



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of CDS-Interface NW

on 03/06/2013

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	Limited
1.06 Disaster Planning	Satisfactory
1.07 Analyzing and Reporting Information	Satisfactory

Percent of indicators rated Satisfactory:85.71%
Percent of indicators rated Limited:14.29%
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:96.43%
Percent of indicators rated Limited:3.57%
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

Latrice Covington, Contract Manager, Department of Juvenile Justice

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

Mark Shearon, Shelter Program Manager, Arnette House, Inc

Crystal Westman, MS

Clinical Supervisor/Residential Counselor

Arnette House, Inc

Persons Interviewed

- | | | |
|--|--------------------------|-------------------------|
| <input checked="" type="checkbox"/> Program Director | 1 Case Managers | 0 Maintenance Personnel |
| <input type="checkbox"/> DJJ Monitor | 1 Clinical Staff | 4 Program Supervisors |
| <input checked="" type="checkbox"/> DHA or designee | 1 Food Service Personnel | 5 Other |
| <input type="checkbox"/> DMHA or designee | 0 Health Care Staff | |

Documents Reviewed

- | | | |
|---|--|---|
| <input type="checkbox"/> Accreditation Reports | <input checked="" type="checkbox"/> Fire Prevention Plan | <input 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 | 6 Health Records |
| <input type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 6 MH/SA Records |
| <input checked="" type="checkbox"/> Contract Monitoring Reports | <input type="checkbox"/> PAR Reports | 12 Personnel Records |
| <input checked="" type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 33 Training Records/CORE |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 0 Youth Records (Closed) |
| <input type="checkbox"/> Escape Notification/Logs | <input type="checkbox"/> Sick Call Logs | 0 Youth Records (Open) |
| <input 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

- 4 Youth 6 Direct Care Staff 0 Other

Observations During Review

- | | | |
|--|---|--|
| <input 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 checked="" 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 checked="" 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

Strengths and Innovative Approaches

Rating Narrative

CDS Family and Behavioral Health Services, Inc. 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 the following areas:

- Aging Services
- Behavioral Health
- Opioid Treatment Programs
- Business and Services Management Networks
- Child and Youth Services
- Employment and Community Services
- Vision Rehabilitation
- Medical Rehabilitation
- 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 real-time access to licensed clinicians. The agency Chief Operation Officer and Senior Counselor are both 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 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 dots to more effectively manage multiple medications and to reduce errors.

The program has two (2) licensed mental health counselor (LMHC) and one (1) registered mental health counselor intern that are all certified by the State of Florida Department of Health's Division of Medical Quality Assurance and accessible to the program. One of the two (2) licensed LMHC professionals is the primary residential Counselor of the residential program.

3.06 Behavior Management Strategies

Great examples of staff meeting and yearly evaluations reflecting consistency in consequences and rewards.

Standard 1: Management Accountability

Overview

Narrative

CDS Family and Behavioral Health Services, Inc. – Interface Youth Program Northwest provides both residential and non-residential programs. This program site is located in Lake City, Florida. CDS-Northwest provides services through a direct local service provider contract with the Florida Network of Youth and Family Services (FNYFS). The CDS-NW agency primarily provides CINS/FINS services in Bradford, Union and Putnam Counties. CDS-NW 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 CDS-NW location is operated by two (2) Regional Coordinators. The Regional Coordinator position is the highest ranking position for the agency at this location. The agency assigns the daily operation and direct responsibility of each shelter to the Residential Director at each youth shelter. The agency also has Residential and Non-Residential counselors, Residential Direct Care and Non-Residential staff members. The agency has a Centralized Human Resources and fiscal departments handle all personnel and financial matters. Each area program has a licensed clinician that oversees and review all youth that have suicide risk issues. Each program also provides general counseling and mental health services to youth and families. These services are delivered at their respective location. 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-NW program agency conducts screenings prior to hiring of all staff members. All staff members receive training at their respective service locations. In addition, many agency trainings combine trainings so that staff members at each location to be trained simultaneously on various training topics.

1.01 Background Screening

Satisfactory

Limited

Failed

Rating Narrative

CDS – Interface NW has a detailed policy that complies with the requirements for background screening of employees, volunteers, mentors, and interns. All persons working or volunteering at CDS – Interface NW are background screened prior to having contact with youth. The agency completes a three (3) year driving history and local law enforcement checks for all employees as well. A total of six (6) eligible employees files were reviewed for this indicator – three (3) were hired within the past year and three (3) were in-service employees. All files were organized and have documented evidence that background screens were completed prior to hire dates with no exemptions required. Three (3) employee files had a completed five (5) year rescreen, which was completed prior to the hire date. The agency provided evidence that the Annual Affidavit of Compliance with Good Moral Character was completed and submitted to DJJ Background Screening prior to the January 31st deadline.

1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy to address the requirements of this indicator. The agency code of conduct requires all staff to report any incidents of abuse immediately. A review of formal reporting documents and surveys were reviewed and conducted onsite to determine the past or current existence of an abusive youth shelter environment.

A total of two (2) DJJ Central Communications Center (CCC) incidents and five (5) documented grievances were reviewed to assess if there was evidence present to substantiate concerns that youth do not feel safe, secure and or threatened by any forms of abuse or harassment.

A total of four (4) youth surveys were conducted onsite to determine if any physical abuse, profanity, threats, or intimidation were present. The majority of youth indicated that they are familiar with how to report incidents of abuse. Of these surveys, all residents indicate that youth feel safe and that the services provided by the agency are good to very good. Four (4) staff surveys indicate that there were no reports of threats, use of profanity, abuse or intimidation.

The agency promotes expression of youth input by allowing youth to provide written comments on a Hassel form. The Hassel form allows youth to provide information to the staff about issues of intimidation, threats or bullying. Once completed by a resident, the Hassel form is submitted by the resident to a staff person to attempt to make staff aware of potential problems being experience by residents prior to further escalation.

Documentation of each resident grievance does not fully indicate how management addressed the issues expressed in each grievance. Agency management should revised the current practice on follow-up to each official grievance and add more information indicating how youth concerns will be addressed.

1.03 Incident Reporting

Satisfactory

Limited

Failed

Rating Narrative

CDS – Interface NW has a concise policy on abuse reporting that includes Department of Juvenile Justice (DJJ) Administrative Rule 63F-11, which meets the reporting requirements for this indicator. Employee training files contain documentation of incident reporting/Central Communications Center (CCC) training. Documentation of all incidents was available onsite and legibly recorded on the agency's unusual event report or incident report - CCC. There were a total of 28 incident and unusual event reports for the past six months. There is documentation that the CCC was called within two hours of the incident or within two hours of becoming aware of the incident for two reportable incidents. Staff and youth surveys indicate all are familiar with the reporting requirements and procedures.

1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

The program has a written policy and procedures in place to ensure new employees receive 80 hours of required training their first year and 40 hours training per year after the first year. In addition, the policy and procedure in place includes all training requirements indicated in the standards. A total of twelve (12) current staff files were reviewed which included full and part time staff (1 non residential staff and 11 residential staff).

The files included training hours tracking logs and certificates of attendance and agendas. In some of the files it was difficult to locate the training information [recommend program update forms to make it easier to read/maintain].

9 out of 9 files were reviewed for compliance with the Annual Training requirements (2nd year and after). All nine staff training files met and/or exceeds training requirements.

The annual training plan covered a variety of training topics but was inconsistent on trainings across the board such as some but not all training plans covered crisis intervention skills, suicide prevention, signs/symptoms of mental health and substance abuse, universal precautions and cultural competency.

Three files were reviewed for compliance with first year training. One out of three files contained documentation 80 hours of training had been completed. The other two files reflect at least 40 hours of training remain but the two staff members still has adequate time to complete this before the training year ends.

1.05 Interagency Agreements and Outreach

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy on Prevention Outreach that meets the requirements for this indicator. The agency also has a detailed Outreach Plan for Targeting Youth for Program Services. The agency has many interagency agreements that include the service area of Columbia, Dixie, Hamilton, Lafayette, and Suwannee Counties. The interagency agreements for the service area are with the Sheriff's Office, county school, local police, teen court, or United Way of Suwannee Valley. The designated outreach staff person is located in Alachua County. Therefore, facility staff is conducting outreach for their service area but there is no documentation. Some outreach is documented on an Outreach – CINS FINS form that is entered into NetMIS but does not include the service area for this facility.

The agency offers referrals for medication management and alcohol and other drug use/abuse through Meridian Behavioral Health Care, which has offices in the service area. The agency assists youth with educational issues by enrolling youth in the local school while at the shelter. Staff participates in group presentations and discussions, individual meeting, the display and distribution of materials at community events, media events and interviews.

Most interagency agreements are for counties outside the service area of this shelter.

There is no documentation of outreach in all counties of the service area

1.06 Disaster Planning

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy on Disaster Planning for this indicator. There is a detailed disaster preparedness plan with detailed procedures for evacuation, hurricane, tornado, fire, flooding, hostages, shootings, chemical spills, bomb threats, terrorist acts, etc. The plan also includes processes for episodic emergency care. The disaster preparedness plan includes the responsibility of all staff, including a phone tree. Employee training files contain documentation that disaster preparedness training is provided yearly before the start of hurricane season. There is an egress plan in all rooms of the facility. An additional copy of the disaster preparedness plan is kept in the youth care staff office.

The facility has a generator that is tested weekly to handle power outages. There is a facility van to transport residents and staff if necessary. The disaster plan includes designated evacuation facilities. The plan outlines a process to contact the Florida Network of Youth and Family Services if there is a decision to evacuate. The facility keeps evacuation supplies on hand that are checked yearly before hurricane season. The agency participates in the Universal Agreement Emergency Disaster Shelter.

The disaster preparedness plan does not specifically discuss youth riots.

1.07 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

The agency has specific monthly and quarterly reports that it generates to assess its performance regarding major operations and programmatic trends. The agency reports track agency trends, patterns and risk management issues. CDS Family and Behavioral Health Services, Inc. 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.

The agency provided two (2) cases of that demonstrated the agency's ability to follow-up regarding on violations of agency work performance or code of conduct 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 some of the 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 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.

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 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.

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 demonstrate improvement and on-going adjustments as needed.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

The non-residential Counseling Program provides non-residential services for youth and their families in primarily Columbia, Dixie, Hamilton, Lafayette and Suwanee Counties. The non-residential component consists of a one (1) Family Action Senior Residential/Non-Residential and 1 Family Action Case Manager. The program's Direct Care initially handles calls for service from the public, as well as calls through the crisis intervention and screening services. The screening determines eligibility and 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 has coordinates the Case Staffing Committee, a statutorily-mandated committee that develops a treatment plan for habitual truancy, lockout, ungovernable, and runaway youth when all other services have been exhausted or upon request from the parents/guardians. The Case Staffing Committee can also recommend the filing of a CINS Petition with the court if needed.

CDS Family and behavioral health services, Inc is contracted to provide both shelter and non-residential services for youth and their families in Hamilton, Columbia, and swannie County. The program provides centralized intake and screening twenty-four hours per day, seven days per week. Trained staff are available at the program site to determine the needs of the family and youth. Upon referral, a screening for eligibility is conducted and the screening is the initiation of the assessment process. Information regarding the youths' presenting problems, living situation, etc. is collected. Upon intake into either program (residential shelter or non-residential services), a more thorough assessment is completed. The facility at this time has two full time counselors one is a licensed counselor who provides services to the residential clients as well as carrying a small case load of non-residential client. The other counselor is a master's level registered intern who sees non-residential clients in the school and at home for a total of twelve week program. After all assessments are completed, and a case services plan with the family during the initial family session is developed. If the assessment indicates the need for a referral to a more intensive or specialized service such as substance abuse or mental health treatment, the counselor makes the necessary referral for service. After the development of the case service plan, the counselor works with the family to implement the plan. Counselors document progress towards completion of the service plan goals.

2.01 Screening and Intake

Satisfactory

Limited

Failed

Rating Narrative

There is a Screening and Intake policy in place for both the residential and non-residential programs.

I received 8 files both residential and non-residential. All screenings were completed within either on the same day as intake or the next day, which exceeds what the standards say of seven calendar days of a referrals. All the eight charts that were received all showed that the parents, and youth were given a copy of the rights and responsibilities, the grievance process, and all charts had a copy a list of resources that are in the area that the family or youth could use if needed, which exceeds what is listed in the standards. The intake paperwork also gave the clients and parents information regarding the CINS/FINS services that this agency offers to all their clients information about case staffing committee, CINS petition and CINS adjudication.

All files reviewed were marked confidential and were well organized. This made it easy to find all required documents.

Out of the 8 files reviewed 1 file was missing the initiated date for services and was also missing initials on the "mother's sheet" form by each entry showing that the parent/guardian did complete all forms, after looking at the chart it did show that the parent/guardian had completed all the forms with signatures and dates on each form. Out of the 8 files 1 was missing a staff signature and date on the discharge inventory statement form.

2.02 Psychosocial Assessment

Satisfactory

Limited

Failed

Rating Narrative

The provider has a psychosocial assessment form in each chart for assessing the needs of each client after they have completed that intake paperwork. Out of the 8 files received both residential and non-residential, all of the eight files had the assessment forms filled out either the same day as the intake or the next day, which exceeds the standards of completing the assessment within 72 hours for residential clients and 2-3 face to face contacts for non-residential clients. All the eight files were completed by a master's level counselor and had supervisor sign off on each file. This also exceeds the standard as the standard reads that the psychosocial assessment are to be completed by either a bachelor's or master's level staff. This facility at this time only has master level and licensed counselors and case managers. Out of the eight file 1 file had a positive hit for suicide on the intake questionnaire form. The policy for a positive hit on suicide is to have the client transported either by their caregiver or the police department to the local Mental Health agency Meridian Behavioral Health Care, Inc to have a professional assess for he risk of suicide. If the youth is released from MBHC without any finding of current risks of suicide then the youth returns to the

facility with a discharged summary from MBHC and the youth is placed on constant sight and sound. The licensed counselor on sight then sees the youth and completed the suicide assessment within 24 hours.

No Exceptions

2.03 Case/Service Plan

Satisfactory

Limited

Failed

Rating Narrative

This facility developed their case or service plan with their youth and parents if they are available at the time. After reviewing all eight charts all of the eight charts showed that the case plan was completed within the allotted time frame for the standard, which is 7 working days following the completion of the assessment. Each plan had goals listed and needs that were identified on the intake assessment listed on each plan, each plan also has objectives and used role playing and worksheets to document the progress being made by each youth on their specific goals. All eight charts had the following on each service plan; type, frequency and location of service, the person responsible, target dates, completion dates, date when plan was initiated and signatures of all responsible parties. The charts included goals and objectives for the youth that included, but not limited to, improve school attendance, increase anger management skills, develop positive decision making, and learning positive communication skills with authority figures.

Two out of the eight files had reviews completed, of those all information was completed with notes correlating with the review of the services plan with the youth and their caregivers. Two out of the two charts that had reviews were completed before the due date which exceeds the standards of having a review completed every 30, 60, 90-day intervals.

No Exceptions

2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

Rating Narrative

I reviewed eight files, all eight files all showed a referral had been completed for services after discharge. Referrals are being completed based on the needs of the youth and families to the local agencies. For services that included but not limited to, medication management and substance abuse. It was shown through out the chart in the notes and service plan which goals and objectives the youth was working on and when the youth had completed the goals was also listed both in the session notes and on the service plan.

One out of eight of the files completed a referral for case management staffing. The case staffing documentation was all completed with recommendations for the youth and family to complete, the notes prior to the case staffing showed that the youth and family as well as the counselor did follow up and make sure that all the recommendations were being followed and completed. Within the past year since the last audit there was only one youth that had a referral completed for a case staffing, this chart had all the completed paperwork for the case staffing process. It was noted that this youth did not need any other follow up case management services and did not need to pursue any judicial interventions as the youth and family completed all the recommendations by the completion date.

Both programs have a 180-day follow up binder and combined they are at 99 % compliance based on the year to date Florida Network Netmis report.

No Exceptions

2.05 Counseling Services

Satisfactory

Limited

Failed

Rating Narrative

All of the eight files that were reviewed indicated and documented service plans which addressed the needs of the youth and family that were reflected on the assessment and intake forms. All of the charts had documented progress notes which explained all services being provided to the youth each entry had a signature and a date of the counselor. All the progress notes reported that monitoring of progress being made by the youth each session and what goals they are working on and which goals they have completed. Out of the eight files two had case plan reviews. Both reviews had correlating progress notes showing the connection between the counselor, youth and family.

The shelter is providing group counseling seven days a week on diverse subject matter such as the following: substance abuse, coping skills, emotional intelligence, character education, sexual health, crime, integrity etc. The shelter has a group counseling spiral notebook that shows

the dates and group content of each group reported. There were a few times within the past 6 months in which the counselor had group 2 times in one week regarding two separate topics. Each entry had the date, and signature of the counselor facilitating the groups. It was also noted in the book on a few occasions that group did not happen due to only having one child in the shelter. It also reported on a few occasion that the groups did not happen due to staff sickness, holidays or vacations.

The facility has a policy of reviewing the charts. This policy includes; a list of each chart that was reviewed, date of review, any corrections that have to be completed to the chart and by whom, a review date and lists if the corrections have been completed by the next review date.

No Exceptions

2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

Rating Narrative

The facility has only had one youth since the last audit that has been referred for the case management staffing. This chart indicated that this youth did attend a case staffing with a list of the local case staffing members present that include; MBHC, DCF, DJJ, CPS, Christ Central, and CDS. The team decided on goals and objectives for the youth and family to complete by a target date, which was completed before the date it was due, via the progress notes and referral forms completed by the youth, family and staff. Through the policy and procedure and talking with the staff on-site it was documented that if a youth was to attend the case staffing and not comply with the recommendations, the team would attend another case staffing were the team would let the youth and family know the importance of completing all the services that were listed in the case staffing, and if the goals/services are not completed then the team would refer the youth and family to the court system.

It was reported that the staff tries to make every effort to help the youth and family to obtain all the goals and services. The petition process is used as the last resource for the youth and family.

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

All of the eight youth records reviewed were marked confidential and are kept in a locked secure location.

Each file had a table of contents that listed all the services and location of the service in the chart

Of the eight charts 3 were open in binders, with separate dividers for sections that kept files organized and easy to access information for the open charts and youth.

Of the eight charts 5 were closed charts. These charts were not as organized as the open charts. These files they were placed in a manila folder and did not have dividers in the chart listing the different sections of the paperwork in the folder, which was confusing.

Best practice would be to have dividers in all sections to make it more organized and make it easier to access the information in the chart.

Standard 3: Shelter Care

Overview

Rating Narrative

The CDS IYP-NW youth shelter is located in Lake City, Florida in Columbia County. The facility operates twenty-four hours per day, seven days per week, every day of the year 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 seven (7) youth in the shelter. The shelter is comprised of a detached building that has separate split level design with female and male sides of the facility. Each residential side of the shelter can accommodate up to six (6) youth. The female and male sides of the facility are separated by a dayroom. The facility includes a kitchen, Direct Care Work station, dual function dining areas 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. There is a kitchen onsite where all meals are prepared. 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 program staff for the Residential staff includes two (2) Regional Coordinators, one (1) Senior Youth Care Worker, twelve (12) Youth Care Workers and 1 administrative. A Senior Residential Counselor and a Case Manager are also 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 medication and first aid supplies are stored in the staff office in a locked desk behind a locked door near the dining/office area. The Direct Care Worker staff offices are located inside the youth shelter adjacent to the day room. The residential shelter also includes administrative offices for both Regional Coordinators, Counselors and Case Managers and the administrative Assistant. 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 hours of being submitted to management.

At the time of the quality improvement review, the shelter was providing services to seven (7) CINS/FINS youth. The shelter is not designated by the Florida Network to provide staff secure services and is not licensed under Chapter 397.

CDS Interface NW was built in 1998 and was expanded on in the spring of 2011 to incorporate a new Boys and Girls dorm and living area as well as a multi- purpose room. The Program is very clean and well kept inside and out. The Program has gone above and beyond in their Policies and Procedures in this Standard Area. The Program has developed documentation to capture data in this standard to help improved the Shelter Environment. Although the Program has gone above and beyond in creating their documentation the consistence with filling it out still needs to be worked on. The Program has met all requirements when it comes to Staffing requirement however they do need to work on the recruitment of more qualified male staff to ensure every shift is covered by at least 1 male and 1 female staff on each shift.

3.01 Youth Room Assignment

Satisfactory
 Limited
 Failed

Rating Narrative

The program has very clear P & P regarding Youth Room assignments and the supporting documentation that is provided in the charts go above and beyond the requirements of the standards. I reviewed 8 client charts today. 4 open and 4 closed charts. Of those only one chart had a Collateral Contract due to being placed on constant sight and sound. All required documentation for this standard was provided within the chart and was very understandable.

Even though the program exceeds the required documentation for this standard they are not consistently using all of their documentation to its fullest. The Screening Health Addendum form is not being completed in 5 of 8 charts reviewed this form was not completed. The Information for Parents checklist Form there was 6 of the 8 charts reviewed that this form was not checked. Also, the Alerts Listed on the face of the client binders of the 8 charts reviewed 7 were not completed and one of those the client was on medication and had Suicide Alert that was not circled.

3.02 Program Orientation

Satisfactory
 Limited
 Failed

Rating Narrative

The programs P & P regarding Program Orientation is very clear and well organized. The Program goes above and beyond in there documentation when it comes to this Standard. I reviewed 8 file, 4 open and 4 closed charts. All the charts have clear documentation within this standard.

There are no exceptions in this standard at this time.

3.03 Shelter Environment

Satisfactory Limited Failed

Rating Narrative

The Program has all safety, fire and health inspection current with nothing being sited on any of them. Facilities furnishing are very well kept and free of graffiti. The grounds are very well maintained and the lighting inside and out are adequate. The youth have lockers accessible to them to lock up any personal items if requested. The bed linens are clean and usable.

The program conducts several fire drills a month which is above the standards requirements. However, after reviewing the last 6mths of the fire drill log it was observed that on the average each month there is several drills that are over the required 2min time and best practices would be to look into the reason for that and try to bring that time down to below 2min.

3.04 Log Books

Satisfactory Limited Failed

Rating Narrative

6mths of log books reviewed. Log Books are bond books that are set in 2 week increments. Log Book captures a lot of information and allows supervisors to post pass down information for all staff to see. A color coded highlighting system is in place but does not appear to be consistence.

All though there is several signatures of staff throughout the logbook it does not appear to be constant that each staff signs and review each shift. Best Practice would be that Directors and Counselors when reviewing the log book do so in a different color or highlight their entries so staff can distinguish the entries. Corrections in log book are sometimes struck through with several lines and not initialed.

Rating Narrative

The program has a very clear schedule posted throughout the facility that is easily accessible to the youth and staff. The schedule accounts for all required activities listed within the standard.

There are no exceptions in this Standard at this time.

3.06 Behavior Management Strategies

Satisfactory Limited Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of this indicator. All staff receives training in the use and implementation of the FACE system (Facilitating Activity & Communication Effectively).

The CDS IYP Northwest shelter program utilizes a behavior management system that is clearly defined in the Participant Orientation Packet provided to youth during the intake process. During the intake process the FACE system is explained to youth along with the associated privileges and consequences at the three different phases.

The FACE system accommodates youth at three different phases. The assessment phase is entry level lasting for 3 days designed to give the participant an opportunity to become familiar with the system. The daily phase is where the participant is expected to understand the system and demonstrate the appropriate life skills behaviors, thus accumulating points assigned by staff towards privileges. The achievement phase differs from daily phase in that participant's have the opportunity to engage with staff in negotiating their points to obtain their privileges for the next 24 hours.

Youth earn points throughout the day that are recorded by staff on an individual youth point sheet. The points are totaled up daily at 4:30pm during point conference and youth are placed on the appropriate level for the following 24 hours based on their point accumulation. Youth may move between phases (up or down) after each 24 hour behavioral assessment period. Youth may also be offered the opportunity to earn extra points for volunteering to complete extra tasks or chores or assisting staff with daily programmatic activities.

Youth may lose points or could result in the participant moving to the Sub System status for any of the following reasons: running away, physical violence, sexual activity, usage or possession [of tobacco products, firearms, weapons, explosive devices, alcohol or drugs], criminal activity, suspension from school, destruction of property; personal or program, possession of lighter or matches, entry into the bedroom of participants of opposite gender.

The CDS IYP Northwest shelter also defines specific rights and responsibilities for youth and staff to follow during their time at the shelter to encourage appropriate behaviors, positive relationships and a safe environment.

If youth feels that an error was made in the daily points or phase assignment they can verbally appeal to staff or a program supervisor and file a formal grievance if the issue is still not resolved.

An interview with program staff indicated that they believe the current FACE system is effective, especially for youth who placed at the facility for less than 30 days, but may lose some effectiveness for the few youth who stay for longer periods of time.

Staff is trained during new employee orientation and yearly on the behavior management system. Management monitors staff execution of the FACE system and reviews findings with staff at their staff meetings and yearly evaluations.

3.07 Behavior Interventions

Satisfactory

Limited

Failed

Rating Narrative

The program has a Behavior intervention policy which was last reviewed and approved by the agency COO in 2012. The program staff is not trained to use any physical intervention, which is in accordance with their "hands off" policy. The staff is trained in verbal de-escalation and emergency crisis intervention techniques during new employee orientation and annually. If a youth's behavior becomes beyond the staffs control no physical intervention takes place, instead law enforcement is called. The program does not use group punishment, room restriction, or deny any youth their basic needs such as but not limited to regular meals and snacks, clothing, sleep, physical or mental health services, educational services, exercise, contact with parent/guardian(s) or religious needs.

There are no current or past physical interventions regarding this indicator.

3.08 Staffing and Youth Supervision

Satisfactory

Limited

Failed

Rating Narrative

The program has very clear policies and procedures for Staffing and Youth Supervision in place. All shifts are covered according to Florida Administrative Code with a 1:6 ratio during waking hours and 2 staff on every overnight. Schedules are posted on a dry erase board in the Direct Care offices. On-call schedules are covered by available PRN employees but if not them they try to evenly cycle through the staff to be fair to everyone. The program has a very good accountability system for the overnight bed checks and it clearly shows that bed checks are completed every 10 mins which is clearly above and beyond the standard.

Exceptions- due to limited staff the weekend 3 to 11pm shift appears to be staffed by 2 female staff on a regular basis. Best Practice would be that the program tries to recruit more male staff to correct this situation to get within the current standards.

3.09 Staff Secure Shelter

Satisfactory

Limited

Failed

Rating Narrative

This Agency is not considered a Staff Secure Facility according to the Network.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The CDS-NW 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 has 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 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 to address the requirements of this indicator. The current policy related to this indicator is called the Residential Admission: Preliminary Physical Health Screening. The purpose of the policy is to ensure that residents admitted to the youth shelter have no acute health or medical conditions that require immediate medical attention and do not possess conditions that the agency is unable to adequately address and poses no harm to the resident, other youth and staff in the facility.

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) Section 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 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 nine (9) cases (4 open and 5 closed files) were reviewed to assess requirements of this indicator. Of the client 9 files reviewed, all files contain the fourteen (14) page 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 nine (9) files reviewed contained evidence of general documentation of the majority of health screening questions. There are minor exceptions noted across both open and at least one closed client file.

The current written policy /procedure does not fully explain the the medical or health referral process and follow-up medical care. The policy should provide additional instructions on the medical/health steps the agency staff members are expected to follow when screening for health conditions.

Of the 4 open cases, 1 open case did not document the correct health question number response on the 28 question General, Physical Health Screening section to match the resident's existing medical condition of a sprained ankle. The form only documented a number 1 for ankle-sprain when it should have marked 1 for recent injury and 2 for current pain. Another open chart does correctly mark that the client was recently hospitalized, but the staff member completing the screening did not fully documentation of the reason why the client was hospitalized. One (1) closed file does not document reason for taking medication in the general summary section of the health screening form similar to other files of youth that are also taking medications. In general there is some discrepancy in whether staff members are to document brief explanation for a "Yes" response for taking medications in that section or in the summary section at the bottom of the file.

4.02 Suicide Prevention

Satisfactory

Limited

Failed

Rating Narrative

The agency had a written policy and plan that outlined the suicide prevention and response procedures. The title of this policy is Suicide Assessment. The policy was last updated on March of 2009. The plan indicated each youth admitted to the shelter will be screened for suicidal risk by using the Intake the six (6) suicide risk questions on the CINS/FINS Intake form. If the youth answers "yes" to any of the 6 questions, the 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 room respectively. Once the youth is on sight and sound observation, a full assessment is conducted by the Licensed Mental Health Counselor (LMHC). 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.

The shelter utilizes three (3) levels of supervision: constant sight and sound, discontinue sight and sound; and normal supervision in the general population. 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.

A sample of three (3) client files over the last six (6) months was conducted onsite. A total three (3) closed files were reviewed. All 3 files contained evidence of general documentation that indicated a suicide risk screening was completed during the initial intake and screening process. All 6 files contained documentation that indicated the suicide screening results were reviewed and signed by the supervisor who was also the licensed mental health counselor or a Masters Level Counselor under the supervision of 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 or non-licensed staff under the direct supervision of the licensed professional. The supervision level was not changed or reduced until approved by a licensed professional. All 3 cases were applicable for requirements of a suicide risk assessment and were applicable for sight and sound supervision requirements. All 3 youth were placed on the appropriate level of supervision based on the suicide risk assessment results. All 3 files contained the required documentation. Supportive documentation was reviewed to include precautionary observation logs and thirty minute checks. Each case contains 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 three (3) separate log books.

Two (2) of three (3) files do not have evidence of the shift supervisor's signature on the agency Observation Log on the Day Shift counts when remove and sound 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 agency medication policy was last updated in July 2012. The current policy includes section that include 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 agency houses medication documents in individual client files. Each resident has a three (3) ring binder that includes a total of eight (8) sections. The Medication section is located in section two (2) of the client file.

An onsite observation of storage practices was conducted to determine the agency's adherence to this indicator. This review found that all medication was stored behind a locked door. The resident medications were maintained in a key locked metal cabinet inside a combination locked aluminum box. The medication room has a locked door that limits entry and is not accessible youth. Oral medications and topical medications are stored separately. All oral medications are stored in plastic zip locking bags labeled with the residents name on the outside of the bag that is housed inside of hard plastic container. Similarly, all oral medications are stored in plastic zip locking bags labeled with the residents name on the outside of the bag that is housed inside a plastic container.

The facility has a secure refrigerator that is designated for medication only. At the time of this onsite QI review, the refrigerator was operational and had no contents. The agency does not provide over-the-counter medication and did not have any stock over-the-counter medications. A perpetual inventory with running balances was maintained for all medications. All controlled medications are counted once per shift, three (3) times per day. All non-controlled medications are counted when given and a minimum of once per week. At the time of the review, there were both controlled and non-controlled medications were being maintained by facility. The sharps maintained at the shelter consisted of scissors and a pill cutter. The shelter maintained a weekly count of the sharps at each shift change for the last six (6) months. The sharps form documents that a certain sharp was counted and a signature of the staff person that conducted the count.

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 files have major sections completed including the client's name of youth, name of pharmacy, date that medication was dispensed by the pharmacy, name of prescribing provider, directions for use, expiration date and warning statements.

The policy also requires that staff members must follow measures/steps to ensure that all medication entering the shelter originate from a licensed pharmacy. The policy addresses that all medications that enter the facility with a resident admitted to the program must be accompanied by a doctor's prescription. Of the cases reviewed onsite, all cases had evidence that the medication entering the facility included documentation that the agency verification process was completed by a staff member. The Verification section on the MDL does not include the actual date that the verification was conducted and the staff member that completed the process. Its recommended that the Verification process/form be revised to include the actual date that the verification was conducted and the staff member that completed the process.

A review of active medication distribution logs of youth currently in the shelter on medications were conducted onsite. A sample of the medication distribution records included two (2) current medication charts and six (6) closed charts. These medication charts were reviewed to assess the agency's adherence to standard. Seven (7) out of eight (8) files have major sections completed including the client's name of youth, picture, medication dosage, allergies, side effects, staff initials, youth initials. The Medication Distribution Log (MDL) contains evidence of the staff member's printed name, signature and initials. A review of The MDL in all 8 charts indicates that Youth initials are documented, but no full signatures are documented.

The medication distribution logs (MDL) of one (1) closed client file case found counts that indicate that the shift to shift counts on October 3, 2012 were not documented consistently with MDL dosage chart for the same period. The majority of sharps counts are both signed and checked by the staff person completing the count. Sharps counts conducted for the months of January 2013 and February 2013 do not have evidence of a signature and check in each sharp category as the previous four (4) months. The current verification section on the MDL does not clearly document the date when the medication was actually verified by a staff person. At the time of this onsite program review, the items in the agency medication box included a pill cutter. The agency was instructed that all pills requiring splitting are the responsibility of the residents' parent/guardian or they should be returned to a pharmacy for spitting. Two (2) MDL charts are missing a colored dot on the MDL log that corresponds with the medication that is stored in the medication cabinet. Three (3) MDL charts are missing documentation of any know allergies. One MDL chart is missing evidence of documentation of the reason for the medication.

4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy and procedure in place that addresses all requirements of this indicator. A total of six (6) files were reviewed for this indicator (three open and three closed). Five out of 6 files reviewed indicated that the youth has either a current or past medical condition or a mental health condition. In each case there was proper documentation that the programs alert system policy was followed.

The program has a participant information board which indicates which youth has a medication alert. This board was observed to be accurate and reflected proper alerts for current clients. In addition, alerts are placed on client files on the Intake/Assessment Form, the Medication Record Log form and on the outside cover of the client's file with either an "Allergy" or a "Medical/Mental Health Alert" label. If a youth has a food allergy it is the programs policy that the alert is posted in the kitchen on the special diet/food allergy board. There were no youth in the program during the review with a food allergy.

Participant board and program logbook entries were reviewed to indicate staff members were provided sufficient information and instructions regarding the youth's medical condition/concerns, allergies and information to allow them to recognize and respond to the need for emergency

care and treatment.

4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

Rating Narrative

The program has a facility operating procedure to facilitate the provisions of emergency medical and dental care to include obtaining off-site emergency services, parental notification and implantation of a daily log. The policy indicates that all staff is trained in emergency procedures to include First Aid and CPR. After reviewing 12 personnel files all staff were up to date on their certifications. Knife –for- life and wire cutters were located in the Direct Care Office. First aid kits are maintained in the Direct Care Office. After interviewing the Co-Regional Coordinator, she reports that there has not been any cases of Emergency care within the Program in the last two years to the best of her memory. When checking the CCC incidents and internal incidents there was no Emergency Incidents to be found.

There are no exceptions at this time.