



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of CDS-Interface East

on 04/10/2013

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 Interagency Agreements and Outreach	Satisfactory
1.06 Disaster Planning	Satisfactory
1.07 Analyzing and Reporting Information	Satisfactory

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

Standard 3: Shelter Care

3.01 Youth Room Assignment	Satisfactory
3.02 Program Orientation	Satisfactory
3.03 Shelter Environment	Satisfactory
3.04 Log Books	Satisfactory
3.05 Daily Programming	Satisfactory
3.06 Behavior Management Strategies	Satisfactory
3.07 Behavior Interventions	Satisfactory
3.08 Staffing and Youth Supervision	Satisfactory
3.09 Staff Secure Shelter	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	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

Keith D. Carr, Lead Reviewer/Forefront LLC-Florida Network of Youth and Family Services

Carolyn Kehr, Youth and Family Alternatives, Inc.

Becky Lynn, DJJ Circuit 5



Quality Improvement Review

CDS-Interface East - 04/10/2013

Lead Reviewer: Keith Carr

Tom Popadak, FLN Training Coordinator

Heather Prince Director of Adolescent Services Stewart Marchman Act Behavioral Healthcare

Persons Interviewed

- | | | |
|--|--------------------------|-------------------------|
| <input checked="" type="checkbox"/> Program Director | 2 Case Managers | 0 Maintenance Personnel |
| <input type="checkbox"/> DJJ Monitor | 3 Clinical Staff | 2 Program Supervisors |
| <input type="checkbox"/> DHA or designee | 0 Food Service Personnel | 5 Other |
| <input type="checkbox"/> DMHA or designee | 0 Health Care Staff | |

Documents Reviewed

- | | | |
|--|---|---|
| <input type="checkbox"/> Accreditation Reports | <input type="checkbox"/> Fire Prevention Plan | <input type="checkbox"/> Vehicle Inspection Reports |
| <input type="checkbox"/> Affidavit of Good Moral Character | <input type="checkbox"/> Grievance Process/Records | <input type="checkbox"/> Visitation Logs |
| <input type="checkbox"/> CCC Reports | <input type="checkbox"/> Key Control Log | <input type="checkbox"/> Youth Handbook |
| <input type="checkbox"/> Confinement Reports | <input type="checkbox"/> Logbooks | 7 Health Records |
| <input type="checkbox"/> Continuity of Operation Plan | <input type="checkbox"/> Medical and Mental Health Alerts | 6 MH/SA Records |
| <input type="checkbox"/> Contract Monitoring Reports | <input type="checkbox"/> PAR Reports | 12 Personnel Records |
| <input type="checkbox"/> Contract Scope of Services | <input type="checkbox"/> Precautionary Observation Logs | 8 Training Records/CORE |
| <input type="checkbox"/> Egress Plans | <input type="checkbox"/> Program Schedules | 14 Youth Records (Closed) |
| <input type="checkbox"/> Escape Notification/Logs | <input type="checkbox"/> Sick Call Logs | 24 Youth Records (Open) |
| <input type="checkbox"/> Exposure Control Plan | <input type="checkbox"/> Supplemental Contracts | 0 Other |
| <input type="checkbox"/> Fire Drill Log | <input type="checkbox"/> Table of Organization | |
| <input type="checkbox"/> Fire Inspection Report | <input type="checkbox"/> Telephone Logs | |

Surveys

- 3 Youth 5 Direct Care Staff 0 Other

Observations During Review

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

Comments

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

Rating Narrative

Staff members interviewed onsite and others that participated during the onsite program review are well prepared for the onsite Quality Improvement review. Staff responded to requests for information in a timely manner.

I have never been on a QI Review before where there were not "Exceptions" in Standard Two. This program has clear, easily understood, thorough documentation and record keeping practices. It was a pleasure (and learning experience) to be part of this review.

This review of the Interface East program was a delight. The staff were accessible and cooperative at all times.

Strengths and Innovative Approaches

Rating Narrative

CDS Family and Behavioral Health Services, Inc. is a behavioral health agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF). The agency's accreditation is valid through April 2015. CARF International is an independent, nonprofit accreditor of health and human services in Behavioral Health as well as Aging Services, Opioid Treatment Programs, Business and Services Management Networks, Child and Youth Services, Employment and Community Services, Vision Rehabilitation, Medical Rehabilitation and DMEPOS (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies).

The agency has a Risk Management Team Assessment and conducts internal assessments of operational and program data. This information is evaluated by specific teams and reports are generated on a monthly and quarterly basis.

The agency has access to the agency's Chief Operation Officer who is a licensed Mental Health Counselors. These staff members administer suicide risk assessments and provide consultant to staff members that are qualified to administer suicide risk assessments on residential and non-residential participants on an as needed basis.

The agency's Regional Coordinator promotes the services of the agency at the Juvenile Crime Prevention Office on a weekly-monthly basis in East Palatka, Florida. The agency also participates in a local organization called the Heart of Putnam Coalition that showcases a partnership of local government, health care, education, business, civic and health entities to celebrate the collaboration local organizations.

The CDS-East program received a grant award from Home Depot. The company sent an associate-led volunteer Home Depot team of workers to CDS-NW in Palatka to provide cosmetic exterior improvements and upgrades to the youth shelter.

The agency uses a customized logbook to document major activities and events that occur in the residential shelter across all work shifts. The logbook includes directions, areas for signature, tasks, chores, youth counts and numerous other activities.

The agency utilizes a Medication Distribution Client Log with a colored dot alert system. The system uses a matching dot format to effectively manage multiple medications in order to reduce the rate of medication distribution errors.

Standard 1: Management Accountability

Overview

Narrative

CDS Family and Behavioral Health Services, Inc. – Interface Youth Program East provides both residential and non-residential programs. This program site is located in Palatka, Florida. CDS-East provides services through a direct local service provider contract with the Florida Network of Youth and Family Services (FNYFS). The CDS-East agency primarily provides CINS/FINS services in Bradford, Union and Putnam Counties. CDS-East also operates other Residential and Non-Residential programs in Gainesville and Lake City, Florida respectively. All three (3) program locations report to the agency's Chief Executive Officer and Chief Operations Officer that are located in Gainesville, Florida. The daily operations of CDS-East 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 1 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 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.

1.01 Background Screening

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place that addresses all of the key elements of this QI indicator. The monitor reviewed a total of ten (10) employee background screenings. Ten (10) employees were found eligible for this QI; no employees were applicable for exemptions obtained prior to working with youth (if rated ineligible). Ten (10) of ten (10) personnel files reviewed had completed background screenings of employees prior to their date of hire. Three (3) of ten (10) employees were re-screened for the required five (5) or more years of employment. The Annual Affidavit of Compliance with Good Moral Character Standards (Form IG/BSU-006) were completed by the program and sent to the DJJ Background Screening Unit by January 31st of each year. Copy of Affidavit maintained for QI documentation.

Additional review of this indicator included the agency background screening policy. The agency's policy for this indicator is well defined and Outlines procedures and required documentation for background screening completion. Overall, the files were consistently maintained and data was easily accessed for background screening review.

1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

Rating Narrative

The agency has policies and procedures that address the major requirements of the Abuse Free Environment indicator. The agency provides copies of two (documents) related to this indicator called the Behavioral Expectations for Staff policy (last updated in October 2010) and the Standards of Conduct policy (last updated in May 2012). The Behavioral Expectations for staff policy ensures that the staff behaves in a professional manner which encourages a positive work environment and modeling of appropriate behavior for our participants. All staff members are required to follow the behavioral guidelines outlined in the CDS Behavioral Health Services, Inc. employee hand section titled, "Ethical Conduct and Employee Professionalism". The Standards of Conduct policy ensures that the client's served by the agency follow written rules that advise program participants of the rights that they have including rights, responsibilities, and providing guidance for participant and the orientation process. The agency has a process to document staff behavior that violates the Behavioral Expectations for Staff. The agency provided four (4) documented write ups on employee work performance and behavior issues. These cases have

The agency has a grievance process that is in place. The agency posts the Abuse Hotline number in five (5) places in the residential shelter. The agency has the abuse hotline number on the bulletin board in the entry way of the shelter; the hall leading to the boy's dorm; the kitchen; the boys' and girls' day rooms. All youth are informed of the agency's abuse hotline during the orientation process. The Florida Abuse Hotline number is listed on page ten (10) of the Parent/Guardian Orientation Packet.

The agency did not report any cases of current incidents of physical and/or psychological abuse, verbal intimidation, use of profanity, and/or excessive use of force. The agency reported no cases in the last six (6) months related to physical and/or psychological abuse, verbal intimidation, use of profanity, and/or excessive use of force. A total of three (3) Direct Care staff surveys and five (5) resident surveys were conducted onsite. All staff completing a survey reported that no abuse or intimidation, harmful threats toward residents. All residents completing a survey reported that services were good to very good and four (4) out of five (5) reported not hearing any profanity in the shelter

environment. The agency provided a total of six (6) cases that involved a range of employee work place behavior, code of conduct and job performance issues. The agency documented work performance issues involving one (1) employee not maintaining appropriate physical boundaries with staff members; 2 cases of missing medication distribution times; and 1 case of failure to properly supervise participants. In each case the agency documented the incident with a work place Memorandum citing the work performance issues. All memorandums were signed by each staff member in three out of the four (4) cases reviewed. In addition, the agency provided two (2) employee cases that involved terminations. The agency investigates all workplace violations and incidents reported by staff and program participants. Once determined agency management notifies the DJJ CCC or Abuse Hotline of all applicable incidents. Then depending on the findings of reported violations, the management then notifies the agency's Chief Operations Officer (COO) and a decision on the type of response is determined. The agency's management then decides in a collective approach to address work place issues by either documenting and counseling staff members and re-training staff members (supervision, suicide, medication, medical, health and safety). The agency documents and reviews all incidents and work place issues with all staff involved and provides the opportunity review and of their workplace issue on an as needed basis.

1.03 Incident Reporting

Satisfactory

Limited

Failed

Rating Narrative

The agent has a current policy in effect. The policy meets all the requirements for the standard. Onsite documentation of all internal reports were available onsite. The write up of the incidents are legible and clearly describe the incident. After reviewing six months of incidents all reportable incidents were called in to the CCC in the required timeframes.

There were five (5) CCC incidents accepted by the CCC that were not in the report that were provided to the lead reviewer by the Office of Prevention and Victime Services. These incidents were reviewed onsite.

1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

All staff were current in CPR and First Aid. All ongoing training files reviewed had Fire Safety, Suicide Prevention, Signs and Symptoms of Mental Health and Substance Abuse, Universal Precautions and Cultural Competency.

There were 3 first year training files reviewed. One of the files was a complete year and met all first year requirements. Two files were not quite at their year and met all the requirements as far as topics but still need more hours.

For first year training for crisis intervention and suicide prevention are scheduled for June 12 -13 2013.

For ongoing training reviewed 7 training files and 2 out of 7 did not meet the requirements of 40 hours.

For ongoing training there was no Crisis Intervention Skills training for the calendar year of July11- June 12. They had a training scheuled to keep them in compliance which was rescheduled by the trainer and was then completed a month later.

1.05 Interagency Agreements and Outreach

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place that addresses all of the key elements of this QI indicator. The documentation reviewed by this indicator included brochures and marketing information used to educate the community/public on the resources and opportunities available at CDS/Interface East. Documents reviewed included: Tri-fold brochure listing services, locations, contact information and times; one page flyer advertising counseling services; one page flyer advertising free counseling availability; one page flyer advertising "what is CDS" Also, annual report reviewed.

Each of the documents reviewed provided information that informed about alcohol, drugs, behaviors and family issues. Copies of documents reviewed maintained for QI file review

Additionally, review included Agreement Binder – with focus on Putnam County specific providers. A review of all current agreements (21) were reviewed onsite.

Review of the agency's outreach binder demonstrated much positive activity. The agency maintains a Outreach Plan that included target population groups, staff assignment, target date and contact person. Review of the Outreach Reports maintained found compliance with the Outreach Plan. Documentation includes agenda's; minutes; meeting handouts, etc. A sampling included the Putnam County Anti-Drug

Coalition; Putnam Juvenile Justice Council; Youth Anti-Drug Coalition; and Tobacco Free Florida.

The agency maintains a "scrapbook" which contains additional photo documentation of events and community outreach activities. Recent grant from Home Depot included extensive exterior upgrades with community investment. The agency maintained before/after photos which displayed community partners supporting the event along with Home Depot volunteers.

The agency is in the process of partnering with on a community wide event community agencies to promote the "Safe and Sober Prom Program.

Lead staff person identified to oversee and coordinate outreach for Putnam County is the agency's Regional Coordinator.

1.06 Disaster Planning

Satisfactory

Limited

Failed

Rating Narrative

The agency has a comprehensive policy in place that addresses all of the key elements of this QI indicator. The review of the agency's plan includes several areas. The file documentation review included:

-Emergency/Disaster call down list which included contact name, home, cell and other options for emergency contact. Contact numbers listed are of current employees. The listing also included notation that all school sites shall follow the plans established by local school board and contact numbers for the Florida Network. Updated 02/13

-Policy established for Communication Guidelines for Emergency/Disaster Situations Revised 4/10

-Business Continuity and Emergency/Disaster Preparedness Plan – Revised 10/10

Preparation Plan defines areas within the agency by date, task, description and responsible staff. Plan is in 4 phases

-General Residential Evacuation Plan – Revised 6/08

-Fire Plan defines equipment, exits, frequency and procedures – Revised 3/10

-Fire Evacuation Drills – plan Revised 6/08

-Bomb Threat Plan - Revised 6/08

-Severe Weather Natural Disaster Plans (included tornadoes, hurricane, flood plan. Etc.

Revised 3/10

-Hostage situation, Shooting Plan and Chemical Spills – Revised 6/08

-Episodic Emergency Care – Revised 8/10

Reviewer compared plan to equipment and supplies - compliant

The agency Disaster plan is detailed and describes procedures to follow in severe weather, emergency evacuations, transportation, evacuation facilities and procedures and process for notification to the Florida Network. Additionally, the reviewer observed the Disaster Food/product supplies onsite. The food observed contained current dated food, candles, flashlights, sanitary wipes, etc. Items were stored in a well organized locked secure area with access via keys only. Items were in compliance with the established policy which includes inventory to be maintained for emergency/disaster situations.

Additional review included the Emergency Plans and Disaster Drills binder. Logs reviewed included the Bomb Threat Drill Log, Fire Drill Log, Utility Failure Drill Log and Violent Threatening Situation Log. All agency logs are well maintained, including date, time, type of drill, staff signature indicating completion of drill, and detailed debriefing/critique with notations if follow up is required, No follow up was noted as being required on any of the drills reviewed.

Dates for emergency drills reviewed included January – 1/06/13 Day Shift, 1/14/13 Evening Shift, 1/05/13 Overnight Shift; February – 2/26/13 Day Shift, 2/13/13 Evening Shift, 2/14/13 Night Shift; and March – 3/22/13 Day Shift, 3/26/13 Evening Shift, 3/01/13 Night Shift.

1.07 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

Agency has specific monthly and quarterly reports that it generates to assess its performance regarding major risks, operations and programmatic trends and issues. Agency reports track agency trends, patterns and risk management issues. 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; and Youth Participation.

The agency provided samples of detailed follow-up regarding violations of agency work performance or code of conduct violations. There were a four (4) cases of administrative write ups related to employee work rule and code of conduct violations. The agency write ups demonstrated written documentation of the Supervisor or Regional Coordinator addressing each issue. In general CDS-East management assesses all said work-related issues, violations and other issues detected or report by program participants and staff members. These issues are addressed collectively with the CDS-East Residential Supervisor and Regional Coordinator. If applicable the agency notifies the DJJ CCC or the Abuse hotline. Dependent on the specific workplace situation the agency notifies the CDS Chief Operations Officer to discuss situations and then determines an outcome. The CDS-East management then conducts or develops a plan to address the issue by either documenting the issue, retraining the staff member(s), coach and counsel staff members if needed, place staff on probation/suspension and terminate their employment with the agency if needed. The agency reported two (2) terminations for workplace violations.

The agency assessed its current medication distribution systems in summer of 2012. As a result of this assessment, the agency revised and issued a new medication distribution policy in July 2012. The policy includes an updated section that addresses the agency's Medication Verification process. On June 22, 2012, Christine Gurk, RN, BSN, CCHP who is a Registered Nursing Consultant with Office of Health Services provided a medication training to employees of CDS Interface Youth Programs. After the formal training, Ms. Gurk met with Cassandra McCray, Regional Coordinator to review our current Medication Record Log and make recommendations for revision. Based on Ms. Gurk's recommendations, CDS revised the Medication Record Log and implemented it in all three Interface shelters.

In November 2012 CIN/FINS the agency conducted a review and assessment of screenings to determine the contributing factors to that did and did not result in a shelter admission. The agency requested that their data department create a monthly report showing screenings that did and did not result in shelter intakes listed by staff members completing the screening. Each month managers look for any patterns, such as staff whose screenings result in more intakes and the opposite to try flush out successful techniques to increase screening to intake ratios.

In November 2012 the Residential Supervisor and a Senior Youth Care Worker, provided additional Medication distribution and documentation training to East Region staff. This training took place in response to a medication error that occurred on November 2012.

In January 2013 a contraband search training was completed with East Region staff in response to several incidents in which contraband was discovered or reported inside the shelter. Agency policies and procedures were reviewed related to Contraband Search. All of these unusual events occurred in December 2012.

On April 1, 2013, CDS-East conducted training on Participant Supervision. The training was delivered to shelter staff and involved updating staff on policies related to this issue. This was in response to an incident that occurred during an outing at a CDS operated shelter. The issue was discussed at CINS/FINS meeting in March 2013. It was determined that the incident occurred due to lack of proper supervision. As a result of the incident, East Region re-trained staff on Supervision procedure.

Over the course of the last year, Interface Youth Programs have made adjustments to the Behavior Management System, FACE, to improve implementation and outcomes. Some of these adjustments included standardizing the points awarded, adding a shift to shift sub-total of points and creating and distributing to all IYP staff a FACE handbook to study and keep as a daily reference guide.

The agency should include evidence that interventions implemented by leadership or new initiatives implemented to address identified issues have evidence that the corrected action or measure demonstrates improvement and on-going adjustments as needed. The agency should consider reviewing the intervention, test or practice and document any status (improvement or changes).

Standard 2: Intervention and Case Management

Overview

Rating Narrative

Standard 2 involves the indicators for the Screening and Intake process. This agency has policy and procedures for all of the indicators in this Standard.

This reviewer examined a total of 10 charts. 7 open charts and 3 closed, which consisted of 3 open non-residential and 2 closed with 4 open residential charts and 1 closed.

This reviewer interviewed the Cynthia Starling, CDC Regional Director; Pam, Residential Director; and Angela, Residential Counselor, and Latina, Non-residential Director.

CDC Interface East has an "informed Consent and Participation Agreement" packet that is written to be understood by a variety of educational levels. The language is clear, concise and understandable. There is a packet for the youth and the parent/guardian.

The non-residential Counseling Program provides non-residential services for youth and their families in primarily Putnam, Bradford and Union Counties. The non-residential component consists of a one (1) Family Action Senior Residential/Non-Residential and 1 Family Action Case Manager. The program receives calls for service from parents/guardians, system partners and the general community. The screening determines eligible youth and family are referred to the 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 Staffings 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.

2.01 Screening and Intake

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure in place that addresses all of the key elements of this CQI indicator.

2.01: From the Non-residential charts (3 open and 2 closed) there were no exceptions. 4 of the non-residential charts had Eligibility Screenings completed within 7 calendar days. One non-residential chart was a phone call in by parent and completed at the time of the call.

The Residential charts (4 open and 1 closed) documented that 2 of the 4 open charts had Eligibility Screenings completed within 7 days of the referral with 2 open and 1 closed chart having no referral.

All 10 charts had evidence that youth and parent/guardian received in writing services that are available to them, their rights and responsibilities, a Parent/Guardian brochure, the potential actions that can occur through the CINS/fINS process, as well as the agency grievance procedure.

This agency provides the youth and parent/guardian with a packet consisting of all the information above, as well as important referral sources, "need to know" telephone numbers, and websites that can be helpful to the family.

The packet is well written and developed to be understood by a variety of educational levels to meet the various needs of the families.

No exceptions were noted during this QI review.

2.02 Psychosocial Assessment

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure in place that addresses all of the key elements of this CQI indicator.

All 5 non-residential charts had Psychosocial Assessments completed within the required 2 - 3 face-to-face sessions. These 5 charts actually had all Psychosocial Assessments completed in one setting.

3 of the 5 residential charts had Psychosocial Assessments completed within the 72 hour period required by this Indicator. Upon interviewing Angela, the residential counselor, she stated that all Psychosocial Assessments are completed within the 72 hour timeframe. Those youth

admitted to the shelter over the weekend are assessed first thing Monday morning or immediately following school on Monday (if the youth went to school that first day). 2 of the 5 residential charts did not have completed assessments because they had just been admitted within 24 hours of the review. The residential counselor had them scheduled for assessments after school that day.

The agency organizational chart indicated the residential and non-residential counselors completing the Assessments met the requirement of the indicator by having a Bachelor or master's level degree.

All Assessments had a supervisor's signature for review within 5 days of the completed assessment.

None of the 10 charts had any youth who were identified with an elevated risk of suicide.

All 9 open charts had documentation easily accessed on the forms and in the designated areas of the chart. The 2 closed chart was well organized and paperwork was easily found for review.

No exceptions were noted during this QI review.

2.03 Case/Service Plan

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure in place that addresses all of the key elements of this CQI indicator.

9 of the 10 Case/Service Plans were completed within 7 working days of the Psychosocial Assessments. 1 was not yet completed as the youth was just admitted the day of the review.

The 9 Case/Service Plans all documented all indicators of 2/03 were completed. 6 of the 10 charts had 30 day reviews. 3 of the 10 had not been open 30 days yet and 1 was closed before the 30 day review was needed.

The Plan had Individual goals for the youth and/or family member. There were parent goals relating to information from the Psychosocial Assessment. The goals were clear and attainable. The agency uses SNAP as part of the goal setting process. The youth and counselor develop this plan together by identifying Strengths, Needs, Abilities, and Preferences. This is a strength based approach and shows vigerous attention to the client's succes.

The residential program has a robust plan providing 2 - 4 objectives for each goal. These objectives are detailed and easily understood by youth on many educational levels.

No exceptions were noted during this QI review.

2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure in place that addresses all of the key elements of this CQI indicator. This Indicator shows strong documentation of family support and coordination of services.

This is evidenced by the Residential Progress notes in all 10 charts providing information clearly marked with IS for Individual Session, FS for Family Session (or parent session) and GS for Group Session. Progress or need of assistance is indicated clearly in the Notes. Referrals were made to Stewart Marchman for substance abuse evaluations and follow-up when there is indication of substance use. A local Boys' Ranch was used as a referral source when more longterm counseling was needed for ongoing behavioral issue.

None of the ten (10) charts had any need for Case Staffing referrals or any court hearings.

No exceptions were noted during this QI review.

2.05 Counseling Services

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure in place that addresses all of the key elements of this CQI indicator.

This agency provides a plethora of counseling services for the clients in both non-residential and residential programs.

10 charts provided vibrant information in the Progress Notes regarding counseling services. Presenting problems were addressed immediately upon admit from the Psychosocial Assessment in the Initial Case Plan for Residential charts had goals for Safety and Following Shelter Rules. The residential and non-residential counseling services for all 10 charts were clearly marked, stated issue addressed, response, and action to be taken.

In 4 of the 5 residential charts (one youth just admitted) were Group Notes on what the group was about and the youth's participation. (Youth worksheets, pictures, etc were in the chart under Misc.)

This agency has a solid, consistent internal process that ensures clinical reviews of case records and staff performance. This is documented with Case Review forms kept in a Review binder. These forms have information concerning the youth, plan, progress, needs, referrals and staff undertakings to help clients achieve their goals. These reviews are signed by all present (staff and supervisor).

No exceptions were noted during this QI review.

2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure in place that addresses all of the key elements of this CQI indicator.

Documentation shows that the family and the committee were all notified within appropriate timeframes. The school district and DJJ rep are present at all case staffings. In addition there are law enforcement and state attorney that attends. As a result of case staffing the youth recieved a revised service plan. The paerent or guardian recieved the recommendations of the committee within the 7 day timeframe. The program works with the circuit court for judicial intervention and had a current court order youth in shelter. The case manager perepared the PDR prior to the court hearing. The program has an established case staffing committee and has regular communication with committee members. The program has an internal procedure for the case staffing process.

No exceptions were noted during this QI review.

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure in place that addresses all of the key elements of this CQI indicator.

All records are marked confidential.The records are kept in a secure room in a locked file cabinet.

All records are maintained in a neat and orderly manner that the reviewer could quickly and easily access information.

No exceptions were noted during this QI review.

Standard 3: Shelter Care

Overview

Rating Narrative

The CDS IYP East program is located at 2919 Kennedy street in Palatka, Florida. The shelter is licensed by DCF as a 12 bed residential facility. The CDS IYP-East youth shelter is located in Palatka, Florida in Putnam County. The agency's CDS-East 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 six (6) youth in the shelter. One of the 6 youth is a Respite referral. The shelter is comprised of a detached building that has separate split level design with female and male sections of the facility. Each residential section of the shelter can accommodate up to six (6) youth. 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 meeting room and multi-purpose 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. There is no onsite school. Youth attend local area schools if they are not on suspension, expulsion or suffering from an illness. The program's Continuity of Operations Plan (COOP) has been approved by the Florida Network. The Florida Network received the program's emergency response plan and hurricane plan that was revised on August 2012. A Universal Agreement for Emergency Disaster Shelter is also in force and was signed by the Program Director. The exterior of the facility is well maintained and the grounds are landscaped. The agency received an exterior makeover that included installing new plants, a vegetable garden, tree swing, meandering walkway, benches and patio furniture.

The program staff for the Residential staff includes a Regional Coordinator, a Residential Supervisor, fourteen (14) Youth Care Workers, and 1 administrative. 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 adjacent to the day room. The medication and first aid supplies are stored in the staff office in a locked cabinet with multiple locks affixed on the 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.

At the time of the quality improvement review, the shelter was providing services to six (6) CINS/FINS youth. The shelter is not designated by the Florida Network to provide staff secure services.

The agency received a \$7000 grant/work project donated from the Home Depot during the last year.

3.01 Youth Room Assignment

Satisfactory
 Limited
 Failed

Rating Narrative

The agency has a written policy and procedure in place that addresses all of the key elements of this CQI indicator.

The facility is a 12 bed shelter consisting of two bedrooms with six beds each. One room is for females and one for males and the beds are numbered in each room for the purpose of bed assignment.

The agency completes a CINS Intake Form that contains criteria for determining room assignment. Criteria include age, gender, physical build, history of aggression and other factors relevant to bed assignment.

A review of six residential files (3 open, 3 closed) revealed that in four of the five cases that all of the criteria was utilized to determine a bed assignment was indicated on the Intake Form.

Interviews with the Residential Counselor and the Lead Youth Care Worker confirmed that bed assignment is always a part of the client intake process.

In one case the room assignment (page 2 of the intake) form was missing. However, the room assignment was indicated on the client information board in the youth care staff office and an interview with staff (Karen) and the youth (Noah W.) also confirmed that he was assigned to bed 3 in the boys dorm.

3.02 Program Orientation

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure in place that addresses all of the key elements of this CQI indicator.

The agency completes an orientation checklist during the intake process for each youth admitted to the shelter. The checklist contains 18 items that address all of the requirements listed in this CQI indicator. The form is signed and dated by the youth and the staff member at intake.

A review of five residential files revealed that all five files contained an orientation checklist that was signed, dated and completed during the initial intake process. All youth receive a copy of the Client Handbook upon admission to the facility which explains all program services.

Interviews with the Residential Counselor and the lead Youth Care Worker also confirmed that the orientation process is consistently documented during the intake process for all youth admitted to the shelter.

No exceptions were noted during this QI review.

3.03 Shelter Environment

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure in place that addresses all of the key elements of this CQI indicator.

The shelter is a 12 bed facility located in Palatka. Because of its relatively small size, the facility has a very comfortable, almost "home-like" feel to it. It is very well maintained, very clean and organized. The two bedrooms have painted murals on the wall that are consistent with trauma informed care principles. There was no evidence of facility damage or graffiti.

The grounds of the facility are nicely landscaped and well maintained. There is an active, working vegetable garden that is maintained by staff and youth and a walking path that meanders around the rear of the property for recreation and relaxation. A new basketball hoop was also installed in June of 2012 by the Home Depot project team.

The facility has adequate space for the programmatic activities conducted there. There is a sufficient supply of linens and towels and personal hygiene supplies for youth. Chemicals, sharps and medications are securely stored. MSDS sheets for all chemicals used at the facility are maintained in a three ring binder in the chemical storage closet adjacent to the kitchen/dining room.

The facility has a 16 camera video monitoring system to ensure youth safety and program security. The monitor station is in the youth care office.

The Residential Group Care health inspection was conducted by the Health Department on 3/29/13 and was rated satisfactory. Insect control services are provided Florida Pest Control.

The fire inspection was conducted by Palatka Fire Department on 8/8/12 and was satisfactory. The fire extinguishers were inspected by Lightfoot Fire Extinguisher Company on 9/4/12.

An inspection of the agency van indicated that all safety requirements were met or exceeded. Tires, brakes, lights and mirrors were all in good condition and functional. First aid kits, fire extinguishers and other safety equipment were all in place as required.

No exceptions were noted during this QI site visit.

3.04 Log Books

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure in place that addresses all of the key elements of this CQI indicator.

The agency maintains a daily log book to document program activities and communicate information across staff from shift to shift and day to day. The agency uses a uniquely formatted log book that was developed by the agency and is utilized at their three shelter sites in Gainesville, Palatka and Lake City.

Entries are legible, made in ink and signed and dated by the staff completing the entry. Corrections are completed according to agency policy

and CQI requirements (single line strike through with staff initials).

The program uses a color coding system to highlight important information:

Blue: Suicide watch, sight and sound.

Yellow: Appointments and general important info.

Orange: Review of previous two shifts.

Pink: Medication.

A review of the log book indicated that staff are consistently following agency policies and CQI requirements. Staff document their review of the log book for the previous two shifts by signing in when they arrive to work.

Program activities and events are vigorously documented and highlighted in four different color codes according to agency policy.

THIS AREA OF PROGRAM PERFORMANCE IS IDENTIFIED AS A BEST PRACTICE.

No exceptions were noted during this site visit.

Rating Narrative

The agency has a written policy and procedure in place that addresses all of the key elements of this CQI indicator.

The program has a daily schedule that includes all planned activities throughout the day. The schedule is posted in the facility in both the boys and girls day rooms and is also reviewed with youth upon admission to the shelter.

Shelter programming includes a plethora of activities such as meals, chores, hygiene, school, life skills, group counseling, faith based activities and recreation time.

No exceptions were noted during this site visit.

3.06 Behavior Management Strategies

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure in place that addresses all of the key elements of this CQI indicator.

The agency has a behavior management system in place that is known as FACE System: Facilitating Activity and Communicating Effectively. There are three levels in the FACE system: Assessment, Daily and Achievement.

Youth remain on the assessment level for three days. Youth have a 72 hour period to complete their initial assessment and adjust to the program rules. During this phase behavioral target goals are identified.

Youth then advance to the Daily level. Youth are assigned 3,300 points that they have to work off by completing daily activities. Youth must earn 250 points daily to earn privileges on this level. On this level youth must earn 100 points to earn their privileges.

Youth move to the achievement level where they earn additional privileges. On this level youth must earn 100 points daily to earn their privileges. Youth remain on the achievement level for the remainder of their stay unless they violate major or primary program rules.

No exceptions were noted during this CQI site visit.

3.07 Behavior Interventions

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure in place that addresses all of the key elements of this CQI indicator.

The agency has written policy prohibiting the use of seclusion and restraint. Surveys of youth and staff confirmed policy this in practice. Surveys also confirmed that youth feel safe at the facility and there were no reports of verbal abuse or use of profanity by staff.

The agency trains their staff in TEAM: Techniques For Effective Aggression Management. Verbal de-escalation skills are learned and practiced.

An interview with the Residential Supervisor revealed that agency has a clearly written policy that is consistently followed by staff. There were no grievances or reports of verbal abuse or use of profanity that the Residential Supervisor could recall during the past 12 months.

One youth survey reported that the staff had sent them to their room as punishment.

3.08 Staffing and Youth Supervision

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure in place that addresses all of the key elements of this CQI indicator.

The program has three shifts: 8:30 AM-4:30 PM, 4:30 PM-12:30 AM, 12:30 AM-8:30 AM.

There is one staff that works 8:30 to 1:30 while youth are at school. At 1:30 another staff arrives and works until 4:30 to provide additional coverage when youth return from school.

On the afternoon shift there are two to three staff depending on the number and composition (male/female) of youth in the facility.

On the overnight shift there are two staff on duty, a male and female, seven days a week.

There is one staff who is bi-lingual that works on the overnight shift who can assist with translation. There are 10 on-call staff to fill in vacancies for staff on vacation or who call out sick.

The Residential Supervisor works from 11 AM to 7 PM to assist with shelter operations and staff coverage schedules. An interview with the Supervisor confirmed the staffing patterns are in compliance with CQI requirements.

A review of staff schedules for the past six months also indicated that the shelter staffing patterns are in compliance with CQI requirements apart from the one exception noted in this report.

During school days Monday through Friday from 1:30 to 4:30 there are two females on duty. Overall there are concerns that the agency does is not able to consistently schedule male staff members on workshifts on a consistent basis. The agency state that they have been challenged to locate and employ qualified male staff to be employed a the CDS-East location.

3.09 Staff Secure Shelter

Satisfactory

Limited

Failed

Rating Narrative

The agency is NOT contracted to provide Staff Secure shelter services.

This indicator is Not Applicable.

N/A

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The CDS-East 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 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 has a Senior Residential Counselor that is a Licensed Mental Health Counselor (LMHC) and Family Action or Non-Residential/Case Manager that is a Registered Mental Health Counselor (RMHC). In addition, 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/local service provider has written procedures to address the admission process to include an in-depth health screening through the completion of a fourteen (14) Intake Assessment form. The health screening form addresses all elements of the indicator: Allergies (general, medication and food allergies); Existing Medications including Dosage Instructions; Health/Nutrition concerns and restrictions; general, Physical Health Screening; Current Observation of Behavior and Physical, Emotional or Mental Health Status. The general health screening section screens for a total of twenty-eight (28) health –related questions that include recent injury; current pain; head injury or chronic headaches; vision problems; history of seizures/blackouts/epilepsy; chronic pain; high blood pressure; heart murmur/condition; sexually transmitted diseases; hemophilia; alcohol/drug abuse problems; orthodontic appliance being utilized; fainting/dizziness; skin problems; diabetes; asthma; digestive system; chronic cough; abnormal gynecological concerns; pregnancy/possible; history of bed wetting or problems sleeping; eating disorder; hepatitis; tuberculosis; disability/physical /mental; immunizations; and prenatal exposure to alcohol, tobacco and other substances. Observation for the presence of scars, tattoos, or other skin markings is also screened for on page one of the Intake form. The Screening tool addressed all elements of the indicator with no exception on the form used by the agency.

The policy requires residents to be screened and any areas of concern and/or need to follow up and initiate the agency medical and mental health alert system. The agency provides access to first aid, CPR and response emergency medical needs to all residents admitted to the youth shelter at all times. The agency's general practice includes requires that if major medical conditions exists the youth will be immediately referred to their physician, emergency room or a public health care department. The practice also indicates that staff members are to contact the parent/legal guardian to obtain information about pending appointments with medical professionals, current medications and general precautions in the case of an emergency. All medical incidents/referrals are required to be documented on a daily log.

A total of six (6) open files were reviewed to assess requirements of this indicator. Of the 6 client files reviewed, all files contain the fourteen (14) section intake form that contains the health screening sections. All major sections health screening questions were documented in each client file. All major areas are completed. The agency also captured additional health screening information on a "Screening Health Addendum". This form captures whether the resident is eligible to receive services and screens for any yes response to six (6) health related questions. These questions ask the resident "In the last 48 hours have you experienced any Fever; Diarrhea; Vomiting; Sore Throat; Continuous coughing and/or sneezing; and cold like symptoms". All six (6) files reviewed contained the required forms. The written procedures addressed the referral process and follow-up medical care protocol performed by the agency.

4.02 Suicide Prevention

Satisfactory

Limited

Failed

Rating Narrative

The agency's CDS-East location utilizes a standardized suicide prevention plan in each of its three (3) emergency shelters located in the North Central Florida. The CDS-East location had a written plan that outlined the suicide prevention and response procedures. The title of this policy is Suicide Assessment. The plan addresses all elements of the indicator and complies with the procedures outlined in the Florida Network's Policy and Procedure Manual for CINS/FINS. This policy was initially approved and has not been revised since the initial approval date. The policy was last updated on August of 2011. The plan indicated each youth admitted to the shelter will be screened for suicidal risk by using the six (6) suicide risk questions on the CINS/FINS Intake form. Policy was approved by the FNYFS August 2011. If the youth answers "yes" to any of the 6 questions, the staff place the youth on sight and sound and then contact the parent/guardian and Residential Supervisor. The observation log is then initiated. Supervision is documented every 30 minutes for Constant Sight Sound supervision and One to One Supervision is documented every 15 minutes. Supervision status is maintained by agency during the assessment process until the Residential Counselor consults the Licensed Mental Health Counselor (LMHC) and receives direction to maintain or remove from the said supervision status. If the resident is removed from the said supervision status, the counts are stopped and the resident is returned to the general population. The agency then faxes the completed assessment to the LMHC for review and signature. A copy of page 5 of the assessment form that is reviewed by the LMHC is faxed back to the program and placed in the resident's file.

If necessary, the agency contacts law enforcement to consider a Baker ACT and transport to a local mental health receiving and treatment facility. In these cases, a youth care worker will immediately refer the youth to Meridian Behavioral Healthcare for a Baker Act screening. Upon return and clearance from Meridian the resident is then placed on constant sight and sound. The agency charts all sight and sound documentation on the agency Observation Log. All checks are required to be conducted in 30 minute or less intervals and fully documented on the Observation form. Youth on sight and sound are monitored within sight and sound of a staff person at all time. Youth on this status sleep in the boys or girls living/day room respectively. Once the youth is on sight and sound observation, a full assessment is completed by the Residential Counselor. The exceptions to this 24 hour rule are weekends and holidays. Once the full suicide assessment is completed by either the LMHC or the Masters level under the supervision of the LMHC the may or may not be taken off this status. If the results are deemed acceptable, the youth is removed from sight and sound status by a qualified mental health professional and placed in to general population.

A sample of five (5) client files over the last six (6) months was conducted onsite. A total of two (2) closed and three (3) open files were reviewed. All 5 files contained evidence of general documentation that indicated a suicide risk screening was completed during the initial intake and screening process. All 5 files contained documentation that indicated the suicide screening results were reviewed and signed by the assigned Masters Level counselor and the supervisor who was also the licensed mental health counselor overseeing the assessment process. All counselors have access to a licensed clinician. All youth that screened positive as a suicide risk, were placed on sight and sound supervision until assessed by a licensed professional. In all cases reviewed, the supervision level was not changed or reduced until approved by a licensed professional. All 5 cases were applicable for requirements of a suicide risk assessment and were applicable for sight and sound supervision requirements. Four (4) out of 5 youth were placed on the appropriate level of supervision based on the suicide risk assessment results. Supportive documentation was reviewed to include precautionary observation logs and thirty minute checks. All 5 cases contain chronological notes documenting the youth being placed on sight and sound. Evidence of youth being removed from sight and sound status is documented in the agency daily log across and the agency program log book.

The notes indicate that the suicide risk screening was completed, but did not designate the level of supervision for one shelter client. The reviewer was able to determine the status from the agency's logbook. The documented note was also high-lighted in blue to easily identify the resident's condition or status.

4.03 Medications

Satisfactory

Limited

Failed

Rating Narrative

The agency has a Medication policy that addresses all major areas of medication distribution and assisting in the delivery of Medication. The policy is called the Medication Provision, Storage, Access, Inventory, and Disposal. The agency medication policy was last updated in July 2012. The current policy includes sections that addresses Prescription Medication; Procedure for Verification Medication; Non-Prescription Medication; Medication Provision, Supervision, and Monitoring, Offsite Medication Distribution; Medication Errors and Refusals; New Prescription, Change in Medication and New Month; Medication Storage; Access to Medication; Inventory Procedures; Medication Counting Procedures; Discharge of Youth with Medication; and Disposal. The policy now requires that staff conduct several medication verification steps. The process requires that all medication entering the shelter originate from a licensed pharmacy. The agency does not provide residents with over the counter (OTC) medications. All residents that require and over the counter (OTC) medication must have a doctor's prescription accompanying the youth at admission to the program. The current medication verification process involves sending a three (3) step process that requires sending an "Informed Consent and Participant" to the pharmacy for verification; Confirming that the form is completed by the pharmacy and returned to the program; and documenting that the verification is documented on the resident's medication distribution log (MDL). The agency maintains a color-coded dot system to ensure the accuracy of each medication that is distributed to the resident. All residents with at least one or multiple MDL charts have a corresponding colored red, blue, green or yellow dot that corresponds with the appropriate controlled or non-controlled medication.

All medications in the shelter are stored in a separate, secure area, which is inaccessible to youth. Oral medications are stored separately from topical medications. There was one injectable medication on site which was an Allergy Epi Pen identified as needed on a case by case basis

for this CINS/FINS youth. 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. Controlled medications are locked in a cabinet behind two (2) locks. Shift-to-shift counts, and a perpetual inventory is maintained, and documented for controlled and prescribed medications. Sharps are maintained in a locked cabinet. A total of fifteen (15) resident craft scissors are maintained in the left bottom drawer in the control room. A total of seven (7) medical scissors are maintained by the agency in four (4) first aid kits in a metal cabinet in the control room and in one (1) transportation van. The agency maintains record of the weekly sharp counts. The counts were recorded on a computer generated print out. The current form documents the date when sharps counts were counted each week. Sharps counts from October 2012 to present April 2013 were reviewed onsite. All sharps counts are documented as required and maintained in a 2 section file folder. The program utilizes a customized Medication Distribution Log (MDL). The MDL contained all the necessary information to include: youth's name (printed and signed), date of birth, allergies, side effects, picture of youth, staff and youth initials on MAR when medication is disbursed and received.

A review of current youth in the shelter currently on Medications was conducted. A sample of the medication distribution records of two (2) current youth in the shelter and four (4) closed files were reviewed to assess the agency's adherence to standard. All cases reviewed contained evidence with documentation of the recent verification procedure. All files have major sections completed including the client's name, picture, current month and year, medication, strength, doctor name, allergies, time received, method of administration (oral, topical, inhalant, ear and eye), special procedures, amount of medication received, directions, side effects/precautions (list top 3), and staff receiving medications. The first page of the Medication Distribution Log (MDL) captures evidence of the dosage being given, staff member's signatures and initials, client's signature and initials and dosage given on the MDL. Youth initials are documented, but no full signatures are documented. Page two (2) of the MDL captures the shift to shift count and weekly inventory count of each medication given to each clients. The MDL on 4 out of client files indicates that youth medication records include all required documentation in the aforementioned areas.

One MDL contained information that indicated that refill dosages of multiple medications were supplied prior to the resident depleting their current medication supplies. The agency's family member provided the refills. There were a total of five (5) reported medication incidents reported to the DJJ CCC in the last six (6) months. All medication error incidents had evidence of follow up that included written deficient workplace performance related Memorandums and re-trainings of the respective staff that were involved in medication errors.

Two (2) closed files contain blank allergies sections that are not marked on page 1 of the medication distribution logs (MDL). The form does not identify what staff member conducted the weekly sharp count. The agency should add a Signature column heading and a line on each row to capture the signature of the staff person completing the weekly sharp count.

4.04 Medical/Mental Health Alert Process

Satisfactory Limited Failed

Rating Narrative

Open charts were reviewed for compliance. All charts reviewed had an alert that was appropriate to their system. Several clients had a medical, food allergy or mental health condition all were marked consistently on the client record and on the client board in the staff office. The program had a procedure that was followed consistently by all staff. The system of numbering is available to staff but not the clients. The clients are not aware of the alert process coding.

None

4.05 Episodic/Emergency Care

Satisfactory Limited Failed

Rating Narrative

The agency has a policy in place that addresses all of the key elements of this QI indicator. The Reviewer assigned to the indicator requested incident over the prior six (6) months that require off-site emergency services. The only youth receiving these services was a DCF case. The Reviewer did not examine the DCF youth file. The Lead Review requested that the agency provide any client cases that received off-site emergency services back to the last QI review in order to assess the agency's adherence to this standard.

The agency staff provided two (2) youth files that involved emergency care for the timeframe going back to the date of the last QI review. One (1) youth file FLJ0231349 was completed in full compliance with department policy and standard.

The reviewer of the indicator noted concerns with youth file 0217810. The file review found that on 07/21/12 staff reported in Progress Notes that youth did not respond following multiple attempts to awaken the youth. The agency staff reported that they repeatedly attempted to awaken youth. Staff called the Resident Supervisor who advised staff to call 911. Youth was transported via paramedics to Putnam Community Medical Center.

Review of policy states that in the event of any life threatening injury or emergency, then staff are directed to first call 911 and then notify supervisor. This procedure was not followed in this incident. The parents/guardian was notified in this case as required by the agency policy. The reviewer has determined that this is a critical client care issue. Copies of policy, progress notes and medical & dental referral log relevant to this incident are included in report as back up documentation.

