



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of CDS-Interface Central

on 04/08/2014

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	Limited
1.05 Analyzing and Reporting Information	Satisfactory

Percent of indicators rated Satisfactory: 80.00%
Percent of indicators rated Limited: 20.00%
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 Psychosocial Assessment	Satisfactory
2.03 Case/Service Plan	Limited
2.04 Case Management and Service Delivery	Satisfactory
2.05 Counseling Services	Limited
2.06 Adjudication/Petition Process	Limited
2.07 Youth Records	Satisfactory

Percent of indicators rated Satisfactory: 57.14%
Percent of indicators rated Limited: 42.86%
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: 83.33%
Percent of indicators rated Limited: 16.67%
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

Danielle Husband, Program Director, Youth and Family Alternatives – RAP House

Janet Hampton, Management Review Specialist, DJJ Office of Program Accountability



Keith Carr, Reviewer, Forefront LLC

Persons Interviewed

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

Documents Reviewed

- | | | |
|---|--|--|
| <input checked="" 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 | 5 MH/SA Records |
| <input type="checkbox"/> Contract Monitoring Reports | <input type="checkbox"/> PAR Reports | 10 Personnel Records |
| <input type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 7 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 | 4 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

- | | | |
|---------|---------------------|---------|
| 9 Youth | 5 Direct Care Staff | 0 Other |
|---------|---------------------|---------|

Observations During Review

- | | | |
|---|--|--|
| <input type="checkbox"/> Admissions | <input checked="" type="checkbox"/> Posting of Abuse Hotline | <input checked="" type="checkbox"/> Staff Supervision of Youth |
| <input type="checkbox"/> Confinement | <input checked="" type="checkbox"/> Program Activities | <input checked="" type="checkbox"/> Tool Inventory and Storage |
| <input checked="" type="checkbox"/> Facility and Grounds | <input checked="" type="checkbox"/> Recreation | <input checked="" type="checkbox"/> Toxic Item Inventory and Storage |
| <input checked="" type="checkbox"/> First Aid Kit(s) | <input type="checkbox"/> Searches | <input type="checkbox"/> Transition/Exit Conferences |
| <input type="checkbox"/> Group | <input checked="" type="checkbox"/> Security Video Tapes | <input type="checkbox"/> Treatment Team Meetings |
| <input checked="" type="checkbox"/> Meals | <input type="checkbox"/> Sick Call | <input type="checkbox"/> Use of Mechanical Restraints |
| <input checked="" type="checkbox"/> Medical Clinic | <input checked="" type="checkbox"/> Social Skill Modeling by Staff | <input type="checkbox"/> Youth Movement and Counts |
| <input checked="" 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

Standard 1: Management Accountability

Overview

Narrative

CDS Family and Behavioral Health Services, Inc. – Interface Youth Program Central provides both residential and non-residential programs. This program site is located in Gainesville, Florida. The CDS-Central program provides services through a direct local service provider contract with the Florida Network of Youth and Family Services (FNYFS). The CDS-Central agency primarily provides CINS/FINS services in Alachua, Gilchrist and Levy Counties. CDS-Central also operates sister Residential and Non-Residential programs in Lake City and Palatka, Florida respectively. All three (3) CINS/FINS program locations report to the agency’s Chief Executive Officer and Chief Operations Officer that are located in headquarters office in Gainesville, Florida. The daily operations of CDS-Central residential and non-residential programs are overseen by a Regional Coordinator. The Regional Coordinator position is the highest ranking position for the agency at this location. The agency also has 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 (3) service locations in their respective service areas. Other uniform program and operations protocols for all 3 locations include training and professional development exercises.

The CDS Behavioral Healthcare agency conducts background screenings prior to hiring of all staff members. All staff members receive on the job and training at their respective service locations. In addition, many agency trainings are consolidated to reduce costs and to ensure that all staff members received standardized training. The agency conducts outreach throughout their designated service regions to local youth, parents/guardians, local community organizations, partners and stakeholders.

The agency utilizes various data collection methods. Designated agency leadership teams develop monthly and quarterly reports that focus on accountability, risk management, contract deliverables, programming and operations. Reports are analyzed by specific staff and specific strategies are developed to address identified issues and goals accordingly.

1.01 Background Screening

Satisfactory Limited Failed

Rating Narrative

The Annual Affidavit of Compliance with Level 2 Screening Standards was submitted to the Department on January 16, 2014. Thirteen staff required a background screening clearance from the Department prior to their hire dates. All staff had received the background screening clearance from the Department prior to their hire dates. Two staff required a five-year re-screening from the Department. Both staff were re-screened according to departmental policy.

1.02 Provision of an Abuse Free Environment

Satisfactory Limited Failed

Rating Narrative

CDS Central has policy and procedures addressing the reporting of child abuse allegations. CDS staff are legally obligated to report all allegations of child abuse to the Florida Abuse Hotline. The policy also allows for youth to self-report child abuse allegations and access must be unimpeded. This information is also included in the employee handbook. Five residential files were reviewed and all youth received orientation on contacting the Florida Abuse Hotline. The shelter has a binder, which contained written abuse allegations. These allegations were faxed to the Florida Abuse Hotline. There were no grievance forms alleging abuse within the shelter. One abuse allegation was made against staff since the last Quality Improvement review. The staff was placed on administrative leave. The staff was reinstated when the allegation was unfounded. Seven personnel files were reviewed for personnel action. Evaluations were positive of staff’s interaction with youth and their families. One staff received a written reprimand for inappropriate language while in the presence of youth. The Florida Abuse Hotline number was posted throughout the shelter. Nine youth completed a survey during the review period. All youth said they knew about the Florida Abuse Hotline number. Seven youth knew where the number was posted in the shelter. Two youth said staff have used inappropriate language when speaking to them or others.

1.03 Incident Reporting

Satisfactory Limited Failed

Rating Narrative

The agency has an Incident Reporting Policy that addresses incident reporting that coincides with the Florida Network and the DJJ CCC policies. The current policy was last reviewed on January 17, 2014. The agency's policy specifies that the agency notifies the Department's Central Communications Center (CCC) within two hours of the incident, or within two hours of becoming aware of the incident.

There were eight CCC reports from November 2013 through April 2014. All eight were reported to the CCC within the two hour time frame of knowledge of the incident. Reports were detailed and documented corrective action taken. All incidents were recorded in the logbooks and maintained in the incident binder.

1.04 Training Requirements

Satisfactory Limited Failed

Rating Narrative

Two training files were reviewed for pre-service hours and topics. Both staff received over eighty hours of training during their first year of employment with CDS Central. Both staff had received program orientation, suicide prevention, fire safety, CPR, first aid, universal precautions, and cultural competency training topics. Both staff did not have documentation of training on crisis intervention, CINS/FINS Core, and Title IV- Procedures. One staff also did not have documentation of training on signs and symptoms of mental health and substance abuse.

Four training files were reviewed for in-service training topics. Three staff had received over twenty-four hours of training annually. One staff had eight hours of training in the calendar year 2013. Three staff had fire safety training. One staff did not. Three staff had current first aid and CPR certifications. One did not. Two staff had crisis intervention training. Two staff did not. Three staff had suicide prevention training and one did not. One staff received training on signs and symptoms of mental health and substance abuse issues and three did not. One staff had training on universal precautions and three did not. One staff had cultural competency training and three did not.

1.05 Analyzing and Reporting Information

Satisfactory Limited Failed

Rating Narrative

CDS Family and Behavioral Health Services, Inc. is an accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF). The agency wide CARF accreditation is valid through April 2015. CARF International is an independent, nonprofit accreditor of health and human services. The agency has a policy that describes the agency's approach to analyzing and reporting information that adheres to the requirement of indicator 1.05. The agency's policy and practices address the method in which the agency conducts its review of internal program and operational reports to assess trends, events and activities across all three (3) of its program sites in Gainesville, Lake City and Palatka, Florida.

The agency has a robust internal process in which its Leadership and Management team consistently reviews findings that are communicated to staff and stake holders. In this process the leadership and management team reviews internal reports on service delivery, risk management and program operations. Further, the agency routinely assesses several performance, data, and operation areas in order to set goals that result in organizational improvement. The agency aims to do this by reducing errors by mastering and following the agency's policies and procedures. The CDS agency conducts systematic documentation of Meeting Minutes, Quarterly Files Reviews, Annual Training Plan/Calendar Enhancement and Strategic Plans.

The agency generates a Five (5) Year Strategic Plan 2013-2018 and Five (5) Year Risk Management Planning for all of its programs across the entire agency. The agency produces an annual update on its progress towards addressing goals developed in the five (5) year plan.

The agency has set several priority goals for the current fiscal year that include training forms, data management, and medication distribution. The agency has a plan to address training that identified and created orientation topics that will be used across all three (3) of its youth shelters. This helped agency Youth Care Workers, Counselors, and Case Managers with new topics that are now standard. Additional QI efforts included training to improve the consistency of the training form. The agency has developed two (2) new forms. The first form is the year 1 counselor training form. The agency lists all requirements of the following for the following sources and time frames associated with them. These include CINS/FINS, CARF, and CDS agency requirements. This captures Pre-Service, In-Service, and General competency of major clinical forms and documents (screening, suicide assessment, treatment plan, progress notes, and other additional training such as PAT, Motivation Interviewing, etc.). The form was implemented in November 2013 across all residential and non-residential staff. The agency has as some minor implementation issues in terms of the document being used across all agencies. The agency in process of developing a similar form to better capture the training required for On-going staff members. The agency has also added the PREA and DCF Deaf and Hard of Hearing topics to first mandatory training requirement. The second key initiative involves addressing issues regarding the Domestic Violence

Referral (DVR) process and Circuits three (3) and eight (8).

The CDS agency is reviewing its Data system with two (2) major goals in mind. The major goals are for the date to be clean and meaningful. As of January 2014 the agency has updated and created a new eight (8) page NETMIS Intake, Risk Form, and Discharge forms on all admissions and discharges. Improvements were made to include major checklists items and definitions to ensure consistency in all definitions and terms used by the agency. The development of these new changes in the agency's forms and documents resulted in less confusion and more consistency in their orientation/on-boarding new and training staff, as well as everyday use. The agency also updated and revised its Service Tracking form. The major change includes the reduction of or elimination of things that we did not do. The form does not include any service that the agency does not perform. This also includes changes to Headings and Sub-Headings.

The agency still maintains its DCF Substance Abuse Licensure for its Central –Gainesville office. This license affords the agency the ability to help address youth with substance abuse prevention efforts. Serious or chronic substance abuse issues are referred to Meridian Behavioral Health Services Inc. the local SAMH provider.

In October and– November 2013, the agency's non-residential program began working towards using of military time to increase the accuracy of the time of when counseling events are taking place in the AM or PM.

The agency utilizes a standard approach to all of its programs that includes a review of monthly and quarterly reports that it produces to aid in its efforts to self assess its performance regarding major operations, programmatic and risk management issues. These agency reports track trends, patterns and risk management issues. Specifically the agency produces the CDS Performance and Risk Management Reports. This report documents monthly CINS/FINS Performance Report Data. In this report the agency tracks data Outputs, Outcomes as it relates to Screenings, Intakes, Assessments, Discharges, Completers, Outreach Events, Adjudicated while at CDS, Total Served, High Risk, and Target Zip Codes. The agency generates a monthly Shelter Utilization report that tracks youth served at each shelter site. The agency produces a CINS/FINS Risk Distribution chart that tracks risk screened and identified during the Intake process of youth admitted to each of its three (3) youth residential and its non-residential programs.

The agency has been working to ensure that all residential and nonresidential counseling staff receive Prevention Assessment (8 training hrs) Tool and Motivation Interviewing (16 training hours) prior to June 30, 2013. In addition, the agency is working to have all nonresidential staff on JJIS to ensure that they are able to enter the PAT in the JJIS system.

The agency also utilizes several internal plans that include a Risk Management plan; a Strategic Plan (5 yr) Business Plan; Performance Improvement Plan; Technology Plan; Accessibility Planning; Cultural Competency & Diversity; Training; Emergency Plan; Volunteer Participation; and Youth Participation.

Agency produces a monthly Incident report for each of its programs. The report tracks runaway, Physical Fight, Law Enforcement, Maintenance, Computers, Medication Error, Outside Medical, Abuse Reporting, Other. The agency utilizes this data to track major risks impacting its programs. A review of its current incidents was conducted onsite. The agency had a total of one (1) incident documented by the DJJ CCC.

The CDS agency is also a pilot site for the DJJ SNAP program.

Since the last on site review in 2013, the agency completed revisions and updates on thirty-two (32) of the agencies policies. The policies updated by the agency cover Standards 1-4 of the CINS/FINS.

In June of each year the agency's produces an annual data packet that includes cumulative Performance and Data Management results for the entire contract year for all programs.

The agency provided once (1) case of that demonstrated the agency's ability to follow-up regarding on violations of agency work performance or code of conduct violations. The agency had three cases of medication errors and the retraining conducted by the agency in each case.

The agency conducts Peer File reviews to determine the accuracy and completion of its clients files on a routine basis. A review of each file is completed according to the requirements of the DJJ QI Indicators that include section 2.01-2.07. The review process involves assessing client file practice to identifying deficiencies, trends, patterns and completeness of files and to correct these findings accordingly.

The agency Stake holder Surveys are conducted on an annual basis by community stake holders. Employee Satisfaction Surveys on conducted on an annual basis. The agency also does surveys of employees for input on all supervisor and management. The agency also request survey from its Business Partners. The agency sent the survey to 25 and 7 staff returned responses. Results are reviewed by the agency EMT and Leadership. Client and family Satisfaction Surveys are conducted upon client exiting the program.

In general the agency should include evidence that interventions implemented by Regional Coordinators and Executive Leadership to address corrective actions, training's and new initiatives must include evidence that the corrected action or new intervention results in demonstrated or measured improvement. The agency should also document any on-going adjustments utilized overtime to reach the intended outcome.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

The non-residential Counseling Program provides services for youth and their families in primarily Alachua, Gilchrist and Levy Counties. The program receives calls for service from parents, guardians, system partners, and the general community. The non-residential component for CDS Central consists of three (3) Family Action staff members. All Family Action Staff members and residential counseling staff members have access to the agency's Chief Operation Officer who is a Licensed Mental Health Clinician. The screening determines eligible youth and family are referred to the respective residential or non-residential program to start the intake process. If the program is full at the time of referral the agency will make a referral for the family to another appropriate community agency, according to the youth's zip code.

The program has the capability to offer both case management and substance abuse prevention education on an as needed basis. The agency conducts Case Staffing's, which are statutorily-mandated committees that develop formalized treatment plans for status offenders when all other services have been exhausted. If needed, the Case Staffing Committee can also recommend the filing of a CINS Petition with the court. Both the Residential Supervisor and residential and non-residential CDS-Central counseling staff are engaged in partnerships with local schools systems regarding the options available for status offenders and the overall petitions process and displayed a high level of knowledge and insight regarding their involvement in the community in this area.

2.01 Screening and Intake

Satisfactory

Limited

Failed

Rating Narrative

Nine files were reviewed for this standard. Five of the files reviewed were residential files and four of the files reviewed were non-residential files. All nine files reviewed met the standard as required.

All nine files had the screenings completed within 7 days of the referral and it was determined all of the residential youth referred were screened and admitted on the same day. The agency also maintains a comprehensive orientation package for parents/guardians and a separate package for youth. All of the required components were included within this package for both the residential program and non-residential program.

There were only minor exceptions noted for this standard. Two of the residential files did not include a parent/guardian checking each box and only included the parent/guardian's signature at the bottom of the page and one residential file did not include the youth checking each box and only the youth's signature at the bottom of the page.

2.02 Psychosocial Assessment

Satisfactory

Limited

Failed

Rating Narrative

Nine files were reviewed for this standard. Five of the files reviewed were residential files and four of the files reviewed were non-residential files. All nine files reviewed met the standard as required, as the psychosocial assessments were all completed within the required time frames and all were completed by a staff member with a bachelor's degree or higher.

There were only minor exceptions noted for this standard. One of the five Residential Assessments did not include a Supervisor's signature.

Also, one of the Residential youth reviewed had been directly released from a Baker Act and admitted to CDS shelter. However, the youth was not placed on Constant Sight and Sound (as required per agency policy) upon admission. Youth denied all 6 questions but had been released from CSU and admitted to shelter on new medications for depression.

2.03 Case/Service Plan

Satisfactory

Limited

Failed

Rating Narrative

Nine files were reviewed for this standard. Five of the files reviewed were residential files and four of the files reviewed were non-residential files. All nine files reviewed reflected the case plans were initiated within the required time frames and the goals were related to the issues identified in the psychosocial assessment.

The Residential files reviewed did not include services prescribed for the youth that had the frequency and duration of the services as measurable or individualized. During the review of the residential files, the frequency of services to be provided was documented in ranges (3-5x a week) or as a maximum (up to 3x a week).

Five of the nine case plans reviewed did not include the youth's signature on the plan (4 Residential and 1 Non-Residential) and three of the five residential case plans reviewed did not include the parent/guardian signature (one included documentation of verbal approval of parent over the phone for the case plan). One Residential file did not include a supervisory signature on the plan.

The Residential files reviewed included three case plans with implementation dates/signature dates or goal dates that did not match. One plan reviewed included the counselor and supervisor signing the plan the day prior to the implementation of the plan, another plan reviewed had an implementation date of 3/19 but the goals were effective 3/17 and all parties signed the plan on 3/26, and a third plan reviewed contained actual goal completion dates that were typed onto the plan, which were after the date the plan was signed by all parties.

The Non-Residential files reviewed included three case plans with implementation and signature dates that did not match. One plan reviewed included electronic date signatures for all parties for 12/18/13, however, there was a note in the file that the counselor did not meet with the youth on 12/18/13 due to school testing and the first session held with the youth and parent was on 1/7/14. Another case plan reviewed included electronic signature dates and the plan was initiated on 12/18/13 but there was no note included in the file documenting the counselor met with the youth and family or a session had occurred. A third Non-Residential file reviewed included a case plan that reflected the youth was admitted for services on 11/11/13, however, the youth had been admitted for services on 11/6/13, as reflected in the NetMIS documentation and the psychosocial assessment. The case plan includes an implementation date of 11/13/13 but all parties signed the plan on 11/11/13 and objectives were started as of 11/11/13. The same plan included a photocopy of the goal page related to Drug prevention instead of the original copy of the sheet and it appeared to have had the dates altered on the goal sheet using white-out.

2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

Rating Narrative

Nine files were reviewed for this standard. Five of the files reviewed were Residential files and four of the files reviewed were Non-Residential files. All nine files reviewed demonstrated clear evidence that the counselor was actively working with the youth and providing support to the family as necessary. The agency maintains a process for making referrals in the community for the youth upon discharge.

2.05 Counseling Services

Satisfactory

Limited

Failed

Rating Narrative

Nine files were reviewed for this standard. Five of the files reviewed were residential files and four of the files reviewed were non-residential files. All nine of the files reviewed included a case plan in the file with goals for the youth and family. The case plans developed addressed the presenting problems at intake and as determined in the psychosocial assessment.

The agency did not consistently meet the requirement of the youth receiving group counseling at least 5 days a week. A review of a 16 week period (12/16/13-4/4/14) demonstrated the youth received an average of 3.5 days of group counseling each week.

Five of the nine files reviewed did not reflect the youth received counseling services as prescribed in the case plan (3 Residential file and 2 Non-Residential files). Two residential youth did not have weekly individual sessions as indicated on service plan. One non-residential case called for bi-weekly family counseling sessions but there was no evidence of family counseling in the file after intake. Another non-residential youth had weekly individual and family counseling prescribed and also had weekly case management prescribed and the notes did not reflect these services occurred weekly as required by the case plan.

The agency reports the development of a new form that is being implemented to review cases in a treatment team setting for the Residential Program. The agency also reports files are reviewed quarterly on a random basis for completeness and review.

2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

Rating Narrative

The agency has two cases that are currently open to the CINS/FINS Case Staffing/Petition Process and both files were reviewed. Neither case reviewed went before the committee as a result of a 7-day letter submitted by a parent/guardian.

The agency acts as the lead for the Case Staffing Committee in the community and both cases reviewed included a representative from the local school district. One of the cases reviewed also included the involvement of the State Attorney's Office and another community agency.

The agency reports the Case Staffing Committee is notified via email regarding the dates of the staffings and the agency provided an email to show the scheduled staffing dates for the school year.

The agency reports the families of both youth were notified verbally over the phone about the staffing, however, the files did not contain the documentation to verify the family had been notified at least 5 days prior to the date of the staffing.

One of the two files reviewed did not include the a new or revised plan for services and did not have documentation that the parent/guardian had received a report within 7 days of the meeting that included the staffing recommendations and reasons for recommendations.

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

The agency maintains the open Residential files in a file cabinet in the staff office of the youth dorm. The room is not accessible to youth and the files are neatly organized in binders. The files are neatly organized and include a chart index system, making navigation through the files very easy. All of the Residential files reviewed included a cover that had Confidential clearly indicated on the file.

The Residential program maintains the closed files in a separate locked room in the shelter building. The closed files undergo a final review process and then are transferred into the closed filing system.

Six Non-Residential files were also reviewed and all six files were marked with confidential on the front cover of the file. The Non-Residential files also contain a chart index system and were well organized and easy to navigate. The Non-Residential files are stored off-site at satellite office locations and the Non-Residential Program Director shared the files are all maintained behind locking doors, in locked cabinets in the community based office settings.

Standard 3: Shelter Care

Overview

Rating Narrative

The CDS-Central youth shelter is located in Gainesville, Florida in Alachua County. The CDS-Central facility operates twenty-four hours per day, seven days per week and is licensed by the Department of Children and families for twelve (12) beds. The agency serves both CINS/FINS and DCF program participants. At the time of the quality improvement review, there were a total of nine (9) youth in the shelter on day one of the onsite program review. The shelter is comprised of a detached building that is a one level landscape or ranch style design. The shelter has both a front and side entrance. The building is designed with equally sized dorms and day rooms for female and male residential clients. Each residential section of the shelter can accommodate up to 10-12 residents. The female and male sides of the facility are equipped with a large dorm, bath rooms and a dayroom. The facility includes a kitchen and dining area, Youth Care Work station, staff offices and a smaller meeting rooms, multi-purpose recreation and an instruction/class room. 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. Youth attend local area schools if they are not on suspension, expulsion or suffering from an illness.

The exterior of the facility is well maintained and the grounds are landscaped. The facility site has limited green space, but does have an open court in the rear of the facility. The rear area of the facility is enclosed by a private wood fencing.

The program staff for the Residential staff includes a Regional Coordinator, a Residential Supervisor, more than twenty (20) full-time and part-time Youth Care Workers and one (1) administrative staff person. A Senior Residential Counselor is assigned to provide counseling and case management services to the residential program. The Direct Care Worker staff members are primarily responsible for completing all applicable admission paperwork, orientating youth to the shelter, and providing necessary supervision and general assistance.

The shelter's direct care staff members are trained to provide the following services for the youth: screening, medication administration; health, mental health and substance abuse screenings, first aid, cardio pulmonary resuscitation (CPR) and referrals. The supervisory and counseling staff members receive referrals and monitor service delivery on a consistent and on-going basis.

The Direct Care Worker staff offices are located inside the youth shelter. The medication and general supplies are stored in the Youth Care Worker staff member's office in a locked cabinet. The residential shelter also includes administrative offices for the Regional Coordinator, Residential Supervisor, Counselor and other staff offices. Residential services, including individual, family, and group services, are provided to youth and families. Case management and substance abuse prevention education are also offered. 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.

The shelter is designated by the Florida Network to provide staff secure services.

3.01 Shelter Environment

Satisfactory
 Limited
 Failed

Rating Narrative

A tour of the shelter revealed that all furnishings were in good repair. The shelter was free of insect infestation and grounds were well landscaped and maintained. There were bathrooms located throughout the shelter and both dorms, male and female, had a bathroom with a shower shared by youth in the dorm. All bathrooms were generally clean and were functional. There was no graffiti observed on any walls, doors, or windows. There is male and female dorm, which each house twelve youth. The dorm area is made up of bunk beds and single beds. Each youth has their own bed with linens, blanket, and a pillow. All appeared to be in good condition. Each youth is also given a bin and with lid to keep personal items in, not of value. There is a daily schedule posted in both the male and female living areas. There was documentation observed in logbooks that the daily schedule is generally followed and youth are engaged in meaningful structured activities with minimal idle time. The youth receive at least one hour of physical activity each day and are provided opportunities to participate in faith-based activities. Youth are provided the opportunity to do homework and read and this was observed during the on-site review. All health inspections are fire inspections were current and noted no violations. There was also documentation of safety inspections for fire extinguishers and sprinklers. The shelter conducts fire drills three times each month, once on each shift.

3.02 Program Orientation

Satisfactory
 Limited
 Failed

Rating Narrative

The agency has a policy for Program Orientation that was last reviewed on January 17, 2014. A review of six youth files revealed that all youth are oriented to the shelter upon intake. An Orientation Checklist is completed, which covers all requirements in the indicator. This checklist was found in all six files reviewed and was signed and dated by the youth and staff member. The youth is also given an Orientation Packet that covers all items discussed on the Orientation Checklist. The youth and parent sign that they received this Orientation Packet. This form was found in all six files reviewed.

3.03 Youth Room Assignment

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy for Youth Room Assignment that was last reviewed on January 17, 2014. The shelter uses the Intake/Assessment Form to classify youth for room assignment. The section on the Intake/Assessment form covers all elements required by the indicator for classifying a youth for room assignment. This portion of the form was found to be completed in all six files reviewed on the day of intake. Four of the files reviewed documented the youth was assigned a bed number and the top or bottom bunk. The remaining two files did not assign the youth a bed or bunk. The classification section was completed; however, the bed number and top or bottom bunk were left blank. One of the six files reviewed documented the youth was on sight and sound supervision at intake and this was documented in the classification section of the Intake/Assessment Form. There was also documentation the youth slept in the dayroom and once the youth was removed from sight and sound supervision the form was updated with the bed number and top or bottom bunk. Initial interactions and observations of the youth were documented in all six files reviewed. There was documentation of collateral contacts and any applicable alerts were documented in the file and entered into the shelters alert system.

3.04 Log Books

Satisfactory

Limited

Failed

Rating Narrative

The shelter has bound logbooks. Each logbook had the beginning and ending date on its title page. There were specific items staff needed to report on for each shift. These included intakes, dispositions, runaways, full suicide assessments completed on each shift, abuse reports, unusual events, emergency mental health and medical events, and other pertinent information. Staff assigned to the shift are noted in the logbooks. The staff responsible for administering medication are designated in the logbooks as well. Youth counts were routinely recorded at the beginning and ending of each shift. The counts documented if the youth were in house or off campus as well. All entries had times and signatures of the recorders. Entries were recorded in black ink. Errors, when they occurred were struck through.

Two incidents were reported to the Central Communications Center (CCC), which involved medication errors. The incidents were recorded in the logbooks. One entry was not detailed.

Rating Narrative

The shelter has policy and procedure addressing the behavior management system. It is also described in a pamphlet. The behavior management system is competency based. Youth are placed on the assessment level when they arrive at the shelter. Youth stay on the assessment level for three days. Youth are expected to read the orientation packet, participate in daily activities, and demonstrate appropriate social skills. Once youth complete the assessment level, they advance to the daily level. At this level, youth are expected to demonstrate additional skills related to anger management, problem solving skills, and accepting feedback. At the achievement level, youth are able to negotiate points and obtain additional privileges. Youth have additional skills they must learn on this level as well. These skills address resisting peer pressure, volunteering, and conflict resolution. Each level has specific skills youth are rated on by staff. Points are awarded for demonstrating the skills associated with each level. The points may be redeemed for additional telephone calls, participation in off campus activities, treats, and extended bed time. Major rule violations will result in placement on the sub system phase. While on the sub system phase, youth are restricted from privileges and must earn additional points in order to "pay off" their fine associated with the major rule violation. Five residential files were reviewed and all youth received orientation on the behavior management system. Staff are evaluated on their implementation of the behavior management system. This is done on an annual basis. It was difficult to determine the staff responsible for monitoring the point sheets for consistent application and deduction of points.

3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

Rating Narrative

The shelter has a video surveillance system. It has a storage capacity of thirty days. Three evenings were viewed during the review period. Each evening, two staff were assigned to the third shift. A female staff was assigned to the female dormitory and the male staff to the male dormitory. Bed checks were conducted at the required fifteen-minute intervals. The shelter has a scanner, which is used to document bed checks. The bed checks are electronically entered and printed and placed in binders. On one evening there was approximately fifty minutes between checks (March 20, 2014). A review of the logbooks found two to three staff were assigned to the third shift. The logbooks also documented that ratio requirements were met. On one day, fourteen youth were in residence and a minimum of three staff were assigned to each shift. A review of the logbooks also found four staff were generally assigned to the second shift. Staffing on the first shift was staggered Monday through Friday. Three staff are assigned to the first shift on weekends. The shelter has a master schedule, which is available to staff.

3.07 Special Populations

Satisfactory

Limited

Failed

Rating Narrative

The agency has written policies that addresses all of the major elements of the 3.07 Special Populations indicator. At the time of this on site QI review, there were a total of four (4) Domestic Violence Respite client case files were reviewed. Of these residents, two (2) youth stayed a total of 4 days; a third youth stayed a total of fourteen (14) days; and a fourth youth stayed in sixteen (16) days in shelter before being discharged from the DVR program. Four (4) out of 4 of the youth began their placements as DVR referrals and later transitioned into CINS/FINS services following their fourteen day placement approved by the Florida Network in accordance with DVR program policies. Each of the youth admitted under the DVR program had documented domestic violence charges making them eligible for admission under the DVR program requirements. Documentation of Florida Network approval of the DVR placement was provided in each of the three cases reviewed. The service plans in each of the 4 files also contained service plans that addressed the DVR placement issues such as anger management, conflict resolution, coping skills and decision making. An interview with the Shelter Manager confirmed that Florida Network policies and procedures related to the DVR program are generally being followed by staff.

The agency had a total of two (2) youth that were designated as Staff Secure Referrals. Both cases are referrals from other Florida Network providers not located in Gainesville, Florida. A review of both cases indicates that the program accepted youth that met the legal requirements of F.S. 984 for being formally courted ordered in to Staff Secure status. The agency does have a program that includes in depth orientation; Assessment and treatment planning specific to the needs as outlined in the court order and other assessment documents. The program approach includes enhanced supervision and counseling, as well as security measures. The program also engages parents with methods that require involvement from parents/guardians and strategies for collaborative aftercare methods.

The CDS agency policy requires that a CDS staff person be designated to monitor all staff secure youth in the shelter by evidence of documentation in the program logbook. Some shift notes do not document consistently that a specific staff member was assigned to monitor a Staff Secure youth on each work shift. Specifically, there twenty-nine (29) instances over a series of work shifts in which the agency did not document the specific staff person identified for monitoring a designated staff secure youth during their staff secure placement. Program file information from the agency indicates that one (1) out of the four (4) DVR youth had stays that extended beyond the fourteen (14) day length of stay.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The CDS-Central program has specific 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. Staff conducting the initial interview and assessment considers the residents' health and mental health status, physical characteristics, maturity level, history including gang or criminal involvement, school performance, and family dynamics. Staff on duty at the time of admission immediately identifies youth who are admitted with special needs and risks, such as risk of suicide, mental health, substance abuse, physical health, or security risk factors, etc.

The Residential Supervisor, Regional Coordinator and or Licensed Clinician are notified immediately if risks and alerts are present and recommendations regarding placement and supervision are provided to the direct care staff. The agency's Chief Operation Officer (COO) is a Licensed Mental Health Counselor. All of the aforementioned staff members have state licenses that are authorized by the State of Florida, Department of Health, Division of Medical Quality Assurance are still in effect. When a resident indicates positive for suicide risk they are placed on Constant Supervision or One-to-One Supervision. This information is documented in the daily log, on the alert board, and in the youth files using internal medical/mental health alert system.

Youth admitted to the shelter with prescribed or over the counter medication the agency secures these medications at that time. The agency then conducts a verification of the medication by contact the pharmacy the originally filled the script. Medications are stored in a double locked cabinet, and topical and/or injectable medications are stored separately from oral medication. The program has a list of staff who are authorized to distribute medication ensures that an approved staff is scheduled on each shift.

The facility is equipped with multiple first aid kits, knife for life and wire cutters. The staff members are trained to provide CPR and First Aid services in case of an emergency. Staff members are also trained on fire safety techniques. As of the date of this onsite review, all fire safety equipment is up to date and functioning.

4.01 Healthcare Admission Screening

Satisfactory
 Limited
 Failed

Rating Narrative

The agency has a policy in place for Preliminary Physical Health Screening last reviewed on January 17, 2014. Upon admission to the shelter, each youth is screened in order to obtain information related to the youth's physical status. This information is recorded on the Intake/Assessment Form. The form addresses all elements of the indicator. Once the intake process is complete, the intake staff person and a supervisor or shift leader reviews the packet including the Intake/Assessment Form. Any health concerns that require a follow-up are addressed at that time through consultation with the parent/guardian and documented on a Medical Health Follow-up Form. If the parent/guardian is unavailable, attempts are made to contact the youth's physician.

A total of six youth files were reviewed, two open and four closed, to assess requirements of this indicator. All files contained documentation of the Intake/Assessment Form was completed the day of the youth's admission. All major sections involving health screening were completed. If necessary, the written procedures addressed the referral process and follow-up medical care.

4.02 Suicide Prevention

Satisfactory
 Limited
 Failed

Rating Narrative

The agency has a Mental Health, Substance Abuse, and Suicide Risk Screening policy in place last reviewed on January 17, 2014. 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.

The agency's CEO is a Licensed Mental Health Counselor (LMHC) and reviews suicide risk assessments completed at the shelter. The shelter employ's two Master's level counselor who complete all suicide risk assessments and then consult with the LMHC. There were four youth files available for review for youth who had been placed on suicide precautions. All four youth were placed on suicide precautions at intake due to issues identified during the screening process. All youth remained on sight and sound supervision until assessed by a qualified professional. All youth were seen and accessed by a master's level counselor, using a suicide risk assessment, within twenty-four hours. All suicide risk assessments contained documentation of consultation with the LMHC. All risk assessments were faxed to the LMHC for review and signature. All youth were placed on normal supervision levels upon completion of the assessment. One of four files documented the youth was on suicide precautions during the overnight shift and there was documentation the youth slept in the dayroom. All four youth had thirty minute observations documented the entire time they were on suicide precautions. All suicide precaution events were documented in the logbook.

One additional shelter file reviewed documented the youth entered the shelter upon release from the local crisis stabilization unit, with a new diagnosis of depression along with medication for depression. Even though all intake screenings documented the youth was not at risk for suicide, the youth was not placed on constant sight and sound supervision at intake, until seen and assessed by counselor, according to the agency's policy.

4.03 Medications

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy on Medication Provision, Storage, Access, Inventory, and Disposal that was last reviewed on January 17, 2014. At intake, all medication is received by a staff member directly from the youth's parent/guardian. Only medications from a licensed pharmacy, with a current, properly labeled patient-specific label intact on the original medication container will be accepted. Any medication not coming from a licensed pharmacy requires written directions for use from the attending physician. Staff must also contact the pharmacy by phone to verify the script is current and valid. Staff must document on the Medication Record Log who they spoke with to verify the medications. The agency provides first aid supplies only, any other non-prescription medicine used by the youth must be provided by the youth's doctor.

Trained staff members assist youth in the self-administration of prescribed medications. When the medication is given youth and staff initial the designated space on the Medication Record Log and staff then records the remaining count in the designated space. All medications are stored in a locked medication cart in the staff work area between the male and female dorms. This area is inaccessible to youth unless accompanied by a staff member. The cart is double-locked and each youth has their own separate tupperware container for their medication. All topical medications are stored in a separate drawer and a small, locked, refrigerator is located in the same area for any medications requiring refrigeration. Controlled medications are locked in a separate container inside the medication cart. The shelter does not give over-the-counter (OTC) medications, unless prescribed, so therefore there are no OTC's to inventory. There was a small supply of sharps, disposable razors youth can bring in, located in a drawer in the staff office; however, there was no weekly inventory maintained for these razors. A sharps inventory was provided for sharps located in the kitchen including two knives and a pair of scissors. This was inventory was completed each time one of these items was used, which usually resulted in inventories being completed approximately twice a month instead of weekly.

There were five youth files reviewed to verify the medication administration process. The youth's Medication Record Log (MRL) is maintained in the youth's individual file. All MRLs reviewed documented the youth's name, a picture of the youth, allergies, side effects, medication the youth was taking with dosage and time to be given, method of administration, side effects/precautions, special procedures/instructions, 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. All MRLs documented medications were given in the time frame specified. A perpetual inventory with running balances was maintained on each MRL, as well as, shift-to-shift inventories for controlled medications and weekly inventories for non-controlled medications. There was also documentation on each MRL that the medication was verified by a pharmacist, there was documentation of the staff who verified the medication and who the staff spoke to at the pharmacy.

There was one CCC report reviewed that documented a missed dose of medication. The missed dose of medication was caught the next day during a weekly medication count. The CCC was notified and an internal investigation was completed. The staff involved in the incident did receive a verbal reprimand and additional training.

There was a small supply of sharps, disposable razors youth can bring in, located in a drawer in the staff office; however, there was no weekly

inventory maintained for these razors. A sharps inventory was provided for sharps located in the kitchen including two knives and a pair of scissors. This inventory was completed each time one of these items was used, which usually resulted in inventories being completed approximately twice a month instead of weekly.

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 that was last reviewed on January 17, 2014. Upon admission to the shelter, each youth receives a preliminary medical, mental health, suicide risk, and substance abuse 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 allergies, food allergies, and any other allergies are noted on the Intake/Assessment Form, the medical record log, and on the outside cover of the youth's file with either an "Allergy" or a "Medical/Mental Health Alert" label. In addition, youth issues, concerns, conditions, or physical restrictions are noted on the youth board using appropriate codes. All incoming staff review the youth board and logbook at the beginning of each shift. Medical and mental health concerns are discussed at internal youth staffing's.

A review of six youth files was conducted to verify the shelters alert process. All six files documented any applicable alerts on the spine of the youth's file. All medical related information was documented on the Intake/Assessment Form inside the file. The alerts and issues documented in the files reviewed corresponded with alerts documented on the alert board in the staff work area/office. Alerts on the board were coded with numbers 1-18, with each number representing a different alert. Staff interviewed were knowledgeable of the alert system.

4.05 Episodic/Emergency Care

Satisfactory Limited Failed

Rating Narrative

The agency has an Emergency Care Policy in place that was last reviewed January 17, 2014. There are procedures in place for staff to follow in various different types of medical emergency situations.

The Shelter has not had any emergency or episodic care events since the last Quality Improvement Review. All staff are trained in CPR, first aid, and AED. The shelter has an Emergency/Episodic Care Log in place in case an event happens. Also the shelter completes emergency medical and dental drills in order to prepare staff for an actual event. The shelter has first aid kits located throughout the building and a knife-for-life and wire cutters.