates the program will provide a safe clean, neat and well maintained environment for the Youth that they serve. In addition the program will provide structured daily programming to engage youth in activities that foster health, social, emotional, intellectual and physical development. The P&P are in compliance with the Florida Network contract and DJJ Quality Improvement Standards. The policy was reviewed and signed by the Chief Operations Officer on 1/20/16.

The persons responsible for the Leisure & Education Activities Program, researches and plans youth activities, schedules, and lesson plans used in the program. Participants are encouraged to participate in a variety of on and off campus activities.

Upon completing the initial entrance interview with the Interface Program Management Team, the QI Review team was provided a tour of the facility by a designated program staff member.

A fire safety inspection report was completed on 11/3/2016 and there were no major issues noted. Health inspection was completed on 2/28/17. The report stated, "Violation corrected all areas, satisfactory at time of re-inspection." The Disaster/Emergency plan was reviewed and signed by the Chief Operation Officer on 10/31/16. Youth are provided the opportunity to participate in meaningful and educational activities seven days a week during awake hours. The daily programming schedule is publicly posted and accessible to both staff and youth.

The Life Skill Educator researches and develop activities, schedules and creates lesson plans used in the program. CDS incorporated 2017 IYP-E Enhanced Summer Residential Program in an effort to keep youth engaged and avoid idle time throughout the summer.

The shelter decorated the areas to create a family living style. Throughout the shelter, there were many posters and inspirational quotes posted. Youth are provided at least one hour of physical activity. The

furnishings appeared to be in a good condition except a few of the couches in the girls room. The program grounds are landscaped and well maintained with a volleyball court and garden.

Each youth has their own bed and was covered with mattresses, pillows, blankets and linens. All bathrooms and shower areas are clean and functional. No graffiti on walls, doors, or windows were detected. Youth have a safe, lockable place to keep personal belongings if requested. CDS does not allow youth to bring any electronics, such as cell phones, I-Pods, I-Pads. However, CDS has a money transaction folder which the youth's monies are kept in a locked place. Youth are able to access it upon request.

Youth are provided with an access to a variety of age appropriate and approved books and board games for reading and leisure. The egress plans, rules and expectations of the program, abuse line, and grievance policies were posted throughout the shelter. Youth are provided the opportunity to participate in a variety of faith-based activities and have an opportunity to opt out in faith-based activities; youth are offered with alternative activities. The chemical closets are locked and only accessible to approved staff. The program appears to be free of insect infestation. Van was locked and the vehicle was equipped with all of the necessary tools (first-aid kits, wire cutters, etc).

There were no exceptions for this indicator.

3.02 Program Orientation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The provider has a written policy and procedures in place where a youth is given an opportunity to learn about the program and its expectations through an orientation. The youth and parent receive an orientation packet and sign and date it within 24 hours of admission.

The provider's procedure requires a screening should be completed using a screening/referral form prior to accepting the youth. In addition, the participant should be made aware of and agree to abide by the rules of the shelter. A review of Participants Orientation packet is done which covers program goals and services, the behavioral program, rules and consequences, search policy, and the grievance process including how to contact the Florida Abuse Hotline.

There were 7 files reviewed: four open and three closed. Youth received a comprehensive orientation and handbook during intake or within 24 hours. The program orientation packet consists of disciplinary action for violation of program rules, grievance procedures, emergency/disaster plans, contraband rules, physical/facility layout map, room assignment, abuse hotline number, and daily activities. All 7 files had the necessary signatures and were completed within 24 hours. Two grievances were filed on 3/5/17. Regional Coordinator followed up on 3/7/17.

There were no exceptions to this indicator.

3.03 Youth Room Assignment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency does have a written policy and procedure to determine a youth's room assignment. There is a room assignment form staff completes to make a determination of room youth will be assigned to.

The agency's procedure requires the room assignment to be determined based on the information gathered during intake, youth's history and status, initial collateral contacts, and initial interactions with and observations of the youth: Suicide risk, perceived maturity, level of aggression and proclivity for

violence, past involvement in aggressive and/or predatory behavior, sexual misconduct, separation of younger youth from older youth, presence of medical, mental, or physical disabilities, gang affiliation, attitude upon admission.

A sample of six files were selected and reviewed: three open and three closed. All six files had the room assignment based on the information collected during intake. Room assignments are noted in the file, alert board and in the log book. Youth who are placed on constant sight and sound are noted on room assignment and progress notes section in the file. There were no youth placed on suicide risk status and the correct status of the youth was noted in the file and log book.

There were no exceptions to this indicator.

3.04 Log Books

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure to ensure that daily activities, guidelines and entries are noted in their log book.

The provider's procedure requires the responsibility of the shift leader to ensure that appropriate documentation occurs on each shift. The program Log Book shall document all incidents when youth leaves and return, physical intervention, intake and departure on each shift, any current deficiencies in the program, the staff on duty on each shift, a review of the program log by incoming shift leader and staff of the previous 3 shifts, weekly review by the Regional Coordinator or Supervisor where a chronological note is made, and any other pertinent information (visits, meetings, schedule contacts).

The log books were selected randomly and reviewed for the last six months. All pertinent information such as safety, suicide, and medical issues were documented. The suicide risk youth were noted and highlighted in blue. The shift leader/Youth Care Workers notes any intake, departure, runaways, abuse reports, CCC reports in the summary section of the log book and signed each shift. All entries are brief and legibly written in ink. Youth and staff involved are clearly documented with date, time and signature.

General information, reviews, suicide, medication related information of the youth are highlighted in different colors to capture the reader's attention. Youth in house and out of house are indicated as IH and OH and reviewed by the shift leader. Entries are made in ink without erasures and the use of whiteout is prohibited. Supervisor reviews are conducted weekly, dated, and signed. However, there were inconsistent documentation of any corrections, recommendations and follow-up required by Program supervisor or designee.

Exception:

There were inconsistent documentation of any corrections, recommendations and follow-up required by Program supervisor or designee.

3.05 Behavior Management Strategies

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy to ensure that a consistent and fair system of privileges and consequences are used. The agency uses the Behavior Management System (BMS) to provide rewards, consequences, and ongoing feedback in order for youth to fulfill program expectations.

The provider uses the FACE system (Facilitating Activity & Communication Effectively) with the intent to

influence the youth to make positive choices and increase personal accountability and social responsibility. The FACE system consists at three different phases (Assessment, Daily and Achievement). The provider has a written procedure explaining the importance of using verbal de-escalation as a first approach and discourages verbal threats to youth when youth becomes unruly. Physical restraints are used as a last resort. In the case the verbal de-escalation or physical intervention to control aggressive behavior are unsuccessful or raises concerns of safety of other participants, law enforcement is contacted to protect the participants and staff.

Upon intake, the youth are explained of the FACE system (Facilitating Activity & Communication Effectively). Youth are explained of point sheet system and how to earn privileges for each day and consequences for violating the program rules. BMS uses wide variety of awards to encourage the participants to complete the program successfully. Youth are placed on three different level-Assessment, Daily, and Achievement. The program utilizes the motivation system such as encouraging youth to be on "Achievement".

Youth who are on achievement can purchase extra sweet snacks and able to gain "Achievement Station" with the points they earn. Appropriate BMS consequences and sanctions are used by the program. Youth are encouraged to use R&R time to (Relax and Redirect) to alter their behaviors to more socially acceptable behaviors. Youth who violates the major house rule is placed on subsystem by a supervisor on duty.

All staff initial training upon hire is within 1 month. There is a protocol for providing feedback of staff regarding their use of BMS rewards and consequences. Supervisor completes a record of action form and the feedback is discussed with the Youth Care Worker. Youth are encouraged to make positive decisions and staff are not to use punishment as a tool.

There were no exceptions to this indicator.

3.06 Staffing and Youth Supervision

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place for staffing and youth supervision, assuring all requirements are in accordance with the Department of Juvenile Justice Quality Assurance Standards.

The agency procedure requires that the Regional Coordinator/Designees are responsible for scheduling and assuring all coverage requirements are in accordance with Florida Administrative Code and Contract. The program shall maintain the minimum staffing ratio: one staff to six youth during awake hours, one staff to twelve youth during the sleep period with at least one staff on duty of the same gender as the youth, one male staff and one female staff scheduled all times.

In reviewing the staff schedules, the program maintains staff ratios as required by the Florida Administrative Code. Over-night shifts consistently maintain a minimum of two staff (one female and one male) present. The program staff schedule is posted in a place visible to staff. There is a holdover over-time rotation roaster that includes contact numbers to reach these staff when additional coverage is needed. Agency is equipped with functioning surveillance cameras which is well positioned. Due to shortage of staff, a male and a female staff were not present during day time on a few occasions. There tends to be more female than male staff. However, a shift leader covered the shift in which the coverage could not be found.

Exception:

Staff observed youth at least every 15 minutes on over-night shift. A few of the checks were noted as every 10 minute increment in the watch log book. It is best practice to use the real time when checking youth.

3.07 Special Populations

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

CDS does have a policy in place for Special Populations. This program has practice, staffing, and programming in place to provide placement for Special Populations assigned to the program.

The program has a staff secure policy which describes the services available to the youth referred to a staff secure placement and provides an overview of the staff secure shelter engagement process focused on the youth and family.

The program also has policies in place for Domestic Violence Respite and Probation Respite Youth.

Staff Secure that includes youth only being accepted if they meet the legal requirements of F.S.984.12 for being formally court ordered into staff secure services. CDS staff secure services consist of five primary components:

1. **In-depth orientation at admission**
2. **Assessment and service planning**
3. **Enhanced supervision and security**
4. **Parental involvement**
5. **Collaborative aftercare**

CDS provides Domestic Violence Respite Care Services for youth ten years old and up to eighteen years of age, who have been charged with an offense of domestic violence. It is specifically designed to provide a safe alternative to secure detention for youth with pending or adjudicated charges of domestic violence.

CDS also provides Probation Respite Care Services for youth ten to up to eighteen years of age referred by DJJ Probation.

Youth eligible for staff secure placement must be adjudicated as a CINS/FINS youth. Youth may be placed in staff secure services for up to ninety days with a possible thirty-day extension. Services shall occur only after other alternative less restrictive remedies have been exhausted. CDS staff secure services consist of five primary components.

Youth eligible for Domestic Violence (DV) Respite placement must have a pending DV charge. A youth may previously have been adjudicated on other charges besides domestic violence, may be on probation and have DCF involvement. The youth also has to have been screened by the JAC/Detention or Screening Unit, but does not meet the criteria for secure detention.

Youth eligible for Probation Respite must be on probation with adjudication withheld.

This program reports that there have not been any inquiries of Special Populations in the last six months to review.

There were no exceptions to this indicator.

3.08 Video Surveillance System

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a video surveillance system policy. The policy was developed to ensure resident, staff and

visitors are monitored through the use of video surveillance while on the property of the residential shelter. The policy was last review by the agencies chief operating officer. The policy requires each residential shelter to operate a video surveillance system 24 hours a day, 365 days a year. The video surveillance system must monitor and capture recordings of agencies happenings including event activities occurrences and incidents that occur on property.

The agency must have a functional video camera surveillance system that operates on a daily basis. The agency must also advise anyone on property by placing a conspicuously posted sign informing them that video cameras are in use for the purpose of security. The video system must only be accessible to staff persons that are trying to operate the equipment.

Agency supervisors must review weekly activities captured on video on a bi-weekly basis and document this review in the agency's logbook. The agency must have cameras that record date, time and location and maintain the ability to produce clear facial images captured on video. The procedures require the cameras not be placed in private spaces such as bathrooms or sleeping quarters. The agency also recently revised the policy to include a process for submitting videos when an investigation or management review including quality improvement reviews are applicable. Upon a request from a need to know party the agency shall make the video copy available to the requesting party within 24 to 72 hours. The agency's video record must record and store a minimum of 30 days of video footage.

The reviewer of this indicator interviewed the regional coordinator and a direct care staff person on the agency's adherence regarding video surveillance system capabilities. The agency has a camera system that was installed on June 22, 2016. And the video camera system is a closed circuit system. The video camera system includes 16 cameras that are high definition 1080P Digital cameras. This system has a commercial digital video recorder HDR system, back up drive, color and infrared capability and 22 inch color LCD display screen.

The agency has a notice that is conspicuously placed in the entryway of the facility. The agency has a total of 16 cameras that are placed in both the interior and exterior of general play locations of the shelter where staff and you can be monitored on video. All cameras are visible and placed in general areas. There are no cameras that are placed in bathrooms and or sleeping quarters.

The agency video surveillance camera system can capture and retain video photographic images including facial images. The agency's system can record date and time as well as location and store the video for up to a minimum of 30 days. The current storage capacity is 7452 GB. Video footage can be stored on a USB flash drive. The camera can operate during a power outage and has a back up battery that can last up to 12 hours. The agency only designates a certain number of staff members that can operate the video surveillance system. The system does have offsite remote capability for two staff persons (the regional director and the residential supervisor).

The agency conducts bi-weekly reviews of the video camera system. These reviews are documented in the agency's logbook. Agency reviews include documentation that some reviews are monitoring overnight work shift. The agency does have a third-party review protocol for parties that require a copy of video footage from the shelter.

No exceptions are noted for this indicator.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The CDS-East program has specific policies and procedures addressing new admissions, screening, assessment, health/mental health conditions and training to ensure safety and appropriate supervision of youth admitted to the residential program. Upon admission, program staff conduct a full intake interview with the youth and their parent/guardian. An initial assessment helps to determine the most appropriate room assignment, what health/mental health conditions the youth is experiencing, how the youth may integrate with the current population, the staff's assessment of the youth's ability and capacity to function within the program rules and expectations, history of criminal involvement, the maturity level of the youth, school functioning and performance and family dynamics. Staff on duty at admission immediately identify special needs, conditions and risks of the youth. This may include risk of suicide, other mental health concerns, psychiatric medication, behavioral health, substance use/abuse, physical health including current issues as well as chronic issues and other potential security and safety risk factors.

There is regular and healthy communication and collaboration between the program shelter supervisor, coordinator and licensed mental health counselor with suicide risk assessments. When a youth is positive on a suicide risk screening, they are immediately placed on Constant Sight and Sound Supervision or One-to-One Supervision until a licensed mental health counselor is able to further clinically assess the youth for any further supervision needs. The agency uses an observation log system in the client file, reviewed by a supervisor, and a daily logbook documentation system as well as an alert white board as part of it's internal medical/mental health alert system. The agency operates and utilizes a medication distribution system using a Med-Station Medication Cabinet. The program utilizes a Registered Nurse (RN) on-site several days a week. The RN monitors the youth's physical health and medication distribution as well as provides training to staff on various physical health issues. Staff are trained to provide CPR and First Aid as well as suicide prevention and assessment, and signs and symptoms of mental illness and substance abuse.

4.01 Healthcare Admission Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy, Residential Admission: Preliminary Physical Health Screening (P-1117), that addresses key elements of this indicator. The policy manual was last reviewed on 1/20/16 and all revisions and additions were approved and signed by the Chief Operations Officer. The policy was last revised in November 2016.

The policy states each youth is provided a preliminary physical health screening to include: current medications for physical health, specific inquiry into symptoms of active tuberculosis, physical health problems, medications, allergies, report of recent injuries or illnesses, and presence of pain of or other physical distress. Additionally, staff shall document on the Intake/Assessment Form observations of evidence of illness, presence of obvious injury, signs of physical distress or illness, difficulty moving or other physical disability, presences of scars piercing, tattoos or other skin markings.

The agency procedure requires, upon admission to the shelter, each youth is screened to obtain information related to the youth's physical status. It is to be recorded on the Intake/Assessment Form. Areas of concern or that need follow-up and initiates the Medical/Mental Health Alert system is noted on page 6 of the form. Both the parent/guardian and the youth are interviewed about the youth's current medications as part of the Medical and Mental Health Assessment screening process. This process is to be conducted by a Registered Nurse if on premises. Otherwise, this interview is to be conducted by on-duty staff and reviewed by the Registered Nurse within 5 business days. The Supervisor/shift leader on duty at the time of admission will review the youth's file and intake packet to assess the need of any immediate action. The assigned residential counselor will consider the information on the Intake/Admission Form

when developing the Case/Service Plan.

A total of eight residential files (5 closed and 3 open) were randomly selected and reviewed of youth served in the last 6 months to assess the requirements of this CQI indicator and agency policy. All 8 files reviewed had a physical health screening upon intake that screened all elements of the agency policy including current medications for physical health, specific inquiry into symptoms of active tuberculosis, physical health problems, medications, allergies, report of recent injuries or illnesses, and presence of pain of or other physical distress. The parent/guardian is the primary source of this information. Additionally, in all 8 files reviewed, staff documented on the Intake/Assessment Form observations of evidence of illness, presence of obvious injury, signs of physical distress or illness, difficulty moving or other physical disability, presences of scars piercing, tattoos or other skin markings. In all 8 files reviewed, a Registered Nurse reviewed all physical health screenings, including the youth's current medication, within 5 calendar days. In 4 or 8 files reviewed, the Registered Nurse reviewed the physical health screening within 1 day.

While the agency does not have written procedures to address a through referral process and a mechanism for necessary follow-up medical care for youth with chronic medical conditions. Upon consulting with the youth shelter manager, by practice the agency discusses acute and chronic medical conditions with the parent/guardian. The agency utilizes a Medical Health Follow-Up form to address acute and chronic medical conditions. The Medical Health Follow-Up form was in 7 of 8 files reviewed. In 1 file no acute or chronic medical conditions was reported.

The agency has Medical Health Follow-Up hand out sheets available for Asthma, Cardiac Disorder, Diabetes, Head Trauma, Hemophilia, Petit mal seizure, Pregnancy, and Tuberculosis. These are all medical conditions mentioned in the standard. The sheets include Tips to Remember, a brief health education concerning these conditions. Additionally, the agency has a TIPS to Remember sheet for ADHD. The sheets also include the participant's name, date, medical instructions and other information/instructions per the parent/guardian.

Current medications for the youth were documented in 5 of 8 files reviewed. In 3 of the 5 files where current medications were documented, the youth was taking multiple medications for multiple medical reasons. The reasons for each medication was well documented. In 3 of 8 files reviewed, it was noted the youth was not taking any current medications. Existing medical conditions (acute and chronic) were noted in 7 of 8 files reviewed. In 1 of 8 files reviewed, no existing medical conditions (acute and chronic) was noted. A medical & dental referrals daily log was reviewed. It is utilized to record medical or dental services (on or off site) rendered to participants, staff, volunteers or visitors at the residential facility. In 4 of the 8 files reviewed, a medical referral was documented in the medical & dental referrals daily log during the youth's stay at the residential facility.

The agency's policy does not have a written procedure that addresses a thorough referral process and a mechanism for necessary follow-up medical care for youth admitted with chronic medical conditions. However, by practice the residential supervisor noted that the parent is consulted with all necessary follow-up medical care for the youth and is provided referrals.

No exceptions for this indicator.

4.02 Suicide Prevention

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy, Suicide Assessment (Residential) (P-1247) that addresses key elements of CQI indicator. The policy manual was last reviewed on 1/20/16 and all revisions and additions were approved and signed by the Chief Operations Officer. This policy was last revised in August 2011.

The agency has two levels of supervision, one-to-one supervision and constant sight and sound supervision. A detailed definition is given for both one-to-one supervision and constant sight and sound

supervision in the policy. One-to-one supervision is the most intense level and is used for youth waiting to be removed from the program by law enforcement for a Baker Act. One staff member (who must be of the same gender as the youth, unless it is documented in the case file and/or log book why it is not clinically appropriate) will remain within arm's length, not to exceed 5 feet, of the youth at all times. Constant sight and sound supervision is for youth who are identified as being high risk of suicide but are not expressing current suicidal thoughts or threats. A staff member must have continuous, unobstructed and uninterrupted sight of the youth and be able to hear the youth. For both levels of supervision, the staff assigned to monitor the youth must document his/her observations of the youth's behavior at intervals of thirty minutes or less.

The policy states all admissions to the program are screened for suicide risk using the Florida Network approved six suicide risk questions. Youth screened indicates a suicide risk are placed on one-to-one supervision or constant sight and sound supervision dictated by need until a clinical assessment is completed by a licensed professional or a non-licensed mental health professional under the supervision of a licensed professional. Additionally, if at any time from when the point when a youth arrives at the shelter and any staff observes or believes a youth presents as an immediate threat to themselves or others, the youth will be placed on one-to-one supervision and staff will immediately call 911 and request assistance from law enforcement for a Baker Act and/or transportation for additional assessment. Furthermore, when staff observes any indicators (behaviors, actions, youth demeanor, conversations, etc.) subsequent to the youth's admission into the program that may reflect an increased risk of suicide, a suicide risk screening may be performed. At any time the youth has made suicide gestures or attempted suicide, the program supervisor shall be notified and informed what procedures have been put in place to insure the youth's protection. Any time there is a suicide attempt the agency CEO/COO, the Florida Network and DJJ shall be notified in accordance with DJJ Incident Reporting Policy.

Upon admission to the residential facility, there are six questions that are asked to each youth via the Interface Intake Assessment form: 1. Have you ever attempted to kill yourself; 2. Are you thinking about killing yourself now; 3. Do you have a plan (specific method) to kill yourself; 4. Do you feel that life is not worth living or wish you were dead; 5. Have you recently been in a situation where you did not care whether you lived or died; 6. Have you felt continuously sad or helpless?

If the youth answers yes to any of these six questions, an assessment must be completed by a licensed professional or an unlicensed professional under the supervision of a licensed professional. An assessment must be accomplished within 24 hours after the screening unless the screening occurs on the weekend (from Friday 5 pm to Monday 9am). Then, the assessment must be completed within 72 hours. If the youth answers yes to question 2 or 3 (with an immediate method to enact the Plan), one-to-one supervision shall be provided until an assessment is completed. If a youth answers yes to question 1, 3 (with no immediate method available to enact the Plan), 4, 5 or 6 the youth shall be placed on constant sight and sound supervision until an assessment can be completed. Staff should initial the following actions when it is completed on the Intake Assessment NetMIS form and note any other actions taken in the designated area: place the participant on one-to-one supervision and constant sight and sound supervision as indicated; begin observation log; complete youth safety agreement; alert a supervisor of participant's status; alert the licensed professional or unlicensed professional of the need for an assessment to occur within 24 hours; contact parent/legal guardian and inform them of the participant's status; document in the program log book; document in the participant file.

When a youth returns from a Baker Act facility, the youth will be placed on constant sight and sound supervision until an assessment of suicide risk can be completed by a licensed professional or an unlicensed professional under the supervision of a licensed professional to determine further supervision needs within 24 hrs. After the youth's return to the shelter, unless the screening occurs on the weekend (from Friday 5 pm to Monday 9am), then, the assessment must be completed within 72 hours.

A total of six residential files (6 closed) were provided to the reviewer that had a completed suicide assessment in the last 6 months to assess the requirements of this CQI indicator and agency policy. Four file documents were reviewed to ensure all elements of the CQI indicator were completed. These documents were 1. Intake/Assessment/NetMIS form; 2. Progress Notes; 3. Observation Log; 4. Suicide Assessment form. In all 6 files reviewed, the suicide screening occurred during the initial intake and

screening process. The suicide screening results were reviewed and signed by the residential supervisor and documented in all 6 files. All 6 youths were assessed by a non licensed professional (master's level) residential supervisor under the direct supervision of a licensed professional within the agency. All 6 assessments were faxed to the licensed mental health professional to be further assessed and reviewed. All 6 youth were appropriately placed on constant sight and sound supervision, based on the definition of constant sight and sound supervision in the program policy until the licensed professional completed a further assessment.

In all 6 files, it was documented that the youth's parent/guardian and residential supervisor were notified once the youth was placed on constant sight and sound supervision level. This was easy to find in the file since it was highlighted in blue in the progress notes. Observation logs in all 6 files documented 30 minute (or less) behavioral observations of the youth by a staff assigned to monitor the youth per the indicator and the program policy until the licensed professional was able to further assess and review the assessment. Five of six youth were further assessed and reviewed by the licensed professional within 24 hours. One of six youth was initially assessed on a weekend (Saturday) and was further assessed and reviewed on Monday, within 72 hours, per program policy exception to the 24 hour standard.

Additionally, the regional coordinator reviewed all 6 suicide assessments. In all 6 suicide assessments there were conferring documented with the residential supervisor and/or the regional coordinator with the licensed professional. Supervision level was not changed/reduced until the licensed professional completed a further assessment.

No exceptions for this indicator.

4.03 Medications

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a detailed medication policy that has been reviewed and approved by the agency's Chief Operations Officer on January 20, 2017. The policy includes provisions for the safe and secure storage, access, inventory, disposal and distribution of medication and or over-the-counter medicines in accordance with general rules and contract requirements. A review of this policy revealed that the general provisions of the agency's policy meets the requirement of the medications performance indicator.

The agency has a designated area where it stores all medications accompanying the client upon admission to the residential shelter. The agency has a designated room that is also used as the youth worker workstation room. This room houses the Pyxis MedStation 4000 medication cabinet. The room is secured by a lock on the door knob and can only be opened with a key. The Pyxis MedStation requires two-step authentication in order to access medications. All medications are stored in the Pyxis MedStation. The only medication that is not stored in the Pyxis MedStation is an EpiPen and/or a prescription inhaler. These are not stored in the Pyxis MedStation so that agency staff can have immediate access in the event of a emergency.

The agency opened the Pyxis MedStation and the reviewer observed that medications were stored in separate drawers inside cubes of the MedStation. The agency has a total of three super users for the MedStation. Of these users, one is a registered nurse, one is a physicians assistant and one is a lead direct care worker. All oral medications are stored separately from injectable and topical medications. Narcotics or controlled medications are also stored in the Pyxis MedStation.

The agency does conduct shift to shift counts on all controlled medications housed in the Pyxis MedStation. These counts are done at shift change and completed by two persons. All non-controlled medications are also counted on four other times during an average month. Two of these counselors conducted on the overnight shift and one on a dayshift and one on the afternoon shift. The agency does

maintain a list of staff that have been trained and are authorized to distribute medication.

The agency has a total of two personnel that are assigned to the oversight and management of the medication distribution process for the shelter program. The agency does have a Registered Nurse that is employed for one of the two positions that oversee the medication distribution process. The second staff person in the part-time position is a Physician's Assistant. The registered nurse has primary responsibility for overseeing the medication process. This nurse was interviewed on site and informed the reviewers that she is there on a part-time basis. Of the 20 hours allotted for nursing staff per week, the registered nurse works the majority of the hours. The registered nurse cannot work the full 20 hours allotted for the position, therefore the Physician's Assistant was hired. Both personnel were hired because of the difficulty in locating registered nurses that were able to work the 20 hours per week required by the shelter program.

The nurse is the primary person distributing medications when they are on site. The nurse also reviews health and admission screening records to verify accuracy and completion of residential health screenings. The nurse reviews health admission screening documentation no more than five days after a client has been admitted to the residence for shelter. The nurse is familiar with the Pyxis MedStation knowledge portal. The nurse produces monthly and weekly reports for the agency. The nurse also oversees the disposal process. The nurse also verifies discrepancies. All discrepancies must be cleared prior to the close of the shift that they occurred on. One nurse works 12 hours per week and the second personnel works 8 hours per week.

The agency uses the required medication verification process. The agency calls the pharmacy, submits the information on the bottle, verifies the product in the bottle, documents information on the medication to distribution log, program log, passed down document, and the client's file.

A review of the medication log indicates that all current clients on medication have a documented medication distribution log and all associated prescription medication information, including risk sheets. There were a total of six clients on medication during the time of this on site review.

The agency has a medication process for notifying the parent/guardian when a medication supply is low. This notification is activated and parents are contacted at twenty-one days, fourteen days, and/or seven days.

A total of 2 Medication errors were documented for this indicator. The agency provided full documentation of the measures taken to address the root cause and the remedial training provided to the staff involved in the error. The staff person was re-trained by the Registered Nurse.

No exceptions are documented for this indicator.

4.04 Medical/Mental Health Alert Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has written policies, Medical and Mental Health Alert Process (P-1119) and Medication – Training and Education (P-1200), that addresses key elements of CQI indicator Medical/Mental Health Alert Process. The policy manual was last reviewed on 1/20/16 and all revisions and additions were approved and signed by the Chief Operations Officer. The policies was last revised in 11/16 and 8/15 respectively. The two policies are intended to inform staff of youth admitted with medical or mental health conditions.

A medical and mental health alert system informs staff concerning a youth's condition such as physical activity restrictions, allergies, common side effects of prescribed medication, food and medications that are contraindicated or other pertinent treatment information. Staff are trained and are expected to recognize and respond to any emergency as a result of a medical, mental health or substance abuse problem which may require emergency care, assessment or treatment. Only designated staff delineated in

writing have access to secured medications. Non-healthcare staff must be trained in medication distribution by a licensed Registered Nurse.

Upon admission to the shelter, each youth receives a preliminary medical, mental health, suicide risk, and substance use screening. Any conditions are noted on the Intake/Assessment Form. All medication the youth is taking is listed on the Intake/Assessment Form and the medication record log. Medication, food and other allergies are noted on the Intake/Assessment Form, the medical record log and the outside cover of the file with either Allergy or Medical/Mental Health Alert label. Participant issues, concerns, conditions or physical activity restrictions are noted on the participant board using the appropriate code number. At the beginning of each shift, all incoming staff are to review the participant board and the program logbook. Medical and mental health concerns are discussed at internal participant staffings. All direct care staff receive training in signs and symptoms of mental illness and substance abuse, suicide risk assessment and prevention and CPR/First Aid.

The agency has a coding system that includes 21 codes for various alerts that can occur in the residential setting. The agency places the appropriate number code(s) on a participant board in the youth care worker office for all staff to see at a glance. A medication board is also in the youth care worker office so all staff can see at a glance. A code definition sheet is taped to the work desk in a highly visible location in the youth care worker office. In the files, medication administration/management is documented in the progress notes and is highlighted in pink. Suicide assessments are completed on blue sheets. The agency also places the appropriate number code(s) on the spine of the youth's file. All alerts are updated as needed.

A total of 3 open residential files were randomly selected to assess the requirements of this CQI indicator and agency policy. Three of three youth had a mental health condition (ADHD). Two of three youth were taking medication for the mental health condition. One of three youth was not on medication for the mental health condition. One of three youth had a runaway history. One of three youth is court ordered into the youth shelter. All of these conditions are coded on a participation board in the youth care worker office as well as the spine of the youth's file. One of three youth had a suicide assessment completed on blue sheets in the youth's file.

Pertinent Medical, Medication and Mental Health training of residential direct care staff (youth care worker) is robust. A new employee (DOH: 2/03/17) training file was reviewed. Trainings included: Medication Management (3/10/17-by the program's registered nurse); CPR/First Aid (2/28/17); Suicide Prevention-General (2/22/17); Suicide Prevention-Residential (2/24/17); Mental Health and Substance Abuse (2/24/17); Agency Policy/Procedure trainings by agency staff includes: Medical and Mental Health Alert Process; Crisis Intervention/Mental Health and Substance Abuse Emissions Youth assessment; Suicide Assessment (residential); Emergency Procedures Packet; Residential Admissions Youth Assessment. In-house training by agency staff include: Medication Distribution (4/11/17), Suicide Prevention/Procedures (4/1/17); Signs/Symptoms of Substance Abuse /Mental Health (4/12/17). Video viewing of: Warning Signs: How to help someone who is suicidal.

A Case Staffings binder was reviewed showing documentation of medical and mental health concerns being discussed at internal participant staffings. Individual and/or group staffings were documented on 2/23/17;3/9/17; 3/16/17; 3/24/17. 4/6/17; 6/15/17.

No exceptions for this indicator.

4.05 Episodic/Emergency Care

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy called Episodic Emergency Care. The intent of the policy is to ensure that the agency has comprehensive guidelines to follow and are prepared to respond to emergencies and injuries of all types, both life threatening and non-life threatening.

The agency has a written policy called Episodic/Emergency Care. The policy was last reviewed on January 20, 2017. The agency's Episodic/Emergency Care policy includes measures to ensure the provision of emergency medical and dental care. The policy includes a specific focus on collecting off-site emergency services; parental notification regarding emergencies; incident reporting to the DJJ CCC and FNYFS; daily logging of events/activities; and returns to the shelter, verification of medical clearances, discharge instructions and follow-up care. In addition, the policy addresses the provision of emergency equipment (first aid kits, knife for life, breathing barriers and blood borne pathogen kits); incident reports to DJJ CCC; critique of off-site emergency care; root cause analysis and emergency situations. The agency has three (3) CINS/FINS shelter sites in the State of Florida. The policy in use at this site is the same across all 3 CDS Shelter shelters.

A review of on-site emergency events was conducted. A review of all incidents in the last 6 months was conducted from December 2016 to June 2017. There was a total of one (1) actual incidents that resulted in hospitalization on June 20, 2017 (back issue and uti). All agency emergency events were documented as incidents in the DJJ CCC Log with evidence of parent/guardian notification requirement and obtaining off-site emergency services (i.e. EMS) accordingly.

The agency has a broad range of emergency related training including CPR/First Aid, Fire Safety, Blood Borne Pathogens, and Disaster Training. The agency has access to a Registered Nurse. The agency also is equipped with 4 first aid kits, a knife for life and wire cutters.

There were no exceptions noted for this indicator.