



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

Review of CDS-Interface East

on 04/13/2016

## 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	No rating

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

### Standard 3: Shelter Care

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

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

### Standard 2: Intervention and Case Management

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

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

### Standard 4: Mental Health/Health Services

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

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

## Overall Rating Summary

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

### Rating Definitions

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

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

### Review Team

#### Members

Ashley Davies, Lead Reviewer and Consultant, Forefront LLC

Kevin Greaney, Program Monitor, Department of Juvenile Justice

Cayse Houston, Team Lead, Youth & Family Alternatives

Felicia Vickers-Brown, Senior Child Care Specialist, Hillsborough County

Raylene Coe, Street Outreach Coordinator, Crosswinds Youth Services

**Persons Interviewed**

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

**Documents Reviewed**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Accreditation Reports                        | <input checked="" type="checkbox"/> Fire Prevention Plan             | <input checked="" type="checkbox"/> Vehicle Inspection Reports |
| <input checked="" type="checkbox"/> Affidavit of Good Moral Character | <input checked="" type="checkbox"/> Grievance Process/Records        | <input type="checkbox"/> Visitation Logs                       |
| <input checked="" type="checkbox"/> CCC Reports                       | <input type="checkbox"/> Key Control Log                             | <input checked="" type="checkbox"/> Youth Handbook             |
| <input type="checkbox"/> Confinement Reports                          | <input checked="" type="checkbox"/> Logbooks                         | 5 Health Records   |
| <input checked="" type="checkbox"/> Continuity of Operation Plan      | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 3 MH/SA Records  |
| <input type="checkbox"/> Contract Monitoring Reports                  | <input type="checkbox"/> PAR Reports                                 | 5 Personnel Records  |
| <input type="checkbox"/> Contract Scope of Services                   | <input checked="" type="checkbox"/> Precautionary Observation Logs   | 5 Training Records/CORE  |
| <input checked="" type="checkbox"/> Egress Plans                      | <input checked="" type="checkbox"/> Program Schedules                | 5 Youth Records (Closed)                                       |
| <input type="checkbox"/> Escape Notification/Logs                     | <input type="checkbox"/> Sick Call Logs                              | 5 Youth Records (Open)   |
| <input checked="" type="checkbox"/> Exposure Control Plan             | <input type="checkbox"/> Supplemental Contracts                      | 0 Other  |
| <input checked="" type="checkbox"/> Fire Drill Log                    | <input checked="" type="checkbox"/> Table of Organization            |  |
| <input checked="" type="checkbox"/> Fire Inspection Report            | <input type="checkbox"/> Telephone Logs                              |  |

**Surveys**

- |         |                     |         |
|---------|---------------------|---------|
| 3 Youth | 6 Direct Care Staff | 0 Other |
|---------|---------------------|---------|

**Observations During Review**

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

**Comments**

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

[Rating Narrative](#)

## **Strengths and Innovative Approaches**

### Rating Narrative

The agency has received several grants over the past year that have allowed them to purchase new items and also create a more Trauma Informed Care environment. Lavender scents, pillows, and stress reduction toys have been added to the shelter. Different areas of the shelter have been painted calm and soothing colors.

The Life Skills Educator has been to both “Why Try” trainings.

The agency is using the Challenge Grant and DJJ funding to install new flooring throughout the shelter. This project started at the time of the on-site review but was not completed.

The Basic Center Grant was used to purchase new pictures for the shelter, as well as, outreach materials.

The shelter has had two key staff members out during the past year due to medical reasons. One staff member was a Supervisor and also did data input and the other staff member is the House Manager. Staff within the agency have been fulfilling the requirements of these two positions, as well as, their own positions.

The shelter also had two long-term overnight staff members leave during the past year. As a result, two other staff members were pulled from their shifts to work the overnight shift, who had never done so.

## **Standard 1: Management Accountability**

### **Overview**

#### Narrative

The CDS Family and Behavioral Health Services, Inc. – Interface Youth Program East conducts background screenings prior to hiring of all staff members through their centralized Human Resources offices located in Gainesville, Florida. All CDS staff members receive on the job training at their respective service locations. In addition, many agency trainings are consolidated to reduce costs and to ensure that all staff members receive standardized training. The agency conduct 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 Regional Coordinator position is the highest ranking position for the agency at this location. 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

The agency has a policy and procedure in place for all new personnel, volunteers, and interns to be background screened prior to their hire date. This meets the requirement of the DJJ Background Screening Policy and Procedures. There has been two new staff hired since the last annual review. Both staff members had documentation that their background screening was completed prior to their hire date. All staff were rated "eligible".

There were three staff members who were due for a five-year re-screening since the last annual review. All three members had their re-screenings completed prior to their anniversary date. All three re-screenings were completed less than one year prior to the staff's initial hire date anniversary. The Annual Affidavit of Compliance was completed and submitted to the DJJ Background Screening Unit on January 8, 2016 which meets the requirement.

There were no exceptions to this indicator.

### **1.02 Provision of an Abuse Free Environment**

Satisfactory

Limited

Failed

#### Rating Narrative

There were no allegations of child abuse reported to the CCC since the last review. The abuse registry number is displayed throughout the facility. According to the Unusual Event Book staff has assisted with three abuse registry calls for youth over the last six months. 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.

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.

Three youth were surveyed and one of the three knew where to find the abuse registry's phone number. All three youth reported that they have not been denied an abuse call. All three answered that they have never heard adults being disrespectful when talking to youth, have not heard staff using profanity when talking to youth, and never heard staff threaten a youth. All three stated that they felt safe at the shelter.

Six staff were surveyed and all responded that they have not stopped nor witnessed other staff stop or delay a youth from making a call to the abuse registry. Five of the six staff responded that they have never heard adults using profanity nor witnessed adults threaten a youth at the shelter.

There were no exceptions to this indicator.

### 1.03 Incident Reporting

Satisfactory

Limited

Failed

#### Rating Narrative

There were eight CCC calls since the last Quality Improvement Review. Of the eight reports, seven were reported within the two-hour time frame. Out of the eight reports, four were also logged in the shelters log book. There were four calls not documented in the logbook. However, two of the four calls not documented did have documentation in the log book that law enforcement was notified of the incident.

Exception:

One CCC report was reported outside the two-hour time frame.

### 1.04 Training Requirements

Satisfactory

Limited

Failed

#### Rating Narrative

There were five staff training files reviewed—one was for first year training requirements and four were for in-service requirements.

The one staff completed all their requirements for first year training. That staff member documented eighty-seven hours of training.

There were four staff training files reviewed for annual in-service training. Each of the four staff completed the required forty hours of annual training. All four staff completed suicide prevention training—two of the four staff had documented fire safety training and all of the staff received crisis intervention training. One of the four staff did not have a current CPR/first aid certification.

There was an individual training file for each staff that included an annual training hour tracking form and related documentation (such as certificates, sign-in sheets, and agendas for trainings attended).

Exception:

One staff member did not have a current CPR/first aid certification.

### 1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

#### Rating Narrative

Monthly, the agency prepares a very detailed report titled "CDS Performance and Risk Management Reports". This report includes performance analysis, CINS/FINS program-wide information, CINS/FINS non-residential items,

residential lists, 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 log report and analysis and projections of contractual requirements from NETMIS. The monthly report also includes an incident report summary for all programs. 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 also includes satisfaction survey results data. CDS conducts quarterly peer reviews on the files. The agency also reviews customer satisfaction data during their monthly management team meeting.

There were no exceptions to this indicator.

### 1.06 Client Transportation

Satisfactory

Limited

Failed

#### Rating Narrative

A written policy is in place for transportation of youth. 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. Cameras have been purchased for the van and once a policy is put in place they will begin to utilize them as well.

A sample time frame was reviewed in the logbooks to ensure single client transport were approved. From March 26, 2016 through April 10, 2016 all single transports were documented in the transportation box in the log book. Out of all the single transports documented there were three that documented they were approved, however; did not document the actual supervisor that approved them.

The vehicle logs documented the use of each vehicle. The documentation included: the 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.

Exception:

There were three single client transports that documented they were approved, however; did not document the actual supervisor that approved them.

### 1.07 Outreach Services

Satisfactory

Limited

Failed

#### Rating Narrative

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 six different DJJ Board and Council Meetings that were attended by an employee of CDS. Attached to the outreach documentation are the meetings' agenda to provide verification of attendance, along with hand-written notes from each meeting. 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.



There were no exceptions to this indicator.

## **Standard 2: Intervention and Case Management**

### **Overview**

#### Rating Narrative

The CDS-East Non-Residential Counseling Program provides non-residential services for youth and their families that are primarily in Putnam, Bradford and Union Counties. 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

The program has written policies and procedures in place to ensure compliance with the Florida Network CIN/FINS Operations Manual and DJJ Quality Improvement Standards. Specifically CDS P-1112 sets forth the program's policies with regard to screening; while CDS P-1151 addresses Intake and Assessments policies. Together these policies ensure a consistent centralized screening and intake process that is completed in timely fashion. Screenings are to be completed within 24 hours of referral for services and no later than seven days after the referral. Assessment is to be started within seven days after a referral and should include the screening, Prevention Assessment for non-residential and Needs Assessment for residential, acquisition of medical history, and when appropriate, a suicide assessment. The program's written policies recognize that the assessment is an ongoing process, but for residential clients it should commence within the first 24 hours.

There were eight youth files reviewed: four residential (two open and two closed) and four non-residential (two open and two closed). The files were neat and consistently ordered making for an efficient review of the required materials. All eight of the files reviewed contained intake documentation in conformance with the indicator. Parents and youth acknowledged receipt of information regarding all of the program's services, rights and responsibilities, grievance procedures, and actions that can occur through involvement in the program. Qualified staff completed the screenings for program eligibility well within the required first seven calendar days after referral. In fact, most were completed the same day as receipt of the referral. The program's centralized intake is available and accessible 24 hours a day, seven days a week.

No were no exceptions for this indicator.

### **2.02 Needs Assessment**

Satisfactory

Limited

Failed

#### Rating Narrative

The program has written policies and procedures in place to ensure compliance with the Florida Network CIN/FINS Operations Manual and DJJ Quality Improvement Standards. Specifically, CDS P-1019 outlines that the Needs Assessment and Prevention Assessment Tool (PAT) needs to be completed by a Bachelor or Master's level staff person and signed by their supervisor. Furthermore, that it needs to be completed within 72 hours of

admission into the Residential program or within the two to three face-to-face meetings for those clients admitted into the non-residential program. This policy also requires that an Individual Plan be developed with the youth and family within seven working days. Re-administration of the PAT is required within the last fourteen days of a non-residential client's program participation when they have been in the program more than 60 days.

There were eight youth files reviewed: four residential (two open and two closed) and four non-residential (two open and two closed). Two of the files did not have a supervisor's signature on the Needs Assessment; although one had a flag indicator to notify the supervisor, the other did not. All other indicator requirements were met in each of the files. All files reviewed indicated timely (within 72 hours or within two to three face-to-face meetings) completion of the Needs Assessment by a properly credentialed staff person. None of the eight files were subject to the suicide risk component, but the program's policy CDS P-1019 does require staff to process suicide risks in conformance with this indicator.

Exception:

Two files did not have a supervisor's signature on the Needs Assessment.

### 2.03 Case/Service Plan

Satisfactory                       Limited                       Failed

Rating Narrative

The program has written policies and procedures in place to ensure compliance with the Florida Network CIN/FINS Operations Manual and DJJ Quality Improvement Standards. CDS P-1162 outlines that an Individual Plan be developed within seven working days and contain measurable goals, actual and target dates of completion, and designation of the staff person responsible for implementing the plan.

There were eight youth files reviewed: four residential (two open and two closed) and four non-residential (two open and two closed). Each file contained a timely prepared Individual Plan that contained clear identified needs and goals; the type, frequency and location of services, the staff person responsible, the targeted and actual date of completion (as applicable). Of the four files subject to individual case plan reviews every 30 days for the first three months and thereafter every six months, all were properly reviewed and signed by the youth and the parent.

There were no exceptions to this indicator.

### 2.04 Case Management and Service Delivery

Satisfactory                       Limited                       Failed

Rating Narrative

The program has policies and procedures in place to ensure compliance with the Florida Network CIN/FINS Operations Manual and DJJ Quality Improvement Standards. CDS P-1163 pertains to Case Management, Counseling and Service Delivery and incorporates, by reference, the DJJ Standards and Florida Network CINS/FINS Operations Manual requirements for this indicator. The program designates the non-residential services provided in accordance with F.S. 984.11 as the Family Action Program.

There were eight youth files reviewed: four residential (two open and two closed) and four non-residential (two open and two closed). Counselor case notes were clear and concise. The reviewer confirms that the assigned counselor/case manager provided referrals, as needed, and coordinated and monitored implementation of the Individual Plan. Of the eight files reviewed, none were referred for additional outside services other than the school district's truancy process. Therefore, only nominal monitoring of court orders occurs in that no official report is provided to the school district-initiated truancy petition. However, the program staff is involved in each truancy case and will provide informal input to the court as to the extent of participation or willingness to participate in the program's intervention services.

There were only three of the eight files reviewed subject to the 30 day follow-up. Only one of those clients was found in the 30-day follow-up notebook provided. None of the eight files reviewed were subject to a 60 day follow-up.

Exception:

Only one of the three applicable files documented a 30 day follow-up.

## 2.05 Counseling Services

Satisfactory

Limited

Failed

### Rating Narrative

The program has written policies and procedures in place to ensure compliance with the Florida Network CIN/FINS contract and DJJ Quality Improvement Standards. The program's policy CDS P-1163 details Case Management, Counseling and Service Delivery procedures and/or processes.

There were eight youth files reviewed: four residential (two open and two closed) and four non-residential (two open and two closed). Counselor notes are maintained in each of the files and reveal that the program is providing targeted services in accordance with each Individual Plan, that there are timely reviews being performed, and the youth and parent are participating in such reviews. When in shelter, the youth in the program are monitored and provided group and/or individual counseling at least five times a week. There is evidence in each of the eight files that the case manager/counselor is monitoring the youth's/family's progress in meeting the goals of the Individual Plan. None of the eight files reviewed were referred to an outside service provider; however, the program's CDS P-1163 policy provides for the counselor/case manager to monitor the youth's/family's progress in such instances. All eight files reviewed contained complete documentation of contacts and progress notes.

There were no exceptions to this indicator.

## 2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

### Rating Narrative

The program has written policies and procedures in place to ensure compliance with the Florida Network CIN/FINS contract and DJJ Quality Improvement Standards. CDS P-1157 establishes the composition of a Case Staffing Committee which must include a representative from DJJ, a representative from the program and a representative from the school district (and may include a representative from the State Attorney's office, an alternative sanctions coordinator, representatives from the areas of health, mental health, social services, the youth and/or the parent or guardian, and any persons recommended by the youth, family or Department). This policy indicates it is for situations where the family or youth have not demonstrated progress in achieving goals of the Individual Plan or the needs of the youth or family are not being met or there is unwillingness to participate in services or if the school or parent requests such a meeting. CDS P-1159 is the written policy to ensure a case staffing is convened when requested by a parent or guardian. This policy provides that within seven working days of receiving a written request, that the counselor/case manager will convene a case staffing.

The program defers to the school district's truancy petition process reportedly under sections 1003.21 and 1003.24, Florida Statutes, according to the school district brochure provided by the program. However, the process in place appears to readily adhere to section 984.151, Florida Statutes.

The program 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". Despite there being a referral to the program, the school district "interventions shall stay in place".

The program advises that once a referral is received from the school district, it attempts to contact the child and parent or guardian to obtain voluntary participation in the program. The program staff tracks the status of truancy cases and provides meaningful input to the school district decision-makers, albeit informally, but does not open a CINS/FINS case on a youth until the parent or guardian voluntarily accepts the program's intervention.

The program does not routinely perform case staffings unless, as CDS P-1159 provides, there is a written request by the parent or school. There have been no such requests since the last Quality Improvement Review.

The circuit court orders youth into the program as a consequence of non-attendance or non-compliance with the school district's truancy interventions (see sec. 984.151(7)&(9), Fla. Statutes). The program opens a file on these 'court-ordered' youth and proceeds with CINS/FINS interventions and case management. The court enforces its order via its contempt powers so there is no resort to referrals for case staffing or for a petition to determine that the "child in need of services" as provided in section 984.151(8), F.S.

There were no exceptions for this indicator.

## 2.07 Youth Records

Satisfactory

Limited

Failed

### Rating Narrative

The program has written policies and procedures in place to ensure compliance with the Florida Network CIN/FINS Operations Manual and DJJ Quality Improvement Standards. Specifically, CDS P-1046 requires all program staff to adhere to all confidentiality laws and to keep client files marked confidential and locked in a cabinet or room.

There were eight youth files reviewed: four residential (two open and two closed) and four non-residential (two open and two closed) and all complied with this indicator's standard for marking. The non-residential files were brought to the reviewer in an opaque, rolling briefcase with two combination locking mechanisms and a large label indicating "confidential" in red. The residential files are stored in a locked office or in a locked cabinet.

There were no exceptions for this indicator.

## Standard 3: Shelter Care

### Overview

#### Rating Narrative

The CDS-East program is located at 2919 Kennedy Street in Putnam County, Palatka, Florida. The facility operates twenty-four hours per day, seven days per week and is licensed by the Department of Children and Families (DCF) for twelve beds. The agency serves both CINS/FINS and DCF program participants. The shelter is comprised of a detached building that has a separate split level design with female and male sections of the facility. Each residential section of the shelter can accommodate up to six youth on each side. The female and male sides of the facility are equipped with a large dorm, bathrooms, and a dayroom. The facility includes a kitchen and dining area, Youth Care Worker station, staff offices, a meeting room, and multi-purpose room. The program residential staff includes a Regional Coordinator, a Residential Supervisor, thirteen Youth Care Workers, an Administrative Assistant, a Community Outreach/ Safe Place Specialist, a Life Skills Educator, and a House Manager. A Residential Counselor is assigned to provide counseling and case management services to the residential program. The Youth Care Workers are primarily responsible for completing all applicable admission paperwork, orientating youth to the shelter, and providing necessary supervision and general assistance.

There is no on-site school. Youth attend local area schools if they are not in suspension, expulsion or suffering from an illness. Youth that are not in school spend a majority of their free time in the dayroom either engaged in planned life skills activities, playing video games, watching television or completing homework assignments on the computers. The program also has an effective grievance process. When submitted, grievances are responded to within twenty-four to seventy-two hours of being submitted to staff or the Residential Supervisor.

At the time of the Quality Improvement Review, the shelter was providing services to three CINS/FINS youth.

### 3.01 Shelter Environment

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has a disaster plan that is updated annually. The plan includes all components consistent with FNYFS policy and procedure manual requirements. The plan was submitted to FNYFS on time this year. All annual fire, safety, and health inspections have been conducted, are up-to-date, and are in compliance with their inspection codes for the agency's jurisdiction. Proper documentation for each was provided and are displayed where necessary. The program appears to be free of insect infestation. The program grounds are landscaped and well maintained with a great garden and a volleyball court. No graffiti was detected on any of the furnishings or walls. Each youth has their own individual bed and was covered with all necessities of mattress, pillow, linens, and a blanket. Each bed was nicely made and the rooms were neat and organized. All lighting appeared to be well lit and functioning. There are several places that youth can have their belongings locked up when necessary by staff. The shelter took pride in painting calming colors in main rooms for the youth along with adding calming scents.

Fire drills were completed each month by each of the three shifts within two minutes or less each time. Forms were not consistently filled out with the number of participants. Out of twenty-one fire drills, six drills were missing the documentation of how many participants in the drill. Out of twenty-one drills, two drills were done with zero youth. The program exceeded the amount of mock drills needed for the quarter. They were able to complete six drills for each quarter; two mock drills per shift per quarter. All mock drills were different and had great narrative and documentation. The program is equipped with all the necessary tools (knife-for-life, first aid kits, wire cutters and biohazard bins). All doors are secured with locks and key control is in place. Van was locked and possessed all necessary items.

Along with detailed egress plans, client rules and expectations, abuse line number, and grievances, the agency has the daily schedule posted in the main living areas for the youth to access. The agency has a policy in regards to faith-based activities, allowing youth to participate if they choose so. If a youth chooses to opt out of faith-based activities, they are allowed to participate in regularly scheduled activities. Faith-based activities are not withheld as

a consequence from the youth. There are a variety of different activities that are scheduled for the youth to partake in.

There were no exceptions to this indicator.

### 3.02 Program Orientation

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has a policy in place where a youth is given the opportunity to learn about the program within the first twenty-four hours of that youth going through intake. The youth and staff go over all the key components of the orientation and each will sign the bottom of the checklist stating they did such. The youth and the parent will receive a participant orientation packet and both sign stating they received it.

There were six files review: three open and three closed. All six had all the necessary signatures and were completed the same day of intake.

There were no exceptions to this indicator.

### 3.03 Youth Room Assignment

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has a policy in place to determine a youth's rooming assignment. There is a rooming assignment form that staff fill out with important youth information that helps determine where the youth will be sleeping.

There were six files reviewed: three open and three closed. All six files had the rooming assignment completed with all the necessary information. All the information that was on the rooming assignment corresponded with the information in other places in the file.

There were no exceptions to this indicator.

### 3.04 Log Books

Satisfactory

Limited

Failed

#### Rating Narrative

This program does have a written policy on how to maintain the daily guidelines and entries in their log books.

A random review of log books was conducted for the last six months. There was documentation in all the log books of pertinent information that could impact the security and safety of the youth in the program, including: dates and times of incidents, events or activities, names of youth and staff involved, medications, behavior, and all signatures were recorded.

Important factors are highlighted in the log book on every shift on each youth. Each highlighted color indicates alerts, medications, and the shift leader on duty. All entries were brief and legibly written. All errors were handled appropriately.

The oncoming Youth Care Workers indicated that they reviewed the previous two shifts in order to be aware of any unusual occurrences or problems.

There was inconsistent documentation of the weekly reviews by the Program Supervisor or designee.

Exception:

There was inconsistent documentation of the weekly reviews by the Program Supervisor or designee.

### 3.05 Behavior Management Strategies

Satisfactory

Limited

Failed

#### Rating Narrative

This program has a written detailed description of the Behavior Management System (BMS). This program's main focus is to influence positive behavior and increase accountability in all youth. This program uses a wide range of awards/incentives to encourage and engage the youth in making positive decisions. This BMS is presented to each youth during the orientation process.

There are consequences and sanctions used in their behavior management strategies. These are appropriate consequences that promote skill-building for the youth. All supervisors and staff are trained to monitor the use and practices of rewards and consequences.

This program uses their BMS to promote order, safety and security, fairness, and protection for all youth. This BMS also serves as a positive reinforcement and recognizes constructive dialogue and peaceful resolutions. A new addition of stress balls, pillows, bright paints, and therapeutic wall pictures were added to the female day room to add additional calmness and serenity.

This BMS also has a FACE System, which includes points and levels of the youth's behavior and its consequences for not following the rules. According to the program's definition of the FACE Sub System, it's defined as "an intensive teaching system used to teach the participants who has engaged in serious, inappropriate behavior the alternative of appropriate behavior."

Point sheets are done by each shift every day and reviewed on a daily basis by oncoming and off-going staff.

There were no exceptions to this indicator.

### 3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

#### Rating Narrative

This program has a policy in place that meets general staffing ratio requirements. This policy requires that minimum staffing ratios are maintained as required by the Florida Administrative Code and Contract—one staff to six youth ratio during awake hours and community events and one staff to twelve youth during sleeping hours. This policy also includes providing at least one staff on duty of the same gender of the youth.

In reviewing the staff schedules, all guidelines were followed during youth awake hours, as well as, sleeping hours. Observation of the staff schedule indicates that during the overnight shift, two staff are always present.

A copy of the staff schedule was provided and it was noted that at all times there was the same gender staff on duty with the youth in the program. It was also noted that every effort is made to schedule male and female ratio; however, they have recently lost staff due to promotions and advancement of higher education. Due to staffing issues, it's often more female staff than male staff.

The program shift schedule is posted in a visible place to be viewed daily. There are holdover overtime rotation rosters that includes contact numbers to reach the staff when additional coverage is needed.

This program is equipped with functioning surveillance cameras well positioned and backup tapes to capture coverage of the last thirty days.



Staff observations and documentation of the youth during sleep hours goes beyond expectations and is documented at five, eight, and ten minute intervals during the evening hours when the youth are asleep.

There were no exceptions to this indicator.

### 3.07 Special Populations

Satisfactory

Limited

Failed

#### Rating Narrative

This program 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 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. The program also has policies in place for Domestic Violence, Probation Respite, and Domestic Minor Sex Trafficking youth. This program reports onsite that there has not been any inquiries of Special Populations with the exception of Domestic Violence (DV).

There were four closed DV files reviewed. The youth were either screened by the local Juvenile Assessment Center (JAC) or by the sheriff's office. A face sheet was included in each file. The length of stay did not exceed twenty-one days. Case plans were found in the files with appropriate goals for aggression management, coping skills, and other interventions designed to reduce the youth's behavior upon exit from the program. Models of Aggressive and Passive Communicators were also in the youth files. Goal setting Worksheets and Certificates of Completion Solutions were also present.

There were no exceptions to this indicator.

## Standard 4: Mental Health/Health Services

### Overview

#### Rating Narrative

The CDS-East program has specific policies and procedures related to the admission, screening, interviewing, client inventory, and room assignment of youth to ensure the safety and appropriate supervision of youth admitted in the program. Upon admission, program staff will conduct a full intake interview with the youth and parent/guardian. An initial assessment occurs to determine the most appropriate room assignment given the youth's needs and issues, the current population at the facility, physical space available, and staff's assessment of the youth's ability to function effectively within program rules and expectations. CDS-East staff members conducting the initial interview and assessment considers the youth's health and mental health status, physical characteristics, maturity level, history including gang or criminal involvement, school performance, and family dynamics. Staff members on duty at the time of admission immediately identify youth who are admitted with special needs and risks, such as risk of suicide, mental health, substance abuse, physical health, or security risk factors. The agency's Chief Operation Officer (COO) is a Licensed Mental Health Counselor.

When a youth indicates positive for suicide risk they are placed on Constant Supervision or One-to-One Supervision. The agency utilizes a daily logbook documentation system and an alert board as part of its internal medical/mental health alert system. The agency operates a detailed medication distribution system using the Pyxis Med-Station 4000 Medication Cabinet. The program has a Registered Nurse (RN) on-site at least four days a week. The shelter has a list of staff members that are authorized to distribute medication. The facility is equipped with multiple first aid kits, knife for life and wire cutters. The staff are trained to provide CPR and First Aid services in case of an emergency. Staff members are also trained on fire safety techniques and various emergencies. As of the date of this onsite review, all fire safety equipment is up-to-date and functioning as required.

### 4.01 Healthcare Admission Screening

Satisfactory

Limited

Failed

#### Rating Narrative

The agency utilizes policy P-1117 to address screening for all past or current medical conditions. The policies state each youth will be provided a preliminary physical health screening and also staff will complete the Intake/Assessment Form. Information obtained from the youth's initial screening is recorded on the Intake/Assessment form and the staff person completing the form will note on page 6 if there are any areas of concern or needed follow-up and will initiate the Medical/Mental Health Alert System. The youth and parent/guardian will also be interviewed upon admission about the youth's current medications. This is part of the Medical and Mental Health Assessment Screening process. This process is conducted by a Registered Nurse (RN) if one is on-site. Otherwise, this interview will be conducted by on-duty staff and reviewed by the RN within 72 hours. The Supervisor/Shift Leader on duty will review the youth's intake packet to assess the need of any immediate action.

A total of five residential files were reviewed to assess requirements of this indicator. Of the five files reviewed, all contained Intake/Assessment forms with all health screening sections completed. The agency also captured additional health screening information on a "Screening Health Addendum". This form captures whether the youth is eligible to receive services and screens for any "yes" response to six health related questions. These questions ask the youth "In the last 48 hours have you experienced any Fever; Diarrhea; Vomiting; Sore Throat; Continuous coughing and/or sneezing; and cold-like symptoms". Of the five files reviewed, four youth were on medications and the medication, as well as, the reasons for the medication were documented. Another form was also completed with parent/guardian documenting the name of the medication, the count, and the reasons for it. Two of the files documented the youth had asthma. Both youth were documented in the Medical and Dental Referrals Daily Log for a physical evaluation by the Nurse.

The agency utilizes a Medical Health Follow-Up form. This form aids the staff regarding any health issue that has been confirmed during the health admission screening. Once a staff person identifies a major health issue, a

specific form with information on the health issue is placed in the youth's file. The form is designed to help increase awareness and knowledge of staff serving the youth of any potential health symptoms or identifiers for them to be aware of. This form is only utilized for specific health issues that include nine different health issues. The two youth with asthma had this form completed in their file. There was also another form in two files for ADHD.

There were no exceptions for this indicator.

#### 4.02 Suicide Prevention

Satisfactory

Limited

Failed

##### Rating Narrative

The agency has policy on Suicide Assessment addressing the requirements of this indicator. The initial suicide risk screening consists of the six questions on the Intake/Assessment form. If a youth answers "yes" to any of the six questions the youth will be placed on constant sight and sound supervision until a full suicide assessment is conducted. If the youth is an immediate danger to themselves or others the youth will be placed on one-to-one supervision and staff will immediately call 911 and request assistance for law enforcement for a baker act. If at any time during the youth's stay in the shelter, the youth expresses any suicidal thoughts or ideations the youth is placed on constant sight and sound supervision until a full risk assessment is completed by a qualified staff.

The agency has two levels of supervision. 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 the same gender as the youth) will remain within arm's length of the youth at all times. The second level of supervision, 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. Staff assigned to monitor the youth must document his/her observations of the youth's behavior at intervals of thirty minutes or less for both one-to-one supervision and constant sight and sound supervision.

There were three youth files reviewed and all three files documented the CINS/FINS Intake form was completed during the initial intake and screening process and two of the youth answered "yes" to one of the six screening questions. All CINS/FINS Intake forms were signed by a supervisor. Both youth were immediately placed on suicide precautions until assessed by a qualified professional. The third youth was also immediately placed on suicide precautions at intake due to the youth's Baker Act history (this youth did not answer "yes" to any of the six screening questions). In all three files, the Suicide Assessment form was completed by a master's level counselor within twenty-four hours. All assessments were faxed to the agency's COO who is a Licensed Mental Health Counselor (LMHC), who then reviewed the assessment with the counselor via telephone and signed the assessment and faxed it back to the shelter. The youth's parent/guardian was also notified (in all three cases) of the youth's suicide precaution status. In all three files the youth was removed from suicide precautions and placed on standard supervision. All three files documented thirty minute observations of the youth were maintained the entire time the youth was on precautions. The observation forms were completed in their entirety and signed by the Residential Supervisor. There was documentation in the logbooks each time a youth was placed on suicide precautions and anytime there was a change in supervision status. This information was highlighted in blue making it easy to find.

There were no exceptions for this indicator.

#### 4.03 Medications

Satisfactory

Limited

Failed

##### Rating Narrative

The agency has a very detailed policy on Medication Provision, Storage, Access, Inventory, and Disposal. The policy has detailed procedures for Prescription Medication, Verification of Medication, First Aid and Over-the-

Counter Medication, Utilization of the Pyxis Med-Station 4000, Medication Provision, Supervision, and Monitoring, Medication Errors and Refusals, Medication Storage, Access to Medication, Inventory Procedures, Medication Counting Procedures, Discharge of Youth with Medication, and Disposal.

The shelter provided a list of sixteen staff who are trained to supervise the self-administration of medications. There were two staff on that list who were listed as "Super Users" for the Pyxis Med-Station. One of those staff members is out on medical leave and the other Super User is the Registered Nurse (RN).

The shelter has hired a Registered Nurse (RN) who has been employed at the shelter since November 7, 2015. The RN is on-site four days a week—Monday, Wednesday, and Friday for three to four hours each day, and Sunday in the morning and again in the afternoon. When the RN is on-site she dispenses medications and all other times trained staff dispense the medications. The RN has begun providing some training to staff, most recently a Universal Precautions training. The shelter has been using the Pyxis Med-Station since the beginning of February 2016.

All youth medication is stored in the Pyxis Med-Station. After the youth's information is entered into the Pyxis Med-Station, a bin within the machine is assigned to the youth. Each medication is stored in its own separate bin within the Med-Station so topical medications are always stored separately. The youth's medication is placed in that bin and once it is closed it can only be opened during assigned medication times or for inventory purposes. Staff using the Pyxis Med-Station have to enter a password as well as their finger print to gain access. The shelter has a system in place for refrigeration of medication if needed; however, there was no medication that required refrigeration during the time of review.

All medications are inventoried at admission, when given by maintaining a perpetual inventory with running balances, and at discharge. All controlled medications are also inventoried each shift by two staff members. The inventories are documented on the second page of the youth's Medication Record Log (MDL). All non-controlled medications are inventoried at least once per week, by two staff members and also documented on the second page of the MDL. All medication inventories are also documented in the Program Log Book and highlighted in pink. All sharps in the shelter are inventoried once per week. This documentation was reviewed for the last six months. A separate inventory is done for the disposable razors, as they are used more often than the other sharps and this ensures all razors are accounted for. This inventory was documented for the last six months also.

There were no youth in the shelter, at the time of the review, who were on medication. As a result, five closed files were reviewed to verify the medication administration process. The agency still maintains hard copies of all documents relating to the medication process, as well as, enters all information into the Pyxis Med-Station, as required. The youth's MRL is maintained in the youth's individual file. All MRL's reviewed documented the youth's name, a picture of the youth, allergies, medication the youth was taking with dosage and time to be given, method of administration, side effects/precautions, special procedures/instructions, the location of the medication in the Pyxis Med-Station, staff initials, youth initials, full printed name and signature of each staff member who initialed a dosage, and the full name and signature of the youth receiving medication. The second page of the MRL documented all daily and weekly inventories, and the verification of the medication with the pharmacist. All MRL's reviewed on site document that perpetual inventory counts with running balances are being maintained on each youth. All MRL's reviewed for the youth also documented that all medications were given at prescribed times. All inventories were completed as required, shift-to-shift for controlled medications and at least weekly for non-controlled medications, and documented on the MRL with two staff member's initials. In addition to documenting on the youth's MRL the agency also documents all medication administration in the Program Log Book. An entry is made with the youth's name, medication, and dosage each time a medication is given. This is highlighted in pink for easy identification.

The shelter has had four CCC reports relating to medication errors in the last six months. However, only one of those errors has been since the implementation of Pyxis Med-Station. This error was a result of the youth receiving a medication thirty minutes late. There were no adverse effects to the youth from this error. The remaining three errors were due to a missing pill/incorrect count, a youth not receiving a medication due to being off-site, and a youth receiving an incorrect dosage of medication. There was documentation staff received a written reprimand due to the error on the missing pill/incorrect count. In addition, the RN also completed a medication training with all staff to review proper procedures. There was documentation reviewed for the youth who missed a dosage of

medication. This youth was off-site with a parent and the staff did not give the medication to the parent to be taken while off-site. This staff was re-trained on the proper procedures for medication administration when the youth is off-site. The third error was due to a youth receiving an incorrect dosage of medication for three days. The youth's prescription was changed to a higher dosage and the staff did not document this correctly on the MRL, as a result the youth was receiving a lower dosage than required. The pharmacist was contacted and reported the youth will have no adverse effects from receiving the lower dosage and to begin the higher dosage at the next scheduled time. This staff member received a written reprimand for this error.

Exception:

The shelter has had four CCC reports relating to medication errors in the past six months.

**4.04 Medical/Mental Health Alert Process**

Satisfactory
  Limited
  Failed

Rating Narrative

The agency has a policy in place for the Medical and Mental Health Alert Process. The system is comprised of several components. The agency has a comprehensive Participant Code list that includes eighteen codes for various alerts that can occur in the shelter setting. The agency places the appropriate number next to the youth's name on their large General Alert Board, located in the Youth Care Worker (YCW) office, for all staff to quickly locate as needed. The code definition sheet is taped to the work desk located in the YCW office. The agency also places Participant Codes on the youth information strip located on the spine of the youth's file. The agency also marks allergy codes in a 3-ring notebook located in the kitchen. The logbook also contains four color codes that include Yellow-general information; Pink-medication; Blue-suicide; and Orange-staff reviews. The pass-down section of the logbook is also utilized to communicate codes and other pertinent youth care and program operations information. All alerts are updated as needed. If an alert is updated on the youth's file it is crossed out and initialed.

A total of five open files were reviewed for adherence to this indicator. All files reviewed had an alert that was appropriate to their screening and assessment results. All alerts documented on the youth's file corresponded with the alerts documented on the General Alert Board. There were no youth in the shelter with any food related allergies.

There were no exceptions for this indicator.

**4.05 Episodic/Emergency Care**

Satisfactory
  Limited
  Failed

Rating Narrative

The agency has an Emergency Care Policy in place. There are procedures in place for staff to follow in various different types of medical emergency situations.

There have been no off-site emergency care events since the last Quality Improvement Review. However, the shelter has completed Medical Emergency Drill on each shift in the last quarter. The drills consisted of a bee sting, a fall, and a nose bleed.

First aid kits are located in the staff office and in the van. The kits are checked monthly for expiration dates and replenished as needed. A detailed log is maintained each time the first aid kits are checked, documenting all items that were replenished in the kit and the expiration dates of all the items. The facility had both a knife for life and a wire cutter in the staff office.

A sample of employee files were reviewed and all but one had current CPR and first aid certifications.

